

*Mid-Valley Behavioral Care Network*

**PROVIDER RE-CREDENTIALING APPLICATION**

*Please type or print all application information.*

**1. IDENTIFYING INFORMATION**

1.1 Name of Applicant Agency \_\_\_\_\_

1.2 Director's Name \_\_\_\_\_  
Program Manager's Name \_\_\_\_\_

1.3 Primary Office Address \_\_\_\_\_  
*Street or Box #*

\_\_\_\_\_  
*City State Zip*

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

1.4 Other Office Address \_\_\_\_\_  
*Street or Box #*

\_\_\_\_\_  
*City State Zip*

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Other Office Address \_\_\_\_\_  
*Street or Box #*

\_\_\_\_\_  
*City State Zip*

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Other Office Address \_\_\_\_\_  
*Street or Box #*

\_\_\_\_\_  
*City State Zip*

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

1.5 Tax I.D. # \_\_\_\_\_

1.6 Agency Medicare # \_\_\_\_\_

1.7 Are services provided in any language other than English or for culturally diverse populations? [ ] **Yes** [ ] **No**

*Language* \_\_\_\_\_ *Services Provided* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Culture* \_\_\_\_\_ *Services Provided* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2. CERTIFICATE OF APPROVAL/ACCREDITATION**

FOR ORGANIZATIONAL MEMBERSHIP:

2.1 Date of most recent Letter(s) of Approval from Oregon AMH \_\_\_\_\_

2.2 For Methadone services and controlled substances:

Attach copy of each: federal and state license/registration, and a copy of latest federal site review and compliance;

Federal DEA Number \_\_\_\_\_ Expiration Date

Federal DEA Number \_\_\_\_\_ Expiration Date

State Number \_\_\_\_\_ Expiration Date

**3. THE FOLLOWING QUESTIONS APPLY TO ANY CLAIMS AGAINST THE AGENCY IN RELATION TO BEHAVIORAL HEALTH SERVICES.**

**Please list any occurrences within the last two years**

**3.1 LIABILITY EXPERIENCE:**

If the answer to the following questions is a “yes”, please provide specifics: *date claim initiated, nature of claim, names of parties, name and location of court, description of status or disposition FOR CLAIMS NOT PREVIOUSLY REPORTED TO MVBCN.*

- 3.1.1 Have there ever been or are there currently pending any mal-practice claims, settlements, judgments or arbitration proceedings involving professional practice?  Yes  No
- 3.1.2 Has professional liability coverage ever been terminated by the carrier?  Yes  No
- 3.1.3 Has professional liability coverage ever been denied?  Yes  No
- 3.1.4 Has the carrier ever excluded any specific procedure or practice from the coverage?  Yes  No

All information submitted in this application is true to my best knowledge and belief. I fully understand that any significant misstatement in or omission from this application as well as any change in, or failure to inform the MVBCN of any changes in, information provided on this application, may constitute cause for denial of participation or cause for dismissal of this provider agency from the MVBCN.

**SIGNATURE**

Name (print or type) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_