

# Provider Data Form – Behavioral Health



**Submit completed form to:**

Email: bhproviders@wellsense.org  
 Fax: (800) 894-0459

**This is a supplemental data form. Please submit with a completed HCAS Provider Enrollment Form.**

To ensure accurate record set-up, complete one form per NPI.

Provider Information			
<b>Name &amp; Degree:</b>		<b>NPI:</b>	
<b>Specialty:</b>			
<input type="checkbox"/> Addiction Medicine (MD, DO) <input type="checkbox"/> Certified Alcohol Counselor (CAC) <input type="checkbox"/> Certified Alcoholism/Drug Abuse Counselor II (CADAC II) <input type="checkbox"/> Licensed Alcohol and Drug Counselor I (LADC I, MLADC) <input type="checkbox"/> Licensed Applied Behavior Analyst (LABA) <input type="checkbox"/> Licensed Clinical Professional Counselor (LCPC) <input type="checkbox"/> Licensed Marriage and Family Therapist (LMFT) <input type="checkbox"/> Licensed Professional Counselor (LPC) <input type="checkbox"/> Master Level Marriage and Family Therapist (MFT) <input type="checkbox"/> Nurse Practitioner, Behavioral Health (APRN) <input type="checkbox"/> Psychiatric Mental Health Nurse Practitioner (Psych NP) <input type="checkbox"/> Psychiatrist-Child & Adolescent (MD,DO)		<input type="checkbox"/> Applied Behavioral Analysis (BCBA) <input type="checkbox"/> Certified Alcoholism/Drug Abuse Counselor (CADAC) <input type="checkbox"/> Licensed Alcohol and Drug Counselor (LADC) <input type="checkbox"/> Licensed Alcohol and Drug Counselor II (LADC II) <input type="checkbox"/> Licensed Clinical Mental Health Counselor (LCMHC) <input type="checkbox"/> Licensed Independent Clinical Social Worker (LICSW) <input type="checkbox"/> Licensed Mental Health Counselor (LMHC) <input type="checkbox"/> Master Level Clinician (MA, MS, MEd) <input type="checkbox"/> Master Level Social Worker (LCSW, MSW) <input type="checkbox"/> Physician Assistant, Behavioral Health (PA) <input type="checkbox"/> Psychiatrist-Adult (MD, DO) <input type="checkbox"/> Psychologist (PhD, PsyD, EdD)	
<b>Currently participating in Medicare?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Medicare Number:</b>	
<b>Currently participating in Medicaid?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Medicaid Number:</b>	<b>State:</b>
<b>Include in provider Directory?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Provider's Race (Optional*):</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to answer			
<b>Provider's Ethnicity (Optional*):</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Some other race <input type="checkbox"/> Declined to answer			
<b>Provider Languages (Optional*):</b> <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese (Cantonese and Mandarin) <input type="checkbox"/> Haitian-Creole <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese (Khmer) <input type="checkbox"/> Other:			

*\* Race, ethnicity, and language information is optional and will be displayed in the Plan's provider directory if disclosed. WellSense does not discriminate or base credentialing decisions on this information.*

Group Information	
<b>Group Name:</b>	
<b>Group NPI:</b>	<b>Group Tax ID:</b>
<b>Additional Addresses:</b> Submit list of additional service locations beyond what is reflected the HCAS form, if applicable.	
<b>Mailing Contact Name:</b>	<b>Mailing Contact Title:</b>
<b>Mailing Contact Email:</b>	<b>Mailing Contact Phone:</b>

## Accessibility

**Genders Served:**  Male  Female

**Ages Treated:**  0-21  22-65  66 and over

**Language Capabilities:**  Cambodian  Chinese (Cantonese and Mandarin)  Haitian-Creole  
 Portuguese  Russian  Spanish  Vietnamese (Khmer)  
 Other:

### Hours of Operation:

Monday	Start:	End:
Tuesday	Start:	End:
Wednesday	Start:	End:
Thursday	Start:	End:
Friday	Start:	End:
Saturday	Start:	End:
Sunday	Start:	End:

**Telehealth Services Available:**  Yes  No

## Areas of Expertise

- Abuse (Physical, Emotional, Sexual)
- Adjustment Disorders
- Attachment / Reactive Attachment Disorder
- Bariatric Counseling
- Bipolar Disorder Treatment
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Eating Disorder Treatment
- Expressive Arts Therapy
- Fire Setting
- Immigration Populations
- Indian Health Services
- Medical Co-Morbidity
- Medication Management
- Mood Disorder Treatment
- Personality Disorders
- Post-Traumatic Stress Disorder Treatment
- Psychotic Disorder Treatment
- Serious and Persistent Mental Illness
- Sexual Offenders
- Trauma-Focused Cognitive Behavioral Therapy
- Treatment of Autism Spectrum Disorders
- Visually Impaired
- Addiction - Non-Substance Related
- Anxiety Disorder Treatment
- Attention-Deficit / Hyperactivity Disorder (ADHD)
- Bilingual or Multi-Lingual Abilities
- Children and Adolescents
- Couple Therapy
- Dual Diagnosis (MH/SUD)
- EMDR
- Family Therapy
- Geriatric Behavioral Health
- Incarceration / Re-entry
- LGBTQ+
- Medication Assisted Treatment (Suboxone)
- Methadone Maintenance
- Obsessive Disorder Treatment
- Persons with Disabilities
- Pregnant and Post-Partum Depression
- Race Based Trauma
- Sexual Disorder
- Substance Use Disorder Treatment
- Traumatic Brain Injury
- Veteran's Issues

## Handicapped Accessibility

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Accessible Examination Table         | <input type="checkbox"/> Accessible Restrooms             | <input type="checkbox"/> Accessible Scales      |
| <input type="checkbox"/> Accessible via Public Transportation | <input type="checkbox"/> Bariatric Examination Tables     | <input type="checkbox"/> Bariatric Scale        |
| <input type="checkbox"/> Elevators in Multistory Buildings    | <input type="checkbox"/> Exterior Building                | <input type="checkbox"/> Gurneys and Stretchers |
| <input type="checkbox"/> Handicap Parking                     | <input type="checkbox"/> Interior Building                | <input type="checkbox"/> Portable Lifts         |
| <input type="checkbox"/> Radiologic Equipment                 | <input type="checkbox"/> Signage & Documents              | <input type="checkbox"/> Signs in Braille       |
| <input type="checkbox"/> TTY for Patient Services             | <input type="checkbox"/> Wheelchair Accessible Exam Rooms | <input type="checkbox"/> Wheelchair Ramps       |

## Other

- Please answer all of the questions by checking the appropriate "Yes" or "No" box.
- If you answered "yes", please include a copy of your certificate.

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a minority owned business?           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a Woman owned business enterprise?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a Veteran owned business enterprise? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a LGBT owned business enterprise?    |

## Next Steps

### Submit the following documents using the contact information provided at the top of this form

- Behavioral Health Provider Data Form
- List of additional service locations if applicable
- HCAS Provider Enrollment Form
- Participating Provider Agreement (if not contracted)
- W-9 Form

***Failure to complete all sections may result in a delayed processing.***