

Provider Specialty Profile



This profile was created to capture specific information that will allow us to improve our referral process by closely matching member needs with provider services. Please note that incomplete information will be rejected.

Provider Information

Name: _____
First Middle Last Suffix

Licensure: _____ State of Licensure: _____ License Number: _____
(MD, ARNP, PhD, LCSW, etc.)

SS#: _____ DOB: _____ Provider e-mail: _____

Individual Medicaid #: _____ Individual Medicare #: _____

Individual NPI #: _____ Individual Taxonomy Type: _____

Group NPI #: _____ Group Taxonomy Type: _____

Credentialing Information

Credentialing Contact Name: _____ Phone: _____

Email: _____ Fax: _____

Council for Affordable Quality Healthcare (CAQH) Participant? Yes No If yes, list CAQH#* _____

*Please be sure all information, attachments and attestations are up to date and access has been granted for Cenpatico to view your data

*If you do not have a CAQH number, you can obtain one by going to proview.caqh.org

*Cenpatico only accepts credentialing submissions through CAQH. For more information, visit www.caqh.org

Practice Information

Group Name/Clinic Name: _____ Tax ID# _____

Please ensure that all practice locations are entered on your CAQH application

Check here if you ONLY offer home based services

Billing Office Contact Information: _____
Name Phone Email address

Billing Address: _____
City State Zip

Mailing Address: _____
City State Zip

Provider Specialty Profile



Office Hours	
MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	
SUNDAY	

Are you currently accepting new members? Yes No

Appointment Availability: Please indicate your availability for the following appointment types:

* **Routine** appointment – within 10 business days (14 calendar days) Yes No

* **Urgent** appointment – within 24 hours Yes No

* **7-day Post Hospital Discharge** appointment Yes No Please indicate location: In home In office

Ethnicity: Please choose the option that best describes your ethnic background (used to meet member referral requests)

American Indian or Alaskan Native

Asian or Pacific Islander

African America, Black

Hispanic or Latino

White, Non-Hispanic

other: _____ (please specify)

Do you provide services in languages other than English? Yes No

If "Yes," what other languages? _____

Does your office staff speak languages other than English? Yes No

If "Yes," what other languages? _____

Do you offer emergency services? Yes No

If "Yes," please describe: _____

Are the following areas in your office handicapped accessible? (Check those that apply)

Building Restroom Therapy Room Parking

What are your age restrictions? Youngest Age: _____ Oldest Age: _____

Do you provide services to both males and females? Yes No

If "No," please explain: _____

Provider Specialty Profile



Treatment Expertise/Specialties

Please select the types of services you offer, including the disorders you treat and the modalities you practice.
(Check those that apply)

NOTE: Please submit evidence of certificates or transcripts that account for the associated trainings in the treatment modalities and/or disorders selected below.

Certifications

<input type="checkbox"/>	Art Therapy	<input type="checkbox"/>	Positive Behavior Support
<input type="checkbox"/>	Center of Excellence	<input type="checkbox"/>	SBIRT
<input type="checkbox"/>	Emergency Services Provider	<input type="checkbox"/>	Targeted Case Management (TCM) Certificate Required
<input type="checkbox"/>	Lead Behavior Analysis Therapist	<input type="checkbox"/>	Trauma Informed Care

Settings/Populations Treated

<input type="checkbox"/>	Adolescents	<input type="checkbox"/>	Homelessness
<input type="checkbox"/>	Adults	<input type="checkbox"/>	Men
<input type="checkbox"/>	Blind/Visually Impaired	<input type="checkbox"/>	Mobile Crisis
<input type="checkbox"/>	Children	<input type="checkbox"/>	Nursing Home
<input type="checkbox"/>	Community Based	<input type="checkbox"/>	Physical Disability
<input type="checkbox"/>	Deaf/Hearing Impaired	<input type="checkbox"/>	Serious Emotional Disturbance
<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/>	Serious Mental Illness
<input type="checkbox"/>	Emotionally Disturbed	<input type="checkbox"/>	Severe Persistent Mentally Ill
<input type="checkbox"/>	Gay/Lesbian	<input type="checkbox"/>	School Based
<input type="checkbox"/>	Geriatric	<input type="checkbox"/>	Telemedicine
<input type="checkbox"/>	Hospital Based	<input type="checkbox"/>	Women
<input type="checkbox"/>	Home Based	<input type="checkbox"/>	Young Children

