Behavioral Health Facility and Ancillary Credentialing Application

Please complete the application thoroughly in its entirety.
The checklist below may not be exhaustive of all materials, but is provided as a guide for the documents required to complete the credentialing process.

Please enclose the following with your completed Behavioral Health Facility/Ancillary Credentialing Application.

- ☐ Copy of the completed Disclosure Information Form found on the Provider Forms page at www.SuperiorHealthPlan.com.
- ☐ Signed and dated W-9 with IRS registered legal business name and billing address information.
- ☐ A copy of your The Joint Commission (TJC)/ Commission on Accreditation of Rehabilitation Facilities (CARF)/Council on Accreditation (COA)/American Osteopathic Association (AOA) accreditation letter with dates of accreditation.
- ☐ A copy of the state or local license(s) and/or certificate(s) under which your facility operates. Include all documentation for multiple facility locations.
- ☐ Medicaid enrollment/certification letter with Medicaid Number.
- ☐ Medicare enrollment/certification letter with Medicare number.
- ☐ A copy of your Clinical Laboratory Improvement Amendments (CLIA) license. (If applicable).
- ☐ A copy of Drug Enforcement Agency (DEA) certificate.
- ☐ A copy of your Pharmacy license. (If applicable)
- ☐ A copy of your professional and general liability insurance policy with the limits of coverage per occurrence and in aggregate, name of liability carrier, and insurance effective date and expiration date (Month/Day/Year).
- ☐ A copy of your National Disaster Medical System (NDMS) agreement. (If applicable)
- ☐ A copy of your state or local fire/health certificate. (Non-accredited facilities only)
- ☐ A copy of your Quality Assurance Plan. (Non accredited facilities only)
- ☐ A copy of your Credentialing Procedures. (Accredited and Non accredited facilities)
- ☐ Description of Aftercare or Follow up Program. (Non-accredited facilities only)
- ☐ A copy of the most recent site evaluation.
- ☐ Organizational Charts including staff to Patient Ratios. (Non accredited facilities only)

Return by mail to:
Superior HealthPlan's Contract Management
7990 Interstate 10 West, Suite 300
San Antonio, TX 78230
Return by email to: SHP.NetworkDevelopment@SuperiorHealthPlan.com
Recredentialing Applications
Re-credentialing applications can be returned using one of the options below:

- Email: Credentialing@SuperiorHealthPlan.com
- Fax: 1-866-702-4831
- Mail: Superior HealthPlan's Credentialing Department, 5900 E. Ben White Blvd., Austin, TX 78741

***Please Note**: A separate Behavioral Health Facility/Ancillary Credentialing Application must be completed for each facility with a unique Federal Tax ID.*

SuperiorHealthPlan.com

Behavioral Health Facility and Ancillary Credentialing Application

Facility Practice Locations

☐ Initial Credentialing

☐ Addition of a new site/service to a current contract

☐ Recredentialing

Legal Name: _____

Parent Company/Health: _____

System Name (if applicable): _____

D/B/A: _____

Facility Type

☐ Hospital
☐ Intensive Family Intervention
☐ Adult Living Facility
☐ Home Health Agency
☐ Federally Qualified Health Center/RHC
☐ Other: _____

☐ Community Mental Health Center
☐ Rehabilitation Center
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Assisted Long-Term Care facility
☐ Outpatient Clinic
☐ Substance Use Treatment Facility

Identify Levels of Care Offered by Facility

(If you are already contracted with Superior, select only the level of care being added)

Psychiatric/Mental Health

	Child	Adol	Adult	Geriatric
Inpatient	☐	☐	☐	☐
Partial	☐	☐	☐	☐
IOP	☐	☐	☐	☐
Observation	☐	☐	☐	☐
Residential	☐	☐	☐	☐
ECT	☐	☐	☐	☐
Other (i.e. SIPP, PRTF)	☐	☐	☐	☐

Substance Abuse, Chemical Dependency

	Child	Adol	Adult	Geriatric
Inpatient Detox	☐	☐	☐	☐
IP Rehab	☐	☐	☐	☐
Partial	☐	☐	☐	☐
IOP	☐	☐	☐	☐
Residential	☐	☐	☐	☐
Ambulatory Detox	☐	☐	☐	☐
Medication Assisted Treatment	☐ Methadone		☐ Suboxone	

Other:

If Detoxification is offered at facility, on which unit are services offered:

☐ Located on Medical Floor/Unit ☐ Located on Behavioral Health Floor/Unit

Are you an Opioid Treatment Provider (OTP)? ☐ Yes ☐ No

Facility Practice Locations

Location #1

Address:

Phone:

Fax:

NPI:

Taxonomy:

	Mental Health (MH)						Substance Abuse (SA)						
Age Category	Inpatient I/P	Partial	IOP	Residential	Observation	Other: ☐	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other ☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of I/P Beds (MH): _____

Number of Medicare Beds (MH): _____

ECT: ☐ Inpatient ☐ Outpatient

Number of I/P Beds (SA): _____

☐ Methadone ☐ Suboxone

☐ Opioid Treatment Provider (OTP)

Location #2

Address:

Phone:

Fax:

NPI:

Taxonomy:

	Mental Health (MH)						Substance Abuse (SA)						
Age Category	Inpatient I/P	Partial	IOP	Residential	Observation	Other: ☐	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other ☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of I/P Beds (MH): _____

Number of Medicare Beds (MH): _____

ECT: ☐ Inpatient ☐ Outpatient

Number of I/P Beds (SA): _____

☐ Methadone ☐ Suboxone

☐ Opioid Treatment Provider (OTP)

Facility Practice Locations

Location #3

Address:

Phone:

Fax:

NPI:

Taxonomy:

	Mental Health (MH)						Substance Abuse (SA)						
Age Category	Inpatient I/P	Partial	IOP	Residential	Observation	Other: ☐	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other ☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of I/P Beds (MH): _____

Number of Medicare Beds (MH): _____

ECT: ☐ Inpatient ☐ Outpatient

Number of I/P Beds (SA): _____

☐ Methadone ☐ Suboxone

☐ Opioid Treatment Provider (OTP)

Location #4

Address:

Phone:

Fax:

NPI:

Taxonomy:

	Mental Health (MH)						Substance Abuse (SA)						
Age Category	Inpatient I/P	Partial	IOP	Residential	Observation	Other: ☐	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other ☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of I/P Beds (MH): _____

Number of Medicare Beds (MH): _____

ECT: ☐ Inpatient ☐ Outpatient

Number of I/P Beds (SA): _____

☐ Methadone ☐ Suboxone

☐ Opioid Treatment Provider (OTP)

Facility Practice Locations

Location #5

Address:

Phone:

Fax:

NPI:

Taxonomy:

	Mental Health (MH)						Substance Abuse (SA)						
Age Category	Inpatient I/P	Partial	IOP	Residential	Observation	Other: ☐	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other ☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of I/P Beds (MH): _____

Number of Medicare Beds (MH): _____

ECT: ☐ Inpatient ☐ Outpatient

Number of I/P Beds (SA): _____

☐ Methadone ☐ Suboxone

☐ Opioid Treatment Provider (OTP)

Location #6

Address:

Phone:

Fax:

NPI:

Taxonomy:

	Mental Health (MH)						Substance Abuse (SA)						
Age Category	Inpatient I/P	Partial	IOP	Residential	Observation	Other: ☐	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other ☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of I/P Beds (MH): _____

Number of Medicare Beds (MH): _____

ECT: ☐ Inpatient ☐ Outpatient

Number of I/P Beds (SA): _____

☐ Methadone ☐ Suboxone

☐ Opioid Treatment Provider (OTP)

Facility Information

Mailing Address: _____

City, State, Zip: _____ County: _____

Administrative Phone: _____ Fax: _____ Email: _____

Billing Address: _____

Billing City: _____ Billing State: _____ Billing Zip: _____

Credentialing Address: _____

Credentialing City: _____ Credentialing State: _____ Credentialing Zip: _____

Federal Tax ID Number: _____

Medicare Provider Number: _____ Issue Date: _____ Expiration Date: _____

Medicare Provider Number: _____ Issue Date: _____ Expiration Date: _____

Are all of your HIPAA transactions conducted from a centralized location? ☐ Yes ☐ No

(If no, please ensure you indicate a separate NPI number per location on page 3.)

Contact Information	Name	Phone	Email Address
Managed Care Contact:			
Credentialing Contact:			
Billing Contact:			
Clinical Director:			

Accreditation Information

Is this facility accredited? ☐ Yes ☐ No

Agency	Acronym	Issue Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers AAAHC	AAAHC		
American Osteopathic Hospital Association	AOHA		
Commission on Accreditation for Rehab Facilities	CARF		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
The Joint Commission TJC	TJC		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
State Facility Operating License	N/A		
Others (please list)			

License and/or Certification

	Issuing Entity	Type of License/Certificate	License Number	Expiration Date
1.				
2.				
3.				
4.				

Does the organizational provider state licensure/certification include a site visit by the state? ☐ Yes ☐ No

If yes, please attach a copy of the audit, the site visit letter including the date of site visit, and any corrective action plan issued.

Insurance Coverage - *(Attach copy declaration pages)*

Current Professional Carier: _____

Amount Per Occurrence: _____ Amount Per Occurrence: _____

Dates of Coverage From: _____ To: _____

Current Worker's Compensation Carrier: _____

Dates of Coverage From: _____ To: _____

If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts.

Accessibility Information

Language(s) spoken at this location:

☐ English ☐ Vietnamese
☐ Spanish ☐ Cambodian
☐ Haitian Creole ☐ Russian
☐ Laotian / Hmong ☐ French
☐ Polish ☐ Other: _____

Wheelchair Accessible? ☐ Yes ☐ No

Is the facility open at least five days per week? ☐ Yes ☐ No

Hours of Operation: 24-hours, or:

Monday	Tuesday	Wednesday	Thursday	Friday
_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____

Conflict of Interest Disclosure Statement

I, _____ , hereby declare that I (or a related party) Do ☐ Do not ☐ have an actual, potential or perceived Conflict of Interest that I wish to disclose to Superior HealthPlan, Inc.
Such disclosure must include, the legal name of the entity involved, its business address, its federal tax ID number, its principal line(s) of business, and the provider's ownership interest (by percentage) and/or management role (including title) with the entity.

Signed (required): _____

Name (required): _____

Title (required): _____

Date (required): _____

If "do" is checked above, you are required to fill out the following summary of your disclosure.

This must include all material facts and the above-listed items of information (use additional paper as necessary):

Legal name of the entity involved: _____

Business address: _____

_____

Federal tax ID number: _____

Provider's ownership interest (e.g., type and percentage): _____

Entity's principal line(s) of business: _____

Sanctions

If any question below is responded to with a "yes", please provide an explanation on a separate sheet, and attach to this Application.

	Yes	No
• Have there been or are there currently pending any malpractice claims, suits, settlements or proceedings involving the facility?	☐	☐
• Has the facility ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐	☐
• Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct?	☐	☐
• Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer, or a Regulatory Agency (CLIA, OSHA, etc.)	☐	☐
• Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?	☐	☐
• Has any employee of the entity who has or will have direct care access to consumers/members ever been convicted of, pled guilty to, or pled noro contendere to any felony including an act of violence, child abuse or a sexual offense?	☐	☐
• Has the corporation, an officer or a board member ever been convicted of a felony?	☐	☐

Mental Health Rehabilitation Services and Mental Health Targeted Case Management

Provider Attestation
Senate Bill 58

WHEREAS, Integrated Mental Health Services d/b/a Superior HealthPlan ("Superior"), has executed an Agreement with _____("Entity") dated _____ pursuant to which Entity has agreed to provide Covered Services to Superior Covered Persons through Entity Clinicians (the "Agreement"); and

WHEREAS, Superior has requested that the undersigned ("Entity") annually attest to the ability to provide Mental Health Rehabilitative Services and Mental Health Targeted Case Management as required by Senate Bill 58 of the 83rd Legislative Session; and

WHEREAS, as a condition of such participation and Entities designation under this Agreement, entity provider must satisfy Superior's training and certification requirements and execute this Attestation acknowledging their agreement to comply with, and be bound by, the terms and conditions of the Attestation.

NOW THEREFORE, Entity hereby agrees as follows, and attests that:

1. Participating Providers are trained and certified to administer, the Adult Needs and Strengths Assessment (ANSA) or the Child and/or Adolescent Needs and Strengths (CANS) assessment tools, agrees to use these tools to recommend a level of care by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system.
2. The Participating Provider has completed all training requirements outlined in the HHSC Uniform Managed Care Manual (UMCM) Chapter 15.3 before delivering any Mental Health Rehabilitation and Mental Health Target Case Management Services.
3. The Participating Entity will complete the Texas Standard Prior Authorization Request Form for all Level of Care (LOC) 4 and LOC deviations and will submit to Superior.
4. The Participating Entity will provide Mental Health Rehabilitative Services and Targeted Case Management using the Department of State Health Services (DSHS) (DSHS) Texas Resiliency and Recovery (TRR) Utilization Management Guidelines and the ANSA or the CANS tools for assessing a member's needs for services.
5. The Participating Entity has the ability to provide Covered Persons with the full array of TRR services either directly or through sub-contract.
6. The Participating Entity is familiar with HHSC's cost reporting process and will participate in this process.

Signature Block to Follow

Entity Name (print): _____

Facility Signature: _____

Signature Date: _____

Tax ID Number: _____

NPI Number: _____

State Medicaid Number: _____

For questions, please contact Superior Provider Services at 1-877-391-5921.

Facility Responsibility Form

I hereby understand that as a prospective/current Superior provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Superior in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Superior's credentialing/recredentialing requirements for all such individuals associated with my practice. By applying for participation with Superior, I hereby fully understand that the information submitted in this application shall be held confidential by the Superior and provided only to individuals connected with the Plan on a need to know basis. Not withstanding the foregoing, I agree to the following:

- Participation in the credentialing review functions of Superior.
- Authorize Superior and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, or other State or Federal regulatory agencies.
- Consent to an inspection by Superior and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- Release from liability all representatives of Superior for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal fromthe participating network.

In order to evaluate this application for participation in and/or continued participation with Superior, the Facility hereby gives permission to Superior to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that Superior will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of Superior.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility is selected or retained, after such selection or retention, the Facility agrees to inform Superior in writing within 10 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by Superior on its own behalf and if the Facility is initially applying for participation, grants this Entity no rights or privileges in any Superior programs or any program until such time as this Entity receives notice of participation. All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. A photo copy shall have the same force and effect as the signed original.

Signature of Entity CEO (or authorized designee): Title:

Name (Print): Date: