Screening Application for Autism Services

EVERNORTH℠

CLEAR FORM

Thank you for your interest in joining the Evernorth Behavioral Health network as a provider of autism services. To consider your practice for network participation, please complete this application and submit it, along with required attachments, to the Evernorth Behavioral Health Contracting Unit at **BehavioralOutpatientClinic@Evernorth.com**.

You can expect a response within 30 days upon receipt of your completed form. Please do not include any additional paperwork (résumé, licenses, etc.) unless requested. **Submission of this screening application does not constitute an offer to join the Evernorth Behavioral Health network and is for screening purposes only.**

Submit the following documentation with this application:

- Service location form(s):
  - A Physical Service Location Form for each service location and clinician
  - If your practice has a home-visit-only service model, please complete a Home-Visit-Only Service Location Form
  - If your practice has a telehealth-only service model, please complete a Telehealth-Only Service Location Form for each service location and clinician
- Completed W-9 forms
- Proof of current professional liability insurance coverage (policy face sheet or certificate of insurance that identifies the clinic named in the application and indicates liability limits and expiration date, and may not be binder policies)
- A sample of your clinic's standardized treatment record forms

Clinic name:	Legal/taxpayer name (as registered with the IRS):	
Taxpayer Identification Number (TIN):	National Provider Identifier (NPI):	Clinic may also be known as :

If your organization uses multiple TINs, please identify the NPI for each TIN:

Taxpayer Identification Number (TIN):	National Provider Identifier (NPI):	Taxpayer Identification Number (TIN):	National Provider Identifier (NPI):
Taxpayer Identification Number (TIN):	National Provider Identifier (NPI):	Taxpayer Identification Number (TIN):	National Provider Identifier (NPI):

PRIMARY CLINIC CONTRACTING CONTACT

Primary contracting contact name:	Title:	Primary contracting email address:	Primary contracting telephone:

ADMINISTRATIVE/MAILING ADDRESS

Clinics (including clinics with multiple locations) can only have one mailing address.
Authorizations and administrative correspondence for all office locations will be sent to this address.

Primary administrative contact:	Title:	Administrative telephone:	Fax number:	
Administrative street address/PO Box:	Suite number:	Administrative city:	State:	Zip Code:
Administrative contact's email:				

CLINIC BILLING ADDRESS

All payments will be sent to this address and Tax Identification Number (TIN)

Primary billing contact:	Title:	Billing telephone:	Billing Fax:	
Billing street address/PO Box:	Suite number:	Billing city:	State:	Zip Code:

CLINIC EMAIL ADDRESS

Please provide a valid email address for each of the three categories to ensure our communications are routed appropriately.

General communications:	Credentialing/contracting:	Billing:

CLINICAL CONTACT INFORMATION

Primary clinical contact:	Title:	Clinical contact telephone:	Primary intake telephone:

Does your clinic have a website? If so, please list here:
☐ Yes ☐ No

Does this website support self-service appointment scheduling? ☐ Yes ☐ No

Please note: users may schedule appointments through this website without direct assistance or correspondence with office staff (i.e., does not include requesting appointments via email, phone, or online form).

Does your clinic have an email address to list in the directory? If so, please list here:
☐ Yes ☐ No

ADMINISTRATIVE INFORMATION

Group professional liability/malpractice insurance *(check all that apply)*

☐ Each prescriber individually insured for limits of: _____

☐ Each non-prescriber individually insured for limits of: _____

☐ Group liability insurance coverage for limits of: _____

Is your practice licensed as a group or is the group operating under providers' individual licenses?

_____

If your practice is licensed as a group, is it accredited?

_____

CLINICAL PROGRAM INFORMATION (AUTISM)

Services Check off the services your agency provides and please indicate how many staff members provide each service.

☐ Assessment Number of staff: _____

☐ Applied Behavior Analysis (ABA) Number of staff: _____

☐ In-home services Number of staff: _____

☐ Social skills groups Number of staff: _____

☐ Individual/family counseling Number of staff: _____

☐ Telehealth Services Number of staff: _____

☐ Other service (please explain) _____ Number of staff: _____

Staff composition Please indicate the number of staff members at your group who fall into each category.

		Full time*	Part time
☐ MD, DO, APRN	Number of staff:		
☐ Independently licensed, PhD level	Number of staff:		
☐ Independently licensed, master's level	Number of staff:		
☐ Board Certified Behavior Analyst® - Doctorate	Number of staff:		
☐ Board Certified Behavior Analyst	Number of staff:		
☐ Board Certified Assistant Behavior Analyst®	Number of staff:		
☐ Nonlicensed, uncertified	Number of staff:		

**24 clinical hours/week constitutes full time*

Please describe your assessment process(es) for new patients. Does you assessment include psychological testing? How long is an average assessment?

_____

What staff composes the treatment team?

_____

Behavioral telehealth:

☐ Yes - I attest that our clinic provides qualified behavioral telehealth services.

☐ No - Our clinic does not provide qualified behavioral telehealth services.

Does this clinic provide Telehealth Services out of this location? ☐ Yes ☐ No

If yes:

☐ Do you provide phone appointments for your Telehealth Sessions *(check box if yes)*?
If necessary, can caregivers participate in phone appointments? ☐ Yes ☐ No

☐ Do you provide Video Appointments for your Telehealth Sessions *(check box if yes)*?
If necessary, can caregivers participate in phone appointments? ☐ Yes ☐ No

☐ Do you provide Remote Patient Monitoring *(check box if yes)*?