Treatment Modalities/ Approaches

<input type="checkbox"/>	Applied Behavioral Analysis (ABA)	<input type="checkbox"/>	Group Therapy
<input type="checkbox"/>	Addictive Disorders	<input type="checkbox"/>	Geriatric Psychiatry
<input type="checkbox"/>	Adolescent Psychotherapy	<input type="checkbox"/>	Gestalt
<input type="checkbox"/>	Adolescent Sex Offender	<input type="checkbox"/>	Hypnosis
<input type="checkbox"/>	Adolescent Psychiatry	<input type="checkbox"/>	Intensive Family Intervention
<input type="checkbox"/>	Adoption Issues	<input type="checkbox"/>	Individual Therapy
<input type="checkbox"/>	Alcohol/SA Treatment	<input type="checkbox"/>	Intensive Outpatient
<input type="checkbox"/>	Anger Management	<input type="checkbox"/>	Intake Assessment
<input type="checkbox"/>	Art Therapy	<input type="checkbox"/>	Medication Management
<input type="checkbox"/>	Attachment Therapy	<input type="checkbox"/>	Methodone/Suboxone
<input type="checkbox"/>	Behavioral Therapy	<input type="checkbox"/>	Mood Disorders
<input type="checkbox"/>	Brief Therapy	<input type="checkbox"/>	Neuropsychological Testing
<input type="checkbox"/>	Biofeedback	<input type="checkbox"/>	Neuro-Linguistic Programming (NLP)
<input type="checkbox"/>	Chemical Dependency Assessment	<input type="checkbox"/>	Outcomes Oriented Therapy
<input type="checkbox"/>	Child Parent Psychotherapy (CCP)	<input type="checkbox"/>	Parent Child Interaction Therapy (PCIT)
<input type="checkbox"/>	Child Psychiatry	<input type="checkbox"/>	Play Therapy
<input type="checkbox"/>	Child Psychological Testing	<input type="checkbox"/>	Psychological Testing
<input type="checkbox"/>	Christian Counseling	<input type="checkbox"/>	Psychoanalytic Therapy
<input type="checkbox"/>	Client Centered Therapy	<input type="checkbox"/>	Psychodynamic Therapy
<input type="checkbox"/>	Cognitive Rehab Therapy	<input type="checkbox"/>	Psychopharmacology
<input type="checkbox"/>		<input type="checkbox"/>	Pain Management

Provider Specialty Profile



Cognitive Therapy	Rationale Emotive Therapy
Community Support Program	Relapse Prevention
Community Support Program for the homeless	Relationship Disorders
Couples Therapy	Sensory Processing/Integration
Crisis Intervention/Stabilization	Sexual Compulsions/Addictions
Critical Incident Debriefing	Sex Therapy
Dialectical Behavioral Therapy	Solution Empowerment Therapy
Developmental Evaluation	Stress Management
Domestic Violence	Tobacco
ECT	Tobacco Cessation
EMDR	Trauma Focused Cognitive Behavioral Therapy
Evaluation/Assessment	Trauma Informed Care (TIC)
Family Therapy	Trust Based Relational Intervention (TBRI)
Family Systems	Weight Management
Gay/Lesbian/Bisexual	

Disorders/Issues

Addictive Medicine	Impulse disorders
ADD/ADHD	Infertility
Addictive Disorders	Inpatient Attending
Adjustment Disorder	Inpatient Consult MD
Adolescent Behavior Disorders	Learning Disability
Adoption Issues	Medical Evaluation
Adult ADD	Medical Illness/Chronic Illness
AIDS/HIV	Men Issues
Anger Management	Mood Disorders
Anxiety/Panic Disorder	Marital Issues
Attachment Disorder	Mental Retardation
Autism/Aspergers	Obsessive Compulsive Disorder
Bipolar Disorders	Oppositional Defiant Disorder
Chemical Dependency	Organic Mental Disorder
Christian/Spiritual	Parenting Issues
Chronic Pain/Pain Management	Personality Disorders
Crisis Stabilization	Post-Partum Disorder
Cultural Issues	PTSD
Child/Parent Bonding	Panic Disorder
Co-occurring Disorders	Phobias
Cognitive Disorder	Physical Abuse
Concussion	Reactive Attachment Disorder
Criminal Offenders	Relapse Prevention
Dementia Disorders	Sexual/Physical Abuse (Adults)
Developmental Disorder	Sexual/Physical Abuse (Children)
Disruptive Behavior	Schizophrenia
Dissociative Disorder	Serious/Persistent Mental Illness
Separation/Divorce	Sexual Disorders
Domestic Violence	Sexual Dysfunction
Dual Diagnosis	Sexual Abuse/Incest
Depression	Sleep Disorder

Provider Specialty Profile



Disabled	Step/Blended Families
Eating Disorders	Stress Management
Equine Assisted Therapies	Self-Injury
Family Dysfunction	Sexual Offender
Feeding Disorders	Substance Abuse
Gay/Lesbian/Bisexual	Suicide
Gender Identity Issues	Tobacco Cessation
Grief/Loss/Bereavement	Women Issues
Head Trauma	Work Related Problems
Home Visits	

Signature: _____

Date: _____