InteCare Addendum to CAQH Application

I. Required Provider Information Needed for CAQH

Last Name ____________________________ First Name ___________________________

Organization Name ____

CAQH Number ____

Service Location Address ____

City __________________________________ State ____________ Zip __________________

II. Clinical Services: (List those that you provide)

Outpatient Clinical Services

❒ Outpatient Psychiatric Treatment _ Geriatric _ Adult _ Adolescent _ Children	❒ Outpatient Substance Use Disorder Treatment _ Geriatric _ Adult _ Adolescent _ Children
❒ Outpatient Medication Management	❒ Medication Assisted Treatment (MAT)
❒ Crisis Evaluation/Intervention	❒ Outpatient Detoxification Alcohol and Other Drugs
❒ Critical Incident Debriefing	❒ Assertive Community Treatment (ACT)
❒ Employee Assistance Program (EAP)	❒ Social Skills Training
❒ Applied Behavioral Analysis	❒ Case Management
❒ Psychological Evaluation	❒ Vocational/Supportive Employment
❒ Substance Use Disorder Evaluation	❒ Therapeutic Foster Care
❒ Psychiatric Evaluation	❒ Supervised Living
❒ Electroconvulsive Therapy (ECT)	❒ Other:
❒ Psychological/Neuropsychological Testing	❒ Other:

Higher Levels of Care

❒ Inpatient	❒ Residential	❒ Intensive Outpatient
❒ Sub Acute	❒ Partial Hospitalization	❒ Other:

III. Areas of Clinical Expertise:

Please check your areas of clinical expertise (*as documented by your professional work experience or specialized training).* Many consumers request providers with expertise in specific areas. By marking these as expertise you will be noted as such in the InteCare provider database, and prospective clients may be informed of this information. Referrals will not be limited by your choices.

☐ ADHD	☐ Forensics	☐ Psychotic Disorders
☐ Adjustment Disorders	☐ Gambling	☐ PTSD/Acute Stress

☐ Anxiety Disorders	☐ LGBTQ Issues ☐ Gender Identity Issues	☐ Reactive Attachment Disorder
☐ Attachment Disorders	☐ Geriatric	☐ Relationship Therapies Including Divorce
☐ Autism Spectrum Disorders/ Pervasive Developmental Disorders	☐ Grief/loss	☐ Schizophrenia
☐ Child Abuse/Neglect	☐ Medical Issues	☐ Severe and Persistent Mental Illness
☐ Child and Adolescent Clinical Syndromes	❒ Gender Specific Therapies	☐ Sexual Abuse Victim (Child)
☐ Chronic Pain	☐ Military Culture	☐ Sexual Abuse Victim (Adult)
☐ Co-Occurring Disorders ☐ Behavioral Health and Physical Health ☐ Psychiatric and Substance Abuse ☐ Substance and Physical Health	☐ Mood Disorders	☐ Sexual Abuse Perpetrator
☐ Obsessive/Compulsive Disorders	☐ Neuropsychology	☐ Substance Use Disorders
☐ Critical Incident Stress Debriefing	☐ Panic/Phobia	(Please List Other) ☐ Other: ☐ Other: ☐ Other: ☐ Other:
☐ Depressive Disorders	☐ Personality Disorders	
☐ Disruptive Behavior Disorder/Oppositional Defiant Disorder	☐ Physical Abuse Perpetrator	
☐ Dissociative Disorders	☐ Physical Abuse Victim	
☐ Domestic Violence	☐ Post Partum Depression	
☐ Eating Disorders/Obesity	☐ Psychological Testing	
☐ Faith Based Counseling	☐ Psychopharmacology	
☐ Fitness For Duty Assessment	☐ Psychosomatic/Somatoform	

IV. Population Served:

❒ Mental Health Adults: Ages18-65	❒ Hispanic/Latino
❒ MH Child & Adolescents: ❒ 0-6 ❒ 7-12 ❒ 13-17	❒ Developmentally Delayed/MR
❒ Substance Use Disorder Adults: Ages 18-65	❒ Deaf/Hearing Impaired
❒ Substance Use Disorder Child & Adolescents	❒ Blind/Sight Impaired
❒ Mental Health Older Adults	❒ Learning Disabled
❒ Substance Use Disorder Adults	❒ Other:
❒ Mental Health Adults: Ages18-65	❒ Other:

V. Preferred Modalities: *Please check those most commonly used*

❒ ADL /Skills Training	❒ Individual Therapy
❒ Assessment/Evaluation	❒ Long-Term Supportive Therapy
❒ Applied Behavioral Analysis	❒ Medication Management
❒ Case Management	❒ Milieu Therapy
❒ Couples/Marital Therapy	❒ Nursing Intervention
❒ Employee Assistance Program	❒ Play Therapy
❒ Family Therapy	❒ Supervised Visitation
❒ Group Therapy	❒ Other:

VI. Treatment Approaches: *("Eclectic" is not a choice, but more than one may be chosen)*	
❒ 12 Step Recovery Model	❒ Motivational Interviewing
❒ Behavior Modification	❒ NLP
❒ Biofeedback	❒ PACT Model
❒ Biological/Medical	❒ Peer Support
❒ Brief Solutions Focused Therapy	❒ Psychoanalytic Therapy
❒ Client Centered Therapy	❒ Psycho education
❒ Cognitive Behavior Therapy (CBT)	❒ Rational /Emotive Therapy
❒ Critical Incident Stress Debriefing	❒Trauma Informed Care
❒ Dialectical Behavioral Therapy (DBT)	❒ Other:
❒ EMDR	❒ Other:
❒ Hypnosis	❒ Other:

VII. Access Information

I. From the time of call to your practice, what is the average amount of time it takes for consumers to be seen for their first **routine** appointment? _______________ Days (Please use data for the last 3 months)

A. Routine Appointments:
Contact Name(s):____

Phone Number(s):____

Please write in the steps for routine access in the space below:

____
____
____
____
____

II. Does your practice have 24 hour life threatening emergency coverage? ❒Yes ❒No
If yes, please describe coverage:

____
____
____
____

A. Crisis Appointments:
Contact Name(s):____

Phone Number(s):____

Please write in the steps for crisis access in the space below:

____
____

III. Does your practice offer urgent care appointments within 48 hours? ❒Yes ❒No

A. Urgent Appointments:
Contact Name(s):____

Phone Number(s):____
Please write in the steps for crisis access in the space below:

If your answer is no for the following questions please attach an explanation:

IV. Do all locations where you practice have handicapped accessibility?
❒Yes ❒No
If not, please attach an explanation.

V. Do all locations where you practice have well lit waiting rooms and treatment rooms?
❒Yes ❒No

VI. Do all locations where you practice have adequate seating?
❒Yes ❒No

VII. Do all locations where you practice have posted office hours?
❒Yes ❒No

VIII. Provider Attestation: Required of all Applicants!

Please note that by signing this addendum you attest that you have read and will comply with the requirements of the InteCare Provider Manual. The InteCare Provider Manual may be accessed at: http://www.intecare.org/wp-content/uploads/2017/12/InteCare-Provider-Manual-Tenth-Edition-2016.pdf

I hereby certify that all information in this addendum and all attached required documentation are correct and complete. I understand that any information entered on this addendum which subsequently is found to be false and/or inaccurate could result in termination of my contract with InteCare.

Printed Name____________________________________

Signature____

Date ___________________________

Checklist for Required Information and Documents

- ☐ CAQH Provider Identification Number
- ☐ CAQH Attestation updated within the past 120 days (We cannot process the application if this is not up to date)
- ☐ Copy of Current Liability Declaration Page (malpractice insurance coverage, or proof of participation in the Indiana Patient's Compensation Fund). Provider's name must appear on the declaration page or must include a notice on the insurer's letterhead listing providers covered on the policy. Limits required are $1,000,000 per occurrence and $3,000,000 aggregate.
- ☐ Copy of DEA Certificate (If applicable)
- ☐ If not board certified, provide a copy of 75 Category 1 CME's completed in the previous 36 months. (MD/DOs only)
- ☐ Copy of Immigration VISA (If not a US Citizen)
- ☐ Two Signed Provider Agreements, Exhibits and/or Addendums, if applicable. (Sign only, do not date the provider agreement; this will be dated after it is officially approved by the Network & Credentialing Subcommittee. (Not Needed for recredentialing)
- ☐ Incorporation by Reference Form
- ☐ W9 with group information listed or individual info, if sole proprietor
- ☐ Collaborative Agreement (APRN's only)