Evernorth Facility Information Form

EVERNORTH℠

DIRECTIONS: To avoid the potential loss of data, please complete the following steps and submit this form.
Step 1: Save this application to your computer
Step 2: Complete the application in its entirety using Adobe Acrobat Reader DC
Step 3: Save the completed application to your computer
Step 4: Email it to **BehavioralFacilityRecruitment@Evernorth.com**

Dear Behavioral Health Care Facility,

Thank you for your interest in joining the Evernorth Behavioral Health network.

The application below is intended for facility-based services and is only a request for information, not an offer to contract. Your facility will receive written response from Evernorth upon receipt of this application within 30 business days.

The application includes the following sections:

- Facility Contact Information
- Accreditation, Licensure, Insurance
- Service, Billing and Mailing Addresses
- Facility Services and Programs
- Program-Specific Information for Medication Assisted Treatment *(only complete if applicable)*
- Behavioral Administrative Guide

Medical Necessity Determinations

Evernorth Behavioral Health uses a suite of existing evidence-based criteria to support your clinical judgment and decision-making processes. They are compliant with state and federal regulations, including parity, and align with and reference various professional organizations.

For more information about our criteria, visit the Evernorth Provider website (Provider.Evernorth.com) > Coverage Policies, see Supporting Behavioral Websites.

Sincerely,

Facility Contracting Team
Evernorth Behavioral Health

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Evernorth Facility Information Form

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Facility Contact Information

Facility Name:	
Director of Managed Care or contracting contact Name and address at your facility to whom the contract should be mailed.	Name: ______ Mailing address: Street ______ City ______ State ______ Zip ______ Email Address: ______ Telephone: (____) ______

Are you an employee of the facility or a consultant contracting on behalf of the facility?

☐ Employee of the facility ☐ Consultant

Accreditation/Licensure/Insurance

Prior to completing this application, please read our [Facility Credentialing Requirements] to ensure that your facility meets minimum requirements.

1. Identify the organization with which your facility is accredited:
   ☐ The Joint Commission ☐ AAHC ☐ CARF ☐ AOA ☐ CHAP ☐ COA ☐ DNV
2. Is your facility Medicare certified? ☐ Yes ☐ No
3. Does your facility have ASAM certification? ☐ Yes ☐ No
   What ASAM level(s) does your program(s) align to? ______
4. Does your state oversight agency perform an onsite licensing survey? ☐ Yes ☐ No
   If yes, what is the date of your last licensing survey? ______
5. Does the state provide you a copy of the survey results? ☐ Yes ☐ No
6. Is your facility licensed by the state for all services/programs that you provide? ☐ Yes ☐ No
   If no, which service/program is not licensed and why?
   ______
7. Does your facility have Professional and General Liability Insurance coverage? ☐ Yes ☐ No
   If yes, please list your coverage limits: ______

Affiliations

Does your facility have any current contracts with the following entities?

Cigna HealthCare	☐ Yes	☐ No
Cigna Healthspring	☐ Yes	☐ No
Evernorth Behavioral Health	☐ Yes	☐ No

Location # 1

Service Address (No PO Boxes)	Billing Address Reimbursements will be made to this address	Mailing Address Correspondence will be mailed to this address
Facility Name		
Dba		
TIN(s)		
NPI		
Street/PO		
City		
State Zip	State Zip	State Zip
Phone ( ) Fax ( )	Phone ( ) Fax ( )	Phone ( ) Fax ( )
Office E-mail		

What is the total number of behavioral health beds at this location? ______________ ☐ N/A

Is this building handicap accessible? ☐ Yes ☐ No

Essential Community Provider? *If yes, select one:* ☐ Family Planning Provider ☐ Federally Qualified Health Center ☐ Indian Health Provider ☐ Other ECP ☐ Ryan White Provider

Location # 2

Service Address (No PO Boxes)	Billing Address Reimbursements will be made to this address	Mailing Address Correspondence will be mailed to this address
Facility Name		
Dba		
TIN(s)		
NPI		
Street/PO		
City		
State Zip	State Zip	State Zip
Phone ( ) Fax ( )	Phone ( ) Fax ( )	Phone ( ) Fax ( )
Office E-mail		

What is the total number of behavioral health beds at this location? ______________ ☐ N/A

Is this building handicap accessible? ☐ Yes ☐ No

Essential Community Provider? *If yes, select one:* ☐ Family Planning Provider ☐ Federally Qualified Health Center ☐ Indian Health Provider ☐ Other ECP ☐ Ryan White Provider

Location # 3

Service Address (No PO Boxes)	Billing Address Reimbursements will be made to this address	Mailing Address Correspondence will be mailed to this address
Facility Name		
Dba		
TIN(s)		
NPI		
Street/PO		
City		
State Zip	State Zip	State Zip
Phone ( ) Fax ( )	Phone ( ) Fax ( )	Phone ( ) Fax ( )
Office E-mail		

What is the total number of behavioral health beds at this location? ______________ ☐ N/A

Is this building handicap accessible? ☐ Yes ☐ No

Essential Community Provider? *If yes, select one:* ☐ Family Planning Provider ☐ Federally Qualified Health Center ☐ Indian Health Provider ☐ Other ECP ☐ Ryan White Provider

Location # 4

Service Address (No PO Boxes)	Billing Address Reimbursements will be made to this address	Mailing Address Correspondence will be mailed to this address
Facility Name		
Dba		
TIN(s)		
NPI		
Street/PO		
City		
State Zip	State Zip	State Zip
Phone ( ) Fax ( )	Phone ( ) Fax ( )	Phone ( ) Fax ( )
Office E-mail		

What is the total number of behavioral health beds at this location? ________________ ☐ N/A

Is this building handicap accessible? ☐ Yes ☐ No

Essential Community Provider? If yes, select one: ☐ Family Planning Provider ☐ Federally Qualified Health Center ☐ Indian Health Provider ☐ Other ECP ☐ Ryan White Provider

Location # 5

Service Address (No PO Boxes)	Billing Address Reimbursements will be made to this address	Mailing Address Correspondence will be mailed to this address
Facility Name		
Dba		
TIN(s)		
NPI		
Street/PO		
City		
State Zip	State Zip	State Zip
Phone ( ) Fax ( )	Phone ( ) Fax ( )	Phone ( ) Fax ( )
Office E-mail		

What is the total number of behavioral health beds at this location? ________________ ☐ N/A

Is this building handicap accessible? ☐ Yes ☐ No

Essential Community Provider? *If yes, select one:* ☐ Family Planning Provider ☐ Federally Qualified Health Center ☐ Indian Health Provider ☐ Other ECP ☐ Ryan White Provider

Location # 6

Service Address (No PO Boxes)	Billing Address Reimbursements will be made to this address	Mailing Address Correspondence will be mailed to this address
Facility Name		
Dba		
TIN(s)		
NPI		
Street/PO		
City		
State Zip	State Zip	State Zip
Phone ( ) Fax ( )	Phone ( ) Fax ( )	Phone ( ) Fax ( )
Office E-mail		

What is the total number of behavioral health beds at this location? ________________ ☐ N/A

Is this building handicap accessible? ☐ Yes ☐ No

Essential Community Provider? *If yes, select one:* ☐ Family Planning Provider ☐ Federally Qualified Health Center ☐ Indian Health Provider ☐ Other ECP ☐ Ryan White Provider

General Facility Information
Website (may display on directory)
Mass Communications e-mail
Please describe the level of medical oversight for your programing (Example: Physician, psychiatrist, nurse) and frequency of interaction.
Does your facility offer boarding? ☐ Yes ☐ No
Does your facility provide transportation? ☐ Yes ☐ No

Facility Services

If your facility provides outpatient medication assisted treatment (MAT) services only, skip to page 12.

