Practitioner Registration Form for Licensed Practitioner

Type of Agency: ☐ COA Agency ☐ Licensed-Only Agency

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 _____

PRACTITIONER INFORMATION

FIRST / M.I. / LAST _____

*** NPI #** _____

*** TAXONOMY CODE** _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

*** DMAP #** _____

EFFECTIVE DATE _____ *Later date between the date of DMAP # or Hire Date*

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.

- Is this practitioner enrolled with Medicare? ☐ YES ☐ NO
  Applies only to MD, NP, PsyD & LCSW
- This practitioner is licensed, or is a board-registered intern, as follows: (mark only one box)

☐ MD/DO ☐ NP/PMHNP ☐ PA ☐ LPC ☐ LPC Intern [1] ☐ LMFT ☐ LMFT Intern [1] ☐ LCSW ☐ CSW Associate[1] ☐ Psychologist ☐ Psychologist Associate Resident [1] ☐ Licensed Psychologist Associate under continued supervision [1] [1] Board-registered intern per OAR 410-172-0660 (5)(a-d)	*** Oregon board license or registration #** _____

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

Authorized personnel signature _____

Original: 03-02-15
Revised: 07-17-18

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 _____ Submitted to WVP date _____ by _____