

Request for Application (RFA)—Facility

Complete the application request below to be considered for the Carelon Behavioral Health Provider Network.



Facility Information

Required fields throughout this form are noted with an asterisk (*).

Facility DBA Name*

Primary NPI*

Facility TIN*

Medicare ID

Medicaid ID

Taxonomy ID*

Active Carelon Behavioral Health Provider ID

Accreditation: *

TJC (JCAHO)

COA

AAACH

Others, please list: _____

NCQA

AOA

DNV

CARF

CHAP

HFAP

Primary Service Address*

City, State, Zip Code

Email

Phone Number

Fax Number

Mailing Address*

City, State, Zip Code

Email

Phone Number

Fax Number

Website

What type of claim form will your organization file?*

UB-04 (formerly UB-82/UB-92 Facility)

Both UB-04 and CMS-1500

CMS-1500 (billed by professional)

EDI Claim Submission

Does your organization have secondary/multiple locations? Yes No

Does your organization have multiple Facility NPIs? Yes No Please list: _____

Does your organization have multiple Facility TINs? Yes No Please list: _____

Does your organization accepting new patients? Yes No

Is your organization Handicap Accessible? Yes No

Is your organization Public Transportation Accessible? Yes No

Request for Application (RFA)—Facility

Complete the application request below to be considered for the Carelon Behavioral Health Provider Network.



Facility Contact

Requestor Contact Name*	Title	
_____	_____	_____
Email*	Phone Number*	Fax Number

Credentialing Contact Name* (if different from above)	Title	
_____	_____	_____
Email*	Phone Number*	Fax Number

Billing Contact Name* (if different from above)	Title	
_____	_____	_____
Email*	Phone Number*	Fax Number

Facility Type

- | | |
|---|--|
| General Hospital | Home Health Agency |
| Freestanding Acute Psychiatric Facility | Freestanding Substance Abuse Rehabilitation Facility |
| Residential Treatment Center | Federally Qualified Health Center |
| Community Mental Health Center | Others, Please list: |
| Outpatient Clinic | |
| Freestanding Intensive Outpatient Program | |

Line of Business Affiliation

- | | | |
|--------------------------|------------------------------|----------------------|
| Commercial (HMO/PPO) | Federal (Military OneSource) | Others, Please list: |
| Dual (Medicaid/Medicare) | Medicare | _____ |
| EAP | Medicaid | |

Request for Application (RFA)—Facility

Complete the application request below to be considered for the Carelon Behavioral Health Provider Network.



Facility Services and Programs

From the list below, please select all applicable services and programs. These services will be taken into consideration for review of the network.

Psychiatric	Child (0-12)	Adolescent (13-17)	Adult (18-64)	Geriatric (65+)	Dual Diagnosis
Inpatient Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partial Psychiatric Care Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partial Hospitalization Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive Outpatient Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Treatment Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subacute Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Disorder	Child (0-12)	Adolescent (13-17)	Adult (18-64)	Geriatric (65+)	Dual Diagnosis
Inpatient Substance Use Disorder – Acute Detox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Substance Use Disorder – Detox Drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Substance Use Disorder – Detox Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Substance Use Disorder – Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone Medication/Dispensing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suboxone Medication/Dispensing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partial Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulatory Detoxification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric Specialty Services

Inpatient Electroconvulsive Therapy

Applied Behavior Analysis

23-Hour Observation

Outpatient Electroconvulsive Therapy

Home Health Care

Crisis/Evaluation in the ER

Halfway House

Others or State-Specific, please list:

Request for Application (RFA)—Facility

Complete the application request below to be considered for the Carelon Behavioral Health Provider Network.



Service Availability and Hours of Operation Required

- Outpatient facilities, physicians, and practitioners are expected to provide crisis intervention services during operating hours and available 24 hours per day, 7 days per week.
- Under state and federal law, licensed providers are required to provide interpreter services to communicate with individuals with limited English proficiency.
- The Organization should have services available Monday through Friday from 9 a.m. to 5 p.m. at a minimum. Evening and/or weekend hours should also be available at least two days per week.

Attestation Statement

I certify that all information provided to Carelon Behavioral Health is true and correct to the best of my knowledge and belief. I agree to notify Carelon Behavioral Health promptly if there are any material changes in the information provided, whether prior to or after my acceptance as a Carelon Behavioral Health participating provider. I understand and agree that if Carelon Behavioral Health discovers that my application contains any significant misstatement, misrepresentations, or omissions, Carelon Behavioral Health may void, in its sole discretion, this application and any related participating provider agreements. I understand that if Carelon Behavioral Health extends credentialing to me, my Participating Agreement will include all lines of business. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue or incorrect could result in my application rejection or termination from the network.

Signature:

Legal Name of Organization

Print Name of Individual Signing for Organization

Authorizing Signature and Title

Date

Please return this form including the Terms and Conditions via fax to 888-643-4396 or via email to RFA@carelon.com

Your request will be review by the Market Network Manager and if the market is open. A Network Manager will reach out to your facility.

Incomplete, incorrect, or illegible forms may delay or prevent proper processing.
If you have any questions, call the National Provider Service Line Monday through Friday, between 8 a.m. and 8 p.m. ET, at 800-397-1630.