Services & Programs ***Please include service descriptions, where indicated** **For reference, treatment populations include:** **Adult - 18-59 | Adolescent - 13-17 | Child - 0-12 | Geriatric - 60 +** *Please note, the following billing codes are only suggestions. Other codes may also be appropriate.*	**Location(s)** **For Example: 1 & 2**
23-Hour Observation Services - Child (Rev Code 762) **Description*	
23-Hour Observation Services - Adolescent (Rev Code 762) **Description*	
23-Hour Observation Services - Adult (Rev Code 762) **Description*	
23-Hour Observation Services - Geriatric (Rev Code 762) **Description*	
Crisis Triage Assessment - Child (Rev Code 914 and CPT Code 90839) **Description*	
Crisis Triage Assessment - Adolescent (Rev Code 914 and CPT Code 90839) **Description*	
Crisis Triage Assessment - Adult (Rev Code 914 and CPT Code 90839) **Description*	
Crisis Triage Assessment - Geriatric (Rev Code 914 and CPT Code 90839) **Description*	
Crisis Triage Intervention - Child (Rev Code 900 and HCPCS Code S9484) **Description*	
Crisis Triage Intervention - Adolescent (Rev Code 900 and HCPCS Code S9484) **Description*	
Crisis Triage Intervention - Adult (Rev Code 900 and HCPCS Code S9484) **Description*	
Crisis Triage Intervention - Geriatric (Rev Code 900 and HCPCS Code S9484) **Description*	
Detoxification Ambulatory - Adolescent (Rev Code 944/945 and HCPS H0014) **Description:* Also known as Outpatient Detox	
Detoxification Ambulatory - Adult (Rev Code 944/945 and HCPS H0014) **Description:* Also known as Outpatient Detox	
Detoxification Ambulatory - Geriatric (Rev Code 944/945 and HCPS H0014) **Description:* Also known as Outpatient Detox	

Facility Services *(Cont.)*	
Services & Programs *(Cont.)*	**Location(s) *(Cont.)***
Detoxification Inpatient (Acute) - Adolescent (Rev Code 126) **Description*	
Detoxification Inpatient (Acute) - Adult (Rev Code 126) **Description*	
Detoxification Inpatient (Acute) - Geriatric (Rev Code 126) **Description*	
Dual Diagnosis Inpatient - Child (Rev Code 124) **Description*	
Dual Diagnosis Inpatient - Adolescent (Rev Code 124) **Description*	
Dual Diagnosis Inpatient - Adult (Rev Code 124) **Description*	
Dual Diagnosis Inpatient - Geriatric (Rev Code 124) **Description*	
Dual Diagnosis Intensive Outpatient Program - Child (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________
Dual Diagnosis Intensive Outpatient Program - Adolescent (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________
Dual Diagnosis Intensive Outpatient Program - Adult (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________
Dual Diagnosis Intensive Outpatient Program - Geriatric (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________

Facility Services *(Cont.)*	
Services & Programs *(Cont.)*	**Location(s) *(Cont.)***
Dual Diagnosis Partial Hospitalization Program - Child (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________	________
Dual Diagnosis Partial Hospitalization Program - Adolescent (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________	________
Dual Diagnosis Partial Hospitalization Program - Adult (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________	________
Dual Diagnosis Partial Hospitalization Program - Geriatric (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________	________
Dual Diagnosis Residential - Child (Rev Code 1001)	
Dual Diagnosis Residential - Adolescent (Rev Code 1001)	
Dual Diagnosis Residential - Adult (Rev Code 1001)	
Dual Diagnosis Residential - Geriatric (Rev Code 1001)	
Eating Disorders Inpatient - Child (Rev Code 124)	
Eating Disorders Inpatient - Adolescent (Rev Code 124)	
Eating Disorders Inpatient - Adult (Rev Code 124)	
Eating Disorders Inpatient - Geriatric (Rev Code 124)	
Eating Disorders Intensive Outpatient Program - Child (Rev Code 905 and HCPCS Code S9480 Preferred, alternate Codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	________
Eating Disorders Intensive Outpatient Program - Adolescent (Rev Code 905 and HCPCS Code S9480 Preferred, alternate Codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	________

Facility Services *(Cont.)*	
Services & Programs ***(Cont.)***	**Location(s)** ***(Cont.)***
Eating Disorders Intensive Outpatient Program - Adult (Rev Code 905 and HCPCS Code S9480 Preferred, alternate Codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	______
Eating Disorders Intensive Outpatient Program - Geriatric (Rev Code 905 and HCPCS Code S9480 Preferred, alternate Codes H0004 or H2036). If HealthPartners in MN, ND and parts of Western WI (H2020 and H2035). **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	______
Eating Disorders Partial Hospitalization Program - Child (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	______
Eating Disorders Partial Hospitalization Program - Adolescent (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	______
Eating Disorders Partial Hospitalization Program - Adult (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	______
Eating Disorders Partial Hospitalization Program - Geriatric (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is a meal included?* ☐ Yes ☐ No *Is meal supervision included?* ☐ Yes ☐ No	______
Eating Disorders Residential - Child (Rev Code 1001)	
Eating Disorders Residential - Adolescent (Rev Code 1001)	
Eating Disorders Residential - Adult (Rev Code 1001)	
Eating Disorders Residential - Geriatric (Rev Code 1001)	
Electro Convulsive Treatment Inpatient - Adult (Rev Code 901)	
Electro Convulsive Treatment Inpatient - Geriatric (Rev Code 901)	
Electro Convulsive Treatment Outpatient- Adult (Billing Code 90870)	
Electro Convulsive Treatment Outpatient - Geriatric (Billing Code 90870)	

Facility Services *(Cont.)*	
Services & Programs *(Cont.)*	**Location(s) *(Cont.)***
Home Health MH/SA - Child (Rev Code 580)	
Home Health MH/SA - Adolescent (Rev Code 580)	
Home Health MH/SA - Adult (Rev Code 580)	
Home Health MH/SA - Geriatric (Rev Code 580)	
MH Inpatient - Child (Rev Code 124)	
MH Inpatient - Adolescent (Rev Code 124)	
MH Inpatient - Adult (Rev Code 124)	
MH Inpatient - Geriatric (Rev Code 124)	
MH Intensive Outpatient Program - Child (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is medication management included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________
MH Intensive Outpatient Program - Adolescent (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is medication management included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________
MH Intensive Outpatient Program - Adult (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is medication management included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________
MH Intensive Outpatient Program - Geriatric (Rev Code 905 and HCPCS Code S9480 preferred, alternate codes H0004 or H2036) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Is medication management included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	________
MH Partial Hospitalization Program - Child (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________ *Is medication management included?* ☐ Yes ☐ No	________

Facility Services *(Cont.)*	
Services & Programs *(Cont.)*	**Location(s) *(Cont.)***
MH Partial Hospitalization Program - Adolescent (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is medication management included?* ☐ Yes ☐ No	______
MH Partial Hospitalization Program - Adult (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is medication management included?* ☐ Yes ☐ No	______
MH Partial Hospitalization Program - Geriatric (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is medication management included?* ☐ Yes ☐ No	______
MH Residential - Child (Rev Code 1001)	______
MH Residential - Adolescent (Rev Code 1001)	______
MH Residential - Adult (Rev Code 1001)	______
MH Residential - Geriatric (Rev Code 1001)	______
SA Intensive Outpatient Program - Adolescent (Rev Code 906 and HCPCS Code H0015 preferred, alternate codes H0005 or H2036) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Are drug screens included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	______
SA Intensive Outpatient Program - Adult (Rev Code 906 and HCPCS Code H0015 preferred, alternate codes H0005 or H2036) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Are drug screens included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	______
SA Intensive Outpatient Program - Geriatric (Rev Code 906 and HCPCS Code H0015 preferred, alternate codes H0005 or H2036) **Please provide program description** *How many hours per session?* ______ *How many sessions per week?* ______ *Is the assessment included?* ☐ Yes ☐ No *Is an individual session included?* ☐ Yes ☐ No *Is a family session included?* ☐ Yes ☐ No *Are drug screens included?* ☐ Yes ☐ No *Is aftercare included?* ☐ Yes ☐ No	______
SA Inpatient Rehabilitation (Sub-Acute) - Adolescent (Rev Code 128)	______
SA Inpatient Rehabilitation (Sub-Acute) - Adult (Rev Code 128)	______
SA Inpatient Rehabilitation (Sub-Acute) - Geriatric (Rev Code 128)	______

Facility Services *(Cont.)*	
Services & Programs *(Cont.)*	**Location(s) *(Cont.)***
SA Partial Hospitalization Program - Adolescent (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________	________
SA Partial Hospitalization Program - Adult (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________	________
SA Partial Hospitalization Program - Geriatric (Rev Code 912/913 and HCPCS Code H0035 preferred, alternate codes G0410, S0201 or H2012) **Please provide program description** *How many hours per session?* ________ *How many sessions per week?* ________	________
SA Residential - Adult (Rev Code 1002)	________
SA Residential - Adolescent (Rev Code 1002)	________
SA Residential - Geriatric (Rev Code 1002)	________

Do the above services include the following physician fees?
Please answer YES or NO for each line

Physician fees	Yes	No
Pathologist	☐	☐
Radiologist	☐	☐
Anesthesiologist	☐	☐
Emergency Room Physician	☐	☐
Attending MD	☐	☐
Attending Psychiatrist	☐	☐

Evernorth Behavioral Health, Inc. requires all Attending Psychiatrists to be contracted, regardless if they are salaried by the facility or community based, and reserves the right to either decline contracting or delay contract execution until such time as Facility's Attending Psychiatrists are contracted. Please include roster and contact information.

Specialty Programs

Please indicate below if your facility currently offers any of the following specialty programs. We would like to understand any special tracks or clinical programs offered for the following populations.
Note: We are not asking if you are willing/able to serve these populations, but want to know if you already have special programming in place.

Programs	Yes	Locations
Emergency/First Responder	☐	
Executive/Professional	☐	
Health Care Professional	☐	
LGBTQI population	☐	
Men only	☐	
Trauma	☐	
Women only	☐	
Young Adult (18-26)	☐	

If you answered "Yes" to any of the above specialties, please provide a detailed description of the program:

Medication Assisted Treatment (MAT)

For reference, treatment populations include:
Child - 0-12 | Adolescent - 13-17 | Adult - 18-59 | Geriatric - 60 +

Please check all that apply:

☐ Federally certified Opioid Treatment Program (OTP)
☐ Office Based Opioid Treatment Program (OBOT)
☐ Outpatient group providing MAT - services rendered by medical providers only
☐ Outpatient group providing MAT - services include medication management and behavioral therapy

What provider types does your program utilize? *Please check all that apply*:

☐ Psychiatrists (board certified in psychiatry and or addictionology)
☐ Independently licensed behavioral health providers
☐ Medical providers
☐ Non-independently licensed and/or unlicensed behavioral health or medical providers

Please provide the following program specific information if MAT service is offered *by your facility*.

1. Indicate the populations treated in your program. *Check all that apply*:
   ☐ Child (0-12 years)
   ☐ Adolescent (13-17 years)
   ☐ Adult (18-59 years)
   ☐ Geriatric (60+ years)
2. Detailed program description of services provided (please attach additional page(s) if necessary).

3. List of MAT medications that are utilized at your facility:
   ☐ Methadone
   ☐ Buprenorphine
   ☐ Suboxone
   ☐ Vivitrol
   ☐ Other: ______________________
4. How are the following medications delivered in your facility? *Check all that apply*:

MAT medication(s) used	By prescription	Onsite dispensing	By prescription AND onsite dispensing
Methadone	☐	☐	☐
Buprenorphine	☐	☐	☐
Suboxone	☐	☐	☐
Vivitrol	☐	☐	☐

5. List of billing codes used and rate proposal:

CPT Code	Proposed rate

Medication Assisted Treatment (MAT) *(Cont.)*

CPT Code *(Cont.)*	Proposed rate *(Cont.)*

6. What billing forms are used by your organization?
   - ☐ CMS 1500 **only**
   - ☐ UB-04 **only**
   - ☐ CMS 1500 **and** UB-04
7. If you only use one of the above billing forms, can you accommodate the others if necessary? ☐ Yes ☐ No
8. If applicable, please include a copy of your SAMHSA OTP Certification, Medicare Certification for OTP, Facility's State License.

Behavioral Administrative Guidelines

Evernorth Behavioral Health Behavioral Administrative Guidelines

The Evernorth Behavioral Administrative Guidelines are accessible at the Evernorth Provider website (Provider.Evernorth.com) > Resources > Behavioral Administrative Guidelines.

There are two sections to this document:

- The first section is the Administrative Guide which helps facilities and providers work with Evernorth Behavioral Health. You'll find information about our Case Management Programs, Quality Management, and getting paid.
- The second section is the Provider Guide. You'll find state specific policies that are part of your contract. Note: the contract does reference the Behavioral Administrative Guidelines.

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