Health Care Professional Screening Form

For behavioral health care professionals

Thank you for your interest in becoming a participating health care professional in Cigna's behavioral health network. To be considered for this network, please complete this form. Electronically key in information on this form or print the form and complete it using legible handwriting. Once completed, return the form in one of the following ways:

- Email to BehavioralHCPEnrollment@cigna.com
- Fax to 855.300.6162

Please note: You must complete all sections of the screening form. Incomplete forms may be excluded from consideration or take more time for Cigna to render a decision.

Applicant Information

** indicates a **required** field*

*Are you licensed to practice independently (without supervision) in the state in which you're providing services? ☐ Yes ☐ No

* Do you have a recruitment code? ☐ Yes ☐ No If Yes, please include here: _____

***Your name**: _____ ***Degree**: _____

First Middle Initial Last

***DOB**: _____ ***Gender**: ☐ M ☐ F ***SSN**: _____ ***License Type (not #):** _____

*Email is a preferred method of communication with participating health care professionals. **Please supply a valid email address for each of the four categories below so that we may route our communications appropriately:**

***Credentialing/contracting email*:** _____

(*****The "Credentialing/contracting email" above will be used by Cigna to contact you in response to this application & any additional credentialing-related correspondence)

Appt. availability email: _____

General communications email: _____

Billing issues email: _____

CAQH # (If known): _____ ***NPI Type1#:** _____

Medicare # (If applicable): _____ **Medicaid # (if applicable):** _____

*Do you provide behavioral health screening, brief interventions, or case management services in a Medical practice with a Cigna contracted physician? ☐ No ☐ Yes

Name of Cigna contracted clinic (if applicable): _____

Taxpayer information (w-9 information – as registered with the IRS):

***Tax ID:** _____

*Taxpayer Name (as shown on your income tax return): _____

Business Name (if different from above): _____

NPI Type2# (Business NPI)

*Street Address _____ Suite _____ *City _____ *State _____ *ZIP _____

*Billing Phone: _____

Pay to information (where checks should be mailed):

*Last name/Business Name: First Name:

*Street Address Suite *City *State *ZIP

*Billing Phone:

*Mailing address (1 mailing address only – for correspondence):

*Street Address Suite *City *State *ZIP

*Service location

*Street:

Suite: *City/State: *ZIP:

County: ***Is office in your home?** Y N

*Appts/Intake Phone:

Fax:

Crisis Phone:

Other: Cell Pager

Additional service location

*Street:

Suite City/State: *ZIP:

County: **Is office in your home?** Y N

*Appts/Intake Phone:

Fax:

Crisis Phone:

Other: Cell Pager

Please copy this page if more space is required

Clinical practice information (to be completed by all practitioners)

*Areas of clinical practice

*Indicate up to **ten (10)** areas which are the primary focus of your practice*

ADHD/ADD
Adoption issues
AIDS/HIV
Anger management
Anxiety disorder
Bipolar disorder
Borderline personality disorder
Conduct/disruptive disorder
Depression
Dissociative disorder
Domestic Violence
Faith-based counseling
Family therapy
Fertility issues
Gambling addictions
Gay/Lesbian issues
Gender identity
Grief/loss
Home visits
Martial/couples therapy
Medical issues/illness
Minority issues
Obsessive compulsive D/O
Panic disorder
Phobias
Psychological testing
Psychotic disorders
PTSD
Sexual Abuse/incest
Sexual disorders
Sexual offenders

*Appointment availability

Cigna requests all applicants to be available for routine appointments within 10 business days after a request for an appointment. Select and attest to any of the following that describe your availability AND expertise.

Crisis stabilization 24/7
If I check this box, I attest that:
- I agree to make myself available through the use of pagers and/or answering services to Cigna participants after hours and on weekends
- My voicemail does not routinely instruct participants to go to the nearest emergency room unless determined to be medically necessary

Crisis stabilization non-24/7
If I check this box, I attest that:
- I agree to make myself available for crisis appointments during business hours only (8:00 AM-6:00 PM)

Intermediate care (urgent)
If I check this box; I attest that:
- I am willing to provide precautionary and preventive care to a participant within 48 hours in order to prevent escalation to a higher level of care

Meet and greet (non-physicians only)
If I check this box, I attest that:

• I am willing to conduct a pre-discharge visit with a hospitalized participant in order to coordinate and schedule an ambulatory follow-up appointment within 2-7 days after discharge

*After hours availability

Evening appointments
Weekend appointments

*Languages

Please list any languages in which you are fluent in conducting therapy (including ASL)

Practitioners who prescribe

Psychiatric nurses

Cigna considers for its network psychiatric nurses who hold a master's degree in nursing with a major in psychiatric or mental health nursing or 18 graduate semester hours in mental health nursing. In order to prescribe medications, Cigna follows the prescriptive authority guidelines for the state in which the psychiatric nurse practices, including state mandates regarding physician supervision and Drug Enforcement Agency (DEA) and Controlled Dangerous Substances (CDS) licensures.

ANCC (American Nurses Credentialing Center) #:

Indicate your current status regarding prescription medications:

I do not provide medication management
I provide medication management and have prescriptive authority as granted by the State in which I practice.
I have my own DEA number, which is
My state does not require a DEA number to prescribe
I can prescribe as part of a collaboration agreement with my supervising physician

Psychiatrists

Please select the category that applies to you

I am not currently board certified

I am board certified in psychiatry or neurology by the American Board of Psychiatry and Neurology
My primary subspecialty is:
Expiration date: _____ OR Lifetime

I am board certified in psychiatry or neurology by the American Osteopathic Association
My primary subspecialty is:
Expiration date: _____ OR Lifetime

I am not a psychiatrist but am an addictionologist certified by the American Society of Addiction Medicine (ASAM)
My current ABMS board certification is:

*Please provide your DEA number:

*Please select the option which best describes your current practice:
Outpatient only
Outpatient and inpatient attending
Inpatient attending only

Specialty networks

Criteria for inclusion

To participate in one of Cigna's behavioral health specialty networks, please ensure you meet the qualifications outlined below. Health care professional attestation will be required for each specialty chosen as well as an attestation for cooperation in a specialty documentation audit. Any required documentation will be requested at a later date. To claim a specialty in one of the following clinical specialties or populations you must meet one or more of the following conditions for each specialty.

1. Certification by a nationally recognized certifying organization.

2. An internship, fellowship, or formal training program in an accredited institution focusing on treatment of one of the designated disorders or groups of patients or use of one of the designated treatment modalities.

3. An accumulation of continuing education units or course work focused on current treatment of one of the designated disorders or groups of patients or use of one of the designated treatment modalities.

4. Significant work experience focused on current treatment of one of the designated disorders or groups of patients. The depth and breadth of experience must demonstrate that you have gained the knowledge and skills to be considered a specialist.

Disorders and treatment modalities

Check only the specialty areas and populations for which you meet the above criteria

Alcohol and substance abuse
Autism – social skills group
Autism – testing and assessment
☐ Autism – treatment
Buprenorphine and Suboxone outpatient treatment **(Physicians Only)** Provide your DEA waiver number
☐ Developmental disorders
Dual diagnosis
Eating disorder
Eye movement desensitization and reprocessing (EMDR)
Maternal Mental Health
Neuropsychological testing
Pain management

*Specialty patient populations

Check at least one. By checking any age group other than Adult you attest that you have a specialty with that population and you are willing to participate in a specialty documentation audit.

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

Employee assistant program (EAP) specialty services

By checking these specialties or certifications you are attesting that you meet all of the criteria listed. You may be required to complete an additional survey and attestation for these services.

EAP assessment and referral
If I check this box, I attest that:
- I am qualified and available to perform short term counseling that focuses on problem identification and resolution and/or referral to an appropriate resource to complete problem resolution

Certified Employee Assistance Professional (CEAP) certification
If I check this box, I attest that:
- I hold a current CEAP certificate granted by the Employee Assistance Certification Commission (EACC)

Critical incident response
If I check this box, I attest that:
- I have received formal training in Critical Incident Response
- I have delivered a minimum of four (4) CIR services in the past two (2) years
- I agree to make changes in my schedule to accommodate CIR requests within 2-12 hours

Employee educational seminars (e.g., employee wellness workshops or training at the workplace)
If I check this box, I attest that:
- I have presented a minimum of four (4) employee wellness seminars in the past two (2) years
- I agree to make changes in my schedule to accommodate requests within three to four weeks
- I am knowledgeable in presenting seminars utilizing PowerPoint
- I can access Cigna EAP educational information electronically – via email or CD

Management referrals
If I check this box, I attest that:
- I am experienced with clients who are required to access services
- I agree to assess an employee and develop a plan to address his or her issues that may be contributing to the workplace problem
- I am qualified and agree to perform a general substance abuse screening as part of my overall assessment
- I am familiar with local resources and agree to serve as an advocate for the client in accessing the proper level of care

• I agree to follow up with referral resources to verify initial compliance with recommended treatment
• I agree to follow up within 24 hours of each appointment with the Cigna EAP consultant

Substance abuse professional (SAP) certification as defined by the Department of Transportation (DOT)

***Note**: Substance abuse licensure or certificate through your state or national entity is not sufficient and does not meet the criteria for this level of service.*

If I check this box, I attest that:

• I have successfully completed a qualification training course recognized by the Department of Transportation (DOT)
• I have satisfactorily completed a post-training examination administered by a nationally recognized professional or training organization recognized by the DOT
• I hold a certificate that indicates I have met all the DOT requirement (effective after 1/1/04) for practice as an SAP and am qualified to use the title of SAP as defined by the DOT

Substance abuse expert (SAE)

***Note**: Substance Abuse Licensure or Certificate through your state or national Entity (for example, CAC, CADAC, LCDC) is not sufficient and does not meet the criteria for this level of service.*

If I check this box, I attest that:

• I have met the Nuclear Regulatory Commission (NRC) requirements (effective March 31, 2010) for providing SAE services.
• I have satisfactorily completed a qualification training that meets the NRC's requirements as well as continuing education related to the SAE function.
• I hold a certificate that indicates I have met all the NRC requirements for practice as an SAE and am qualified to use the title of SAE

☐ **Supervisory training sessions at the workplace**

If I check this box, I attest that:

• I am familiar with the management referral process, including the role of the manager, the EAP consultant, and the counselor
• I have delivered a minimum of four (4) supervisory training sessions in the last two (2) years
• I agree to make changes in my schedule to accommodate these requests within two to four weeks
• I am knowledgeable in presenting seminars utilizing PowerPoint
• I can access Cigna EAP educational information electronically – via email or CD

☐ Behavioral Telehealth

If I check this box, I hereby certify and attest to the following:

• I meet all state requirements to provide behavioral telehealth services, including any licenses and certifications.
• I will provide behavioral telehealth services only in the state (s) where I hold a license.
• I utilize only a secure internet connection and follow all HIPAA requirements.*

**Please consult with the American Telemedicine Association (ATA), a leading international resource and advocate promoting the use of advanced remote medical technologies. They have a list of endorsed technologies for the use of behavioral telehealth services.*

HEALTH CARE PROFESSIONAL ATTESTATION

I understand that if Cigna extends credentialing to me, my Participating Agreement will include all lines of business. I understand that the Cigna agreement is not specific to location or Taxpayer Identification Number but rather is a contract with me as an individual practitioner. I understand that I must treat all Cigna participants equally and must behave as contracted regardless of service location (I will be considered contracted and in-network at all places of service). I understand that I may not charge Cigna participants out-of-network rates. I hereby certify and attest that all of the information above is true and accurate, and misstatement or omission may result in denial of application with or without appeal. If credentialed as a Cigna Behavioral Health participating health care professional, I will cooperate during a specialty documentation audit, if requested, to verify that I meet the outlined criteria for participation in the specialty network(s). I understand that any information provided pursuant to this attestation that is subsequently found to be untrue or incorrect could result in my termination from the Cigna Behavioral Health network. A copy of this attestation shall have the same force and effect as the signed original.

*Healthcare Practitioner Signature: *Date: