



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 CREDENTIALING/RE-CREDENTIALING APPLICATION

DEMOGRAPHICS

Name (Last, First, Middle)

Office Address

City

State

Zip Code

Office Phone

Office Fax

Email

OFFICE INFORMATION

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Billing Contact

Billing Contact Phone

Billing Address (if different from office address)

City

State

Zip Code

Federal Tax ID: _____

Customary Charges	Dollar Amount
Assessment (90801)	
Medication Management (90862)	
Individual (90806 and 90804)	
Family Therapy (90846 and 90847)	
Group Therapy (90853)	
Psychological Testing (96100)	
Case Management (per 15 minutes)	
Skills Training (per 15 minutes)	

PRACTICE TREATMENT INFORMATION

Age Categories:

- Geriatrics (65 and older) Adult (18-64) Adolescent (13- 17)
 Older Child (6 - 12) Younger Child (0 - 5)

Specific Categories:

- Group Therapy Anger Issues
 HIV/AIDS Borderline Personality
 Trauma Domestic Violence
 Developmental Disorders Faith-Based Counseling
 Medical Co-Morbidity Sex Offender Treatment
 Psychological Testing Medication Management
 Sexual Disorders Eating Disorders
 Gay/Lesbian Issues Marriage/Family
 Co-occurring Disorders Fire Setting Evaluation
 Other _____

Languages Spoken by Provider and Staff:

 Provider

 Staff

Please describe your 24-hour or crisis coverage:

Does your office space meet the ADA Accessibility Standards?

Yes No **(please describe)**

Type of Practice:

Solo Single Specialty Group
 Multi-Specialty Group Other: _____

Do you currently have Medicare Certification? Yes No

Treatment Philosophy/Strategies Utilized:

Please describe how clinical supervision is obtained:

LICENSURE AND CERTIFICATIONS

Please mark the following license(s) that you carry in the State of Oregon:

- | | |
|---|-----------------|
| <input type="checkbox"/> Licensed Clinical Social Worker | License # _____ |
| <input type="checkbox"/> Licensed Marriage and Family Therapist | License # _____ |
| <input type="checkbox"/> Licensed Professional Counselor | License # _____ |
| <input type="checkbox"/> Registered Nurse | License # _____ |
| <input type="checkbox"/> Medical Doctor | License # _____ |
| <input type="checkbox"/> Licensed Psychologist | License # _____ |
| <input type="checkbox"/> Psychiatric Nurse Practitioner | License # _____ |
| <input type="checkbox"/> CADC | License # _____ |
| <input type="checkbox"/> Other – please describe below | |

Please list other licenses, credentials or certificates (e.g. board certifications, licenses in other states):

Please list any professional affiliations/memberships (e.g. NASW, APA):

Have you ever worked in a public agency in which you have been deemed a Qualified Mental Health Professional (QMHP)? Yes No

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

PROFESSIONAL REFERENCES

(Please list three peers who have direct knowledge of your clinical abilities. Do not include family members.)

Name _____ Phone: _____

Address _____ City _____ State _____ Zip Code _____

Name _____ Phone: _____

Address _____ City _____ State _____ Zip Code _____

Name _____ Phone: _____

Address _____ City _____ State _____ Zip Code _____

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):

- Resume or CV
- Current State Licenses
- Current Federal DEA Registration
- Board Certification Certificates
- Proof of Current Professional Liability Insurance
- Official Transcripts *(Transcripts only need to be provided if you currently do not have a state issued license to practice medicine, mental health or chemical dependency treatment.)*

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