Special Needs/Supplemental Information: Behavioral Health Practitioners

INSTRUCTIONS

Behavioral health practitioners should complete this form to help us understand the level of training and/or experience you have treating patients with special needs. This information will be included in our provider directories and will help us make clinically appropriate referrals to our members as part of the Horizon Behavioral Health program.

Completed and signed forms may be mailed to: **Horizon BCBSNJ Credentialing & Recredentialing Dept.**
Three Penn Plaza East, PP-14C
Newark NJ 07105-2200

PRACTITIONER INFORMATION

Practitioner Name: ____________________

Practitioner Specialty: ____________________

Practitioner Type 1 NPI: ____________________

Practitioner Telephone: ____________________

Practitioner Email: ____________________

PATIENT POPULATION

Please check the appropriate boxes to the questions below to identify the patient population categories you currently treat and to indicate if you are accepting new patients in these categories.

Do you treat children age 0 to 5?
- ☐ Yes
- ☐ No

Are you accepting new patients age 0 to 5?
- ☐ Yes
- ☐ No

Do you treat children age 6 to 12?
- ☐ Yes
- ☐ No

Are you accepting new patients age 6 to 12?
- ☐ Yes
- ☐ No

Do you treat adolescents age 13 to 17?
- ☐ Yes
- ☐ No

Are you accepting new patients age 13 to 17?
- ☐ Yes
- ☐ No

Do you treat adults age 18 to 64?
- ☐ Yes
- ☐ No

Are you accepting new patients age 18 to 64?
- ☐ Yes
- ☐ No

Do you treat adults age 65 and older?
- ☐ Yes
- ☐ No

Are you accepting new patients age 65 and older?
- ☐ Yes
- ☐ No

(Continues)

SPECIAL NEEDS TRAINING/EXPERIENCE

Do you have formal training and/or experience treating adults/children with special needs including persons with physical, mental, substance abuse or developmental disabilities?

☐ Yes

☐ No

Please indicate if you have training/experience treating patients in the special needs categories below.

Do you have training/experience working with Developmentally Disabled patients?

☐ Yes

☐ No

If "Yes," please explain. ______________________________

Do you have training/experience working with patients who are Blind?

☐ Yes

☐ No

If "Yes," please explain. ______________________________

Do you have training/experience working with patients who are Deaf?

☐ Yes

☐ No

If "Yes," please explain. ______________________________

Do you have training/experience working with Non-Ambulatory patients?

☐ Yes

☐ No

If "Yes," please explain. ______________________________

Do you have training/experience working with patients who have HIV/Aids?

☐ Yes

☐ No

If you selected "Yes," please explain. ______________________________

Do you have training/experience working with Aged patients (i.e., 65 years and older)?

☐ Yes

☐ No

If "Yes," please explain. ______________________________

(Continues)

BEHAVIORAL HEALTH AREAS OF EXPERTISE

Please select six (6) areas of expertise from the list below. If more than 6 areas are selected, we will only retain the first 6 alphabetically.

- ☐ Abuse, Assault and Trauma (PTSD)
- ☐ Adjustment Disorders
- ☐ Adoption
- ☐ Anger Management/Impulse Disorders
- ☐ Anxiety and Panic Disorders
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Autism Spectrum Disorders (Autism/PDD/Asperger's)
- ☐ Bariatric Assessment
- ☐ Behavior Modification
- ☐ Behavioral Therapy for Autism Spectrum Disorders
- ☐ Bipolar Disorders/Manic Depressive Illness
- ☐ Brief Solution Focused
- ☐ Chemical Dependency Assessment/Treatment
- ☐ Childhood/Adolescent Behavioral Disturbances
- ☐ Christian Counseling
- ☐ Cognitive Behavioral Therapy (CBT)
- ☐ Compulsive Gambling
- ☐ Co-Occurring Disorders
- ☐ Cultural/Ethnic Issues
- ☐ Depression
- ☐ Developmental Disabilities
- ☐ Developmental, Individual-differences and Relationship-based Model (DIR)[1]
- ☐ Dialectical Behavioral Therapy (DBT)
- ☐ Disability Assessment/Treatment
- ☐ Dissociative/Identity Disorders
- ☐ Divorce/Blended Family Issues
- ☐ Eating Disorders
- ☐ Electroconvulsive Therapy (ECT)
- ☐ End of Life Issues
- ☐ Eye Movement Desensitization and Reprocessing (EMDR)
- ☐ Faith-Based Therapy
- ☐ Family Therapy
- ☐ Fitness For Duty Assessment
- ☐ Forensics
- ☐ Gangs/Cults
- ☐ Gay/Lesbian/Bisexual Issues
- ☐ Geriatrics
- ☐ Grief/Bereavement
- ☐ Group Therapy
- ☐ Head Trauma
- ☐ HIV/AIDS-Related Issues
- ☐ Infertility
- ☐ Medication Management
- ☐ Men's Issues
- ☐ Military Lifestyles Issues
- ☐ Neuropsychological Testing
- ☐ Obsessive Compulsive Disorder
- ☐ Pain Management
- ☐ Personality Disorders
- ☐ Play Therapy
- ☐ Postpartum Issues
- ☐ Prenatal Issues
- ☐ Psychological Testing
- ☐ Reactive Attachment Disorder
- ☐ Repetitive Transcranial Magnetic Stimulation
- ☐ Schizophrenia Disorders
- ☐ Selective Mutism
- ☐ Sexual Disorders
- ☐ Sleep Disorders
- ☐ Somatic/Conversion/Factitious Disorders
- ☐ Stress Management
- ☐ Telemedicine Services[3]
- ☐ TIC Suppression
- ☐ Tourettes Syndrome
- ☐ Transgender Issues
- ☐ Women's Issues
- ☐ Worker’s Compensation Evaluation

(Continues)

Important Notes about Areas of Expertise

[1] *If you select Developmental, Individual-differences and Relationship-based Model (DIR) as an area of expertise, please include a copy of your certification. Please note that DIR services are considered eligible services only for patients enrolled in Horizon NJ Health plans/products. DIR services are not considered eligible services for patients enrolled in Horizon BCBSNJ plans/products.*

[2] *If you select Telemedicine Services as an area of expertise, please ensure that you also complete the Telemedicine Services Attestation section below.*

MAT/OBAT AND NAVIGATOR ATTESTATION

Behavioral health practitioners who provide Medication Assisted Treatment (MAT) or Office Based Addiction