



JEFFERSON
BEHAVIORAL
HEALTH

Managed Mental Health Care Organization for Coos, Curry, Douglas, Jackson, Josephine, and Klamath Counties
900 SE 8th Street, Suite 100, Grants Pass, Oregon 97526 • Phone: 541-955-9565 • Fax: 541-955-8290

INDIVIDUAL PROVIDER OUT-OF-PANEL CREDENTIALING APPLICATION

DEMOGRAPHICS

Name (Last, First, Middle)

Office Address

City

State

Zip Code

Office Phone

Office Fax

Email

BILLING INFORMATION

Billing Contact

Billing Contact Phone

Billing Address (*if different from office address*)

City

State

Zip Code

Federal Tax ID: _____

PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier

Phone

Address

City

State

Zip Code

Policy Number

Coverage Dates

Policy Type

Coverage Amount Per Occurrence

Policy Expiration Date

ADDITIONAL QUESTIONS

(Please answer the following questions. If you answer Yes to any question, please use a separate sheet of paper to provide an explanation.)

	Yes	No	Not Applicable
Has your license ever been limited, restricted, suspended, revoked or voluntarily surrendered, denied or not renewed, or are any of these actions pending with respect to your license?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been reprimanded by a state licensing agency or are you under investigation by any licensing or regulatory agency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your agency ever been sanctioned by Medicare or Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past seven years have you been convicted of a felony or misdemeanor or are you under investigation with respect to such conduct?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have professional liability claims ever been assessed against you or are there any professional liability cases pending against you now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your liability insurance carrier cancel, refuse coverage or had rate increases because of an unusual risk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL DOCUMENTATION

(Please attach copies of the following documents, if applicable):

- Current State Licenses
- Current Federal DEA Registration
- Board Certification Certificates
- Proof of Current Professional Liability Insurance

CERTIFICATION OF INFORMATION

By signing the below I certify that:

- The information provided is true and correct.
- If any of the information should change I will notify Jefferson Behavioral Health within three (3) days of the change.
- I hereby give Jefferson Behavioral Health permission to verify any and all credentialing information.
- I understand that this credentialing review does not grant me participation as a network provider for Jefferson Behavioral Health. I am only able to see Oregon Health Plan members that are specifically approved on a case-by-case basis by Jefferson Behavioral Health.

Signature

Date