UnitedHealthcare Community Plan

Board Certified Behavior Analyst / Agency Network Participation Request Form

Please read carefully:

- In order to be considered for network participation, you must fully complete all responses. Incomplete forms will delay the response regarding consideration.

PROVIDER INFORMATION:

☐ Individual BCBA Provider in private practice

☐ Agency Provider (indicate total staff numbers within the agency):

Licensed Behavioral Clinicians: MD _____ PhD _____ MSW _____ RN _____

Board Certified Behavior Analysts (BCBA) _____ Supervisory Designation by BACB? _____
Licensed by state? _____

Board Certified Assistant Behavior Analysts (BCaBA) _____ Licensed by state? _____
Paraprofessionals/Tutors _____ RBT/Nationally Certified? _____ Certified by state? _____

Provider Name: _____

Name of Practice (dba): _____

Practice Address: _____

City _____ *State* _____ *Zip* _____

Please indicate if treatment is provided at your private residence. ☐ Yes ☐ No

Phone #: _____ Fax: _____ Email: _____

Correspondence Address: _____
(Credentialing/Recredentialing) (P.O. Box address is not acceptable)

City _____ *State* _____ *Zip* _____

Contact Name (if other than yourself): _____

Phone #: _____ Fax: _____ Email: _____

Remittance Address: _____

City _____ *State* _____ *Zip* _____

Agency Service Area (Counties) _____

How long has your agency been established? ____ years How long providing ABA/IBT svcs? _____

Does your agency utilize televideo technology for supervision or other activities? If yes, please explain:

_____

List the types of intensive behavior approaches your agency utilizes:

_____

List all languages (including sign language) in which you are able to conduct treatment:

_____

Optional –Clinician's own Ethnicity (data utilized to meet member referral requests):

☐ African American ☐ Alaska Native ☐ Native American Indian ☐ Asian

☐ Caucasian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander Other _____

PROVIDER IDENTIFICATION INFORMATION:
(If Agency Provider, please complete information for one BCBA on staff)

_____ Tax Identification Number (TIN)**

_____ ABA/IBT National Accreditation Number and Expiration Date

_____ Behavior Analyst Board Certification Number(s)and Expiration Date

_____ Behavior Analysts License Number(s) and Expiration Date(s)

_____ Additional State Certification Type and Number (if applicable)

_____ National Provider Identifier (NPI) Number

_____ Social Security Number

_____ CAQH Number

_____ Date of Birth

_____ Name of Liability Insurance Carrier / Policy Number

_____ Liability Insurance coverage amounts per occurrence/aggregate

_____ Liability Insurance Effective Date / Term Date

**If you have more than one TIN/group affiliation, please list additional affiliations

_____ _____
Name of Group/Practice TIN

ABA Specialty Requirements:

Individual BCBA -

- Board Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board, ***and***
- State licensure in those states that license behavior analysts
- State certification in those states that certify behavior analysts
- Compliance with all state/autism mandate requirements as applicable to behavior analysts
- A minimum of six (6) months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Minimum professional liability coverage of $1million per occurrence/ $1 million aggregate

Agency Provider –

- BCBAs must meet standards above and hold supervisory certification from the national Behavior Analyst Certification Board if in supervisory role.
- Licensed clinicians must have appropriate state licensure and six (6) months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Compliance with all state/autism mandate requirements as applicable to behavior analysts/ABA practices
- BCaBAs must have active certification from the national Behavior Analyst Certification Board, and appropriate state licensure in those states that license assistant behavior analysts
- Paraprofessionals must have RBT certification from the national Behavior Analyst Certification Board, or alternative national board certification, and receive appropriate training and supervision by BCBAs or licensed clinician
- BCBA or licensed clinician on staff providing program oversight
- BCBA or licensed clinician performs skills assessments and provides direct supervision of paraprofessionals in joint sessions with client and family
- $1 million/occurrence and $3 million/aggregate of professional liability and $1m/$1m of general liability if services are provided in a clinic setting.
- $1million/occurrence and $3million/aggregate of professional liability and $1m/$1m of supplemental insurance if the agency provides ambulatory services only (in the patient's home).

ABA Specialty Attestation Requirement:
I have reviewed the UnitedHealthcare Community Plan (UHCCP) ABA Specialty Requirements that I must meet to be credentialed and contracted as a Board Certified Behavior Analyst and/or ABA Agency Provider. After reviewing the requirements, I hereby attest that by placing a check next to this specialty, I meet UHCCP requirements for this treatment area.

☐ Solo BCBA with required experience in applied behavior analysis/intensive behavior therapies

☐ Agency Provider with required experience in applied behavior analysis/intensive behavior therapies

Areas of Clinical Expertise:
Please indicate populations served and in which you have applied behavior analysis/intensive behavior therapy training and experience for the treatment of Autism Spectrum Disorder and the type of program(s) for which you provide services.

Applied Behavior Analysis/Intensive Behavior Therapies for Autism Spectrum Disorder (populations served)

☐ Preschool *(0-5 years)*

☐ Children *(6-12 years)*

☐ Adolescents *(13-18 years)*

☐ Adults *(18-21 years)*

Clinic-based Programs

☐ Full-day; 5 days a week 6 hours a day

☐ Half-day; 5 days a week, 3 hours a day

☐ Intensive Outpatient, 3 days a week, 3 hours a day

☐ Other (please specify) _____

Non-clinic-based Programs

☐ Home Based (10-40 hours a week)

☐ Community Based (3-6 hours a week)

☐ Other (please specify) _____

Contracted UHCCP Providers have the following rights:

- to review information submitted to support his/her (re)credentialing application
- to correct erroneous information obtained by UHCCP to evaluate their (re)credentialing application (not including references, recommendations and other peer-review protected information)
- to submit any corrections, in writing, within ten (10) days
- to obtain information regarding the status of their application

I understand that UHCCP will require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty designated above. I will cooperate with a UHCCP documentation audit, if requested, to verify that I meet the required criteria. I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this Network Provider Request Form and Specialty Attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the UHCCP network.

Please note that standard credentialing criteria must be met before specialty designation can be considered. All providers must sign this form. Failure to sign this form may cause a delay in the processing of your initial credentialing file.

_____ _____
Printed Name of Applicant / Agency Signatory Designee Date

_____
Signature of Applicant / Agency Signatory Designee
(Signature stamps are not accepted)