

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.)

DOB: _____ Provider e-mail: _____

Member ID #: _____

Individual NPI #: _____ Individual Taxonomy Type: _____

Group NPI #: _____ Group Taxonomy Type: _____

Are you Board Certified? Yes No
If "Yes," what type of Board Certification do you have? _____

Do you have admitting privileges/ affiliations at a hospital? Yes No
If "Yes," please list the hospital(s) where you have privileges: _____

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# _____

Primary Office Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Secure Fax: _____

Please ensure this address and all additional practice locations are entered on your application.

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

Art Therapy	Positive Behavior Support
Center of Excellence	SBIRT
Emergency Services Provider	Trauma Informed Care
Lead Behavior Analysis Therapist	

Settings/Populations Treated

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

Treatment Modalities/ Approaches

Applied Behavioral Analysis (ABA)	Hypnosis
Addictive Disorders	Intensive Family Intervention
Adolescent Psychotherapy	Individual Therapy
Adolescent Sex Offender	Intensive Outpatient
Adolescent Psychiatry	Intake Assessment
Adoption Issues	Medication Management
Alcohol/SA Treatment	Methodone/Suboxone
Anger Management	Mood Disorders
Art Therapy	Neuropsychological Testing
Attachment Therapy	Neuro-Linguistic Programming (NLP)
Behavioral Therapy	Outcomes Oriented Therapy
Brief Therapy	Parent Child Interaction Therapy (PCIT)
Biofeedback	Play Therapy
Chemical Dependency Assessment	Psychological Testing
Child Parent Psychotherapy (CCP)	Psychoanalytic Therapy
Child Psychological Testing	Psychodynamic Therapy
Christian Counseling	Psychopharmacology
Client Centered Therapy	Pain Management
Cognitive Therapy	Rationale Emotive Therapy
Couples Therapy	Relapse Prevention
Crisis Intervention/Stabilization	Relationship Disorders

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Critical Incident Debriefing	Sensory Processing/Integration
Cognitive Rehab Therapy	Sexual Compulsions/Addictions
Child Psychiatry	Sex Therapy
Dialectical Behavioral Therapy	Solution Empowerment Therapy
Developmental Evaluation	Stress Management
Domestic Violence	Tobacco
ECT	Trauma Focused- CBT
EMDR	Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Evaluation/Assessment	Trauma Informed Care (TIC)
Family Therapy	Trust Based Relational Intervention (TBRI)
Family Systems	Weight Management
Gay/Lesbian/Bisexual	Tobacco Cessation
Group Therapy	
Geriatric Psychiatry	
Gestalt	

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: _____