Request for Application (RFA)—Provider

Complete the application request below to be considered for the Beacon Health Options Provider Network.

Please read the following before completing this form:

- **Please complete this form if you are currently not a participating provider in our network.**
- **If your organization is already contracted for Beacon network participation, you do not need to complete the form. Please have your administrator reach out to our Provider Service Line at 800-397-1630.**

Provider Information

Required fields throughout this form are noted with an asterisk (*).

Provider Name/Group Name*

Social Security Number

License Discipline*

Date of Birth* (only for solo)

CAQH ID* (only for solo)

License Number

Medicare ID

Medicaid ID*

Individual NPI*

Practice*: Solo ☐ Group ☐ Behavioral Health Provider? Yes ☐ No ☐

If Solo, are you joining a participating/contracted group with Beacon? Yes ☐ No ☐
(if yes, please do no complete this form and call 800-397-1630)

If Group, please complete the following information below and provide a roster of your providers with Practitioner Full Name, Service Site Address, NPI and CAQH ID.

Group NPI*

Group TIN*

Group Medicaid ID

Total Providers in Group

Requestor Information

If Requestor is same as Provider, skip this section

Requestor Name*

Title

Email*

Website

Phone Number*

Fax Number

Street Address

City, County, State, Zip Code

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Complete the application request below to be considered for the Beacon Health Options Provider Network.

Provider/Contact Address Information

Primary Service Address (City, County, State, Zip Code)

Email* | Phone Number* | Fax Number

Secondary Service Address (City, County, State, Zip Code)

Email* | Phone Number* | Fax Number

Provider Mailing Contact — **Mailing Address** (City, County, State, Zip Code)

Email* | Phone Number* | Fax Number

Provider Billing/Claims Contact — **Billing Address** (City, County, State, Zip Code)

Email* | Phone Number* | Fax Number

Provider Services

This section has to be completed.
Any questions left unanswered/blank will be considered incomplete.

Populations Treated, please check at least one:

Child (ages 1-5) ☐ Child (ages 6-12) ☐ Adolescent (ages 13-17) ☐ Adult (ages 18-64) ☐ Geriatric (ages 65+) ☐

Any Practice Limitations (Age/Gender Restrictions) _____

Are you a Prescriber? Yes ☐ No ☐ DEA License Number: _____

Medication and Dispensing: Methadone ☐ Buprenorphine ☐ Do you have a Data 2000 Waiver? Yes ☐ No ☐

Do you offer evening/weekend hours? Yes ☐ No ☐ Are there secondary/multiple locations? Yes ☐ No ☐

Are you accepting new patients? Yes ☐ No ☐ Are you Board Certified? Yes ☐ No ☐

Speak languages other than English? Yes ☐ No ☐

Other Languages Spoken by Staff: _____

_____

Public Transportation Accessible? Yes ☐ No ☐ Handicap Accessible? Yes ☐ No ☐

Do you have Hospital Affiliations/Privileges? Yes ☐ No ☐ Offer Sign Language? Yes ☐ No ☐

Do you offer Cultural Competency? Yes ☐ No ☐

Meet ADA accessibility requirements? Yes ☐ No ☐

EAP Requirements:

Do you have 2 years of EAP experience or 6 CEU's of SA training? Yes ☐ No ☐

Request for Application (RFA)—Provider

Complete the application request below to be considered for the Beacon Health Options Provider Network.

Provider Specialties

From the list below, please select the top five areas for which you have training and expertise. Only indicated areas of expertise will be considered for review.

- ☐ Adoption issues
- ☐ Anxiety/Depression
- ☐ Autism
- ☐ Alcohol Abuse
- ☐ Case Management
- ☐ Child/Adolescent Issues
- ☐ Cultural and Linguistic Needs
- ☐ Domestic Violence
- ☐ Dual Diagnosis (MH/SUD)
- ☐ Eating Disorders
- ☐ Employee Assistance Program (EAP)
- ☐ Grief/Bereavement
- ☐ Marital/Couples Counseling
- ☐ Medication Assisted Treatment (MAT)
- ☐ Gender/Sexuality/Identity Issues
- ☐ Outpatient (Group, Family, Individual)
- ☐ Post-traumatic Stress Disorder (PTSD)
- ☐ Residential Treatment
- ☐ Sexual/Physical Abuse
- ☐ Telehealth Services
- ☐ Traumatic Brain Injury
- ☐ Others:

Testing Specialties

- ☐ Autism: Cerfiied BCBA
- ☐ ADD/ADHD
- ☐ Psychological Testing
- ☐ Neuropsychological Testing
- ☐ Others, please list:

Line of Business Affiliation

- ☐ Commercial (HMO/PPO)
- ☐ Dual (Medicaid/Medicare)
- ☐ Federal (Military OneSource)
- ☐ EAP
- ☐ Medicare
- ☐ Others, please list:
- ☐ Medicaid

Attestation Statement

I certify that all information provided to Beacon Health Options is true and correct to the best of my knowledge and belief. I agree to notify Beacon Health Options promptly if there are any material changes in the information provided, whether prior to or after my acceptance as a Beacon Health Options participating provider. I understand and agree that if Beacon Health Options discovers that my application contains any significant misstatement, misrepresentations, or omissions, Beacon Health Options may void, in its sole discretion, this application and any related participating provider agreements. I understand that if Beacon Health Options extends credentialing to me, my Participating Agreement will include all lines of business. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue or incorrect could result in my application rejection or termination from the network.

Signature:

_____

Legal Name of Organization — Print Name of Individual Signing for Organization

_____

Authorizing Signature and Title — Date

Please return this form including the Terms and Conditions via fax to 888-643-4396 or email to RFA@beaconhealthoptions.com

Incomplete, incorrect, or illegible forms may delay or prevent proper processing.

If you have any questions, call the National Provider Service Line Monday through Friday, between 8 a.m. and 8 p.m. ET, at 800-397-1630.