Specialties:	Locations:
Autism - Applied Behavior Analysis (ABA)	
Autism - Testing and Assessment	
Autism - Social Skills Group	

Specialty networks

Disorders and treatment modalities:

Specialty networks:	Locations:
Autism - Applied Behavior Analysis (ABA)	
Autism - Social Skills Group	
Autism - Testing and Assessment	
Autism - Treatment	
Developmental Disorders	

Clinic Attestation

I understand that if Evernorth Behavioral Health extends a contract, the participating clinic agreement will include all lines of business. All Evernorth Behavioral Health customers will be treated equally and providers credentialed and affiliated with the clinic locations will be considered contracted. Evernorth Behavioral Health customers may not be charged out-of-network rates. The clinic certifies and attests that all of the information above is true and accurate, and misstatement or omission may result in denial of application with or without appeal. If credentialed as an Evernorth Behavioral Health participating clinic, we will cooperate during a specialty documentation audit, if requested, to verify that the outlined criteria for participation in the specialty network(s) is met. It is understood that any information provided pursuant to this attestation that is subsequently found to be untrue or incorrect could result in the termination of the clinic from the Evernorth Behavioral Health network. A copy of this attestation shall have the same force and effect as the signed original.

Practice information: Appointment availability

Evernorth requests all provider applicants to be accessible for routine appointments within 10 business days. Please select and attest to any of the following that also pertain to the provider's accessibility and expertise.

If "Crisis Stabilization 24/7" is selected, the clinic attests to the following:

- Agrees to be available through the use of pagers and/or answering services to Evernorth customers after hours and on weekends.
- Voicemail does not routinely instruct customers to go to the nearest emergency room unless determined to be medically necessary.

If "Crisis Stabilization Non-24/7" is selected, the clinic attests to the following:

- Agrees to be available for crisis appointments during business hours only (8:00 a.m. to 6:00 p.m.).

If "Intermediate Care (Urgent)"is selected, the clinic attests to the following:

- Is willing to provide precautionary and preventive care to a customer within 48 hours in order to prevent escalation to a higher level of care.

If "Meet and Greet" (non-physicians only) is selected, the clinic attests to the following:

- Is willing to conduct a pre-discharge visit with a hospitalized customer in order to coordinate and schedule an ambulatory follow-up appointment within two to seven days after discharge.

Specialty networks: Criteria for inclusion

To participate in one of Evernorth Behavioral Health's specialty networks, please ensure the clinic meets the qualifications as outlined. Provider attestation will be required for each specialty chosen as well as an attestation for cooperation in a specialty documentation audit. Any required documentation will be requested at a later date. To claim a specialty in one of the following clinical specialties and/or populations, the clinic and its providers must meet one or more of the following conditions for each specialty:

1. Certification by a nationally recognized certifying organization.
2. An internship, fellowship, or formal training program at an accredited institution focusing on treatment of one of the designated disorders or groups of patients, or use of one of the designated treatment modalities.
3. An accumulation of continuing education units or course work focused on current treatment of one of the designated disorders or groups of patients, or use of one of the designated treatment modalities.
4. Significant work experience focused on current treatment of one of the designate disorders or groups of patients. The depth and breadth of experience must demonstrate the attainment of knowledge and skills to be considered a specialist.

If "Dialectical Behavior Therapy (DBT) Adherent" is selected, the clinic attests that the provider will:

- Receive five continuing education units related to dialectical behavior therapy (DBT) per year.
- Have one year clinical experience with DBT.
- Have an established 24/7 crisis availability/plan.
- Participate in an ongoing peer consultation group.

If providing an "office email," is selected, the clinic attests to the following:

- All office email addresses are intended for patient communication, are regularly monitored, and are maintained in a manner consistent with state and federal health privacy laws.

Specialty patient populations

Please check at least one. By checking any age group other than adult, the clinic attests that it has a specialty with that population and is willing to participate in a specialty documentation audit.

Behavioral telehealth

If yes is indicated for "Do you provide behavioral telehealth services," the clinic hereby certifies and attests to the following:

- Meets all state requirements to provide behavioral telehealth services, including any licenses and certifications.
- Will provide behavioral telehealth services only in the state(s) where providers hold a license.
- Will utilize only a secure internet connection and follow all HIPAA requirements.*

*Please consult with the American Telemedicine Association (ATA), a leading international resource and advocate promoting the use of advanced remote medical technologies. They have a list of endorsed technologies for behavioral telehealth services.

CLINIC ATTESTATION

- ☐ **The clinic agrees to use only fully licensed (state licensed to practice independently and without restrictions) and credentialed providers to treat Evernorth customers.**
- ☐ **The clinic agrees to cooperate with Evernorth Behavioral Health's credentialing and recredentialing processes, including the Council for Affordable Quality Healthcare (CAQH) for all of its providers.**
- ☐ **The clinic agrees to participate in roster maintenance post-contract.**
- ☐ **The clinic agrees to participate in a telephonic orientation to Evernorth Behavioral Health's policies and procedures.**
- ☐ **The clinic has completed a review of applicable medical necessity guidelines and Behavioral Administrative Guidelines at Provider.Evernorth.com.**
- ☐ **The clinic understands that it can have only one administrative/mailing location, even if it has multiple practice locations.**

All information provided on this application or in connection with this application is complete and accurate to the best of the clinic's knowledge. Misstatement or omission may result in denial of application with or without appeal. The clinic understands that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in termination from the Evernorth Behavioral Health network. All information submitted to Evernorth Behavioral Health by the clinic will be treated as confidential.

_____ _____

Signature of chief administrator or authorized designee Date

_____

Print name and title of chief administrator or authorized designee

_____

Clinic name

NOTE: Please do NOT submit the online screening form for any individual practitioners if you are submitting the screening application for behavioral health clinics. If Evernorth Behavioral Health elects to pursue a clinic contract with your practice, you will receive information regarding how to credential the individuals as part of the contracting process.