PriorityHealth

Behavioral Health supplemental form

Full name_____

Type of practice: ☐ Private practice ☐ Group practice
☐ Facility ☐ Located in a Federally Qualified Health Center

Name of practice/facility_____

Address_____**City**_____

State_____**ZIP**_____**County**_____

Phone #_____**Secure fax #**_____

Email address_____**Website**_____

Office hours: ☐ Mon._____ ☐ Tues._____ ☐ Wed._____ ☐ Thurs. _____ ☐ Fri. _____
☐ Sat._____ ☐ Sun._____

Explain your policy for after-hours coverage:

_____
_____
_____
_____

How long have you been at this practice/facility? Years_____ Months_____

Are you located in a primary care physician's office?
☐ Yes. PCP name_____

☐ No. Describe your access to medication management services for your patients._____
_____
_____

What is your location/office setting?
☐ Traditional
☐ Non-traditional (church, private residence, non-related business)_____
_____

Do you have experience working with a health benefits company?
☐ Yes ☐ No

Have you previously had a contract with Priority Health?

☐ No

☐ Yes. Explain_____

_____

_____

What accreditation(s) do you currently hold?

☐ CARF ☐ COA ☐ JCAHO ☐ NONE

Professional interests

(Mental health services include treatment for anxiety, depression and crisis intervention)

☐ Borderline personality

☐ Cultural/ethnic issues_____

☐ Domestic violence

☐ Dual diagnosis

☐ Eating disorders

☐ Gay/lesbian issues

☐ Grief issues

☐ Hearing impaired

☐ Other languages

☐ Phobias

☐ Post-traumatic stress disorder

☐ Psychosomatic issues

☐ Sexual trauma

☐ Terminal illness

☐ Other_____

Testing / Procedures

☐ ADD/ADHD (Criteria: Doctorate-level with full licensure)

☐ Psychological testing (Criteria: Doctorate-level with full licensure)

☐ EMDR (Criteria: Submission of certificate copy required)

☐ Neuropsychology (Criteria: Appendix L –Submission of training and work experience required)

Application packets will be sent based on business need to meet access and availability standard for members.

Signature_____Date_____

Email completed form to *PH-PELC@priorityhealth.com* or fax to 616.975.8857.