MMBH Network - Pre-Application Request Form*

*Please do not edit this forms format

Provider Panel Criteria: Providers must be fully licensed and able to practice independently. ***(Provisionally licensed providers will be unable to join the MMBH network)***

1. **Please complete this electronic form - All Fields are Required in** *(if not applicable enter NA for number enter all 0's)*
2. Include a copy of your current resume - Please note the resume/CV MUST include current employer. Format must be in a From/To and Month/Year beginning and ending dates of education, work history and affiliations.
3. **Email this information to MMBHProviderRelationsTeam@Mercy.net**
4. **Please use upper and lower case Do Not use all CAPS due to system requirements.**
5. **Numbers are pre-formatted to be entered and no spaces or special characters should be entered.**

PLEASE FORWARD AN APPLICATION PER THE INFORMATION THAT FOLLOWS:

Application Information

First, Middle, Last Name: _____ Previous Last Name: _____

Degree: _____ License Type: _____ SSN: _____ DOB: _____

Individual NPI: _____ Group NPI: _____ Tax ID: _____

Provider Email: _____

Secondary Email: _____ ☐ Office Staff or ☐ Credentialing Specialist

Provider Home Address:
Include City State Zip _____

Provider Cell Phone Number: _____

Provider Level: ☐ Child/Adolescent Physician ☐ Adult Physician ☐ APRN/PA/PMHNP

☐ Psychologist ☐ Autism (ABA) ☐ Master **Gender:** ☐ Male ☐ Female ☐ Other

Do you speak a foreign language? ☐ Yes ☐ No (If "yes", which ones?) _____ **Are you fluent in sign language?** ☐ Yes ☐ No

Ethnicity: (Optional) ☐ Asian ☐ African American ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Other – Please Specify: _____

Credentialing Contact Name: _____

Credentialing Contact Company Name: _____

Credentialing Contact Phone: _____

Credentialing Specialist Email: _____

Please Check Your Response:

- Are you an existing Optum provider? (*Tier 1 for Mercy Co-Workers)* ☐ Yes ☐ No
  - **If No**, are you in the process of Joining the Optum Network? ☐ Yes ☐ No
- Are you on the Medicare Opt-Out List? ☐ Yes ☐ No
- Are you currently a Medicare Provider? ☐ Yes ☐ No
  - Medicare Provider Number:
    (Required to be Essence HealthCare) _____
  - Are you interested in seeing Essence Healthcare members?
    (A Commercial Medicare Advantage Plan): ☐ Yes ☐ No
- Which service types do you currently offer? **(select all that apply)**:
  - Telephonic Therapy **(telephone/no video)** ☐ Yes ☐ No
  - Telehealth/Telemedicine (telephone **with HIPAA compliant**) ☐ Yes ☐ No
  - Face-to-Face (services **performed in person in an office setting**) ☐ Yes ☐ No
- Are you an ABA provider? ☐ Yes ☐ No
- Are you a MAT (Medication Assisted Treatment) provider? ☐ Yes ☐ No

If you are a PA or NP, who is your Sponsoring Physician? _____

- Are you an existing **Mercy EAP** provider? ☐ Yes ☐ No
  - If no, are you interested in joining the **Mercy EAP** Network? ☐ Yes ☐ No

Primary Practice Information:

Practice Name _____ Publish: ☐ Yes ☐ No

Street Address: _____ Suite _____

City: _____ State: _____ Zip: _____ County: _____

Office Phone: _____ Office Fax: _____

Secondary Practice Information:

Publish: ☐ Yes ☐ No

Street Address: _____ Suite: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____

Additional Information: *(When adding additional locations please include County, Phone and Fax):*

Mailing Information:

Street: _____ Suite: _____

City: _____ State: _____ Zip: _____

Billing Information:

Company Name if Different than Practice Name: _____

Contact Name: _____ Contact Email: _____

Street: _____ Suite: _____

City: _____ State: _____ Zip: _____

Billing Phone: _____ Billing Fax: _____

Either Specify your preferred age range of clients or check all age groups that apply:

☐ Child Ages 0-5 ☐ Child Ages 6-11 ☐ Adolescent 12-17 ☐ Adult Ages 18-61 ☐ Geriatric 62+

If your preferred age ranges are different than above, please specify:

From among the specialties listed below, **RANK the top five (5)** in terms of your interests and expertise. This will help match patient needs and provider specialties and interests. *Rank 1 - 5 "1" indicates the greatest level, "5" = lowest level of interest and expertise* from among your five choices.

☐ ADHD	☐ Grief	☐ Borderline Personality Disorder
☐ AIDS/HIV+	☐ Groups – Adult	☐ Physical Disabilities
☐ Anxiety	☐ Groups - Men's	☐ Post-Partum
☐ Autism	☐ Groups - Women's	☐ Psychosis
☐ Biofeedback	☐ Groups - Recovery	☐ Rehabilitation Counseling
☐ Christian Counseling	☐ Groups - Child/Teen	☐ Serious Mental Illness
☐ Chronic Illness	☐ Home Visits - List Counties *in other*	☐ Sexual Abuse Female
☐ Cognitive TX	☐ Stress/Harassment	☐ Sexual Abuse Male
☐ Conduct DO	☐ Marital Therapy	☐ Sexual Identity
☐ Cultural Diversity	☐ Men's Issues	☐ Sexual Perpetrator Adult
☐ Depression	☐ Intellectual Disability	☐ Sexual Perpetrator Child
☐ Dual Diagnosis	☐ Neuropsych	☐ Substance Abuse
☐ Eating Disorders	☐ Obsessive Compulsive Disorder	☐ Suicide
☐ Gay/Lesbian Issues	☐ Pain Management	☐ Women's Issues
☐ Geriatric	☐ Personality Disorder	

☐ Other _____

The MMBH Credentialing Committee meets monthly and will review your information by comparing it to the providers with the same geographic location and specialties already on our panel to determine if we have a need. Once a determination has been made, you will be notified by MMBH.

For questions, please call Chris Warren at 314-729-4479 or Donna Schmitz at 314-729-4475 or* Fax to 314-729-4636 – *Attn: Provider Relations Team.