Practitioner Registration Form for Non-Licensed Practitioner

COA Agency Only

Reason for Form: ☐ New Practitioner ☐ Updated Information

TODAY'S DATE _____

This form completed by _____

Phone & fax numbers _____ / _____

Email address _____

Please send this form to BCN by fax or secure email to:

Attn: Martha Arevalo
(503) 585-4989 or
marevalo@mvbcn.org

AGENCY INFORMATION

☐ In Panel ☐ Out of Panel

AGENCY NAME _____

PHYSICAL ADDRESS _____

CITY / STATE / ZIP _____

MAILING ADDRESS _____

CITY / STATE / ZIP _____

ALL FIELDS ARE REQUIRED.
• Prior versions of this form will not be accepted.
• This form will not be accepted if any field is blank.
• Signature required. Electronic signature not accepted.

PRACTITIONER INFORMATION

FIRST / M.I. / LAST _____

*** NPI #** _____

*** TAXONOMY CODE** _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

*** DMAP #** _____

EFFECTIVE DATE _____ *Later date between DMAP # or COA Credentialing*

- This practitioner is credentialed by the agency as: (mark only one box)

QMHP – *Specify:* ☐ Graduate degree ☐ RN ☐ OT ☐ Mental Health Intern [1]

☐ QMHA

☐ Peer Support Specialist (attach OHA approval letter)

☐ Peer Wellness Specialist (attach OHA approval letter)

[1] As defined in OAR 309-019-0105

- Services delivered by this practitioner: ☐ Outpatient ☐ MV WRAP/New Solutions ☐ Both

Authorized personnel signature _____

Original: 03-02-15
Revised: 06-15-18

For BCN Use Only – Verification evidence for above items in **bold with *** must be included when signed by reviewers and must be retained per policy.

Rec'd Date _____ Initial Reviewer _____ Date _____

Completed Ticket # _____ Secondary Reviewer_____ Date _____

Date submitter notified about completion status _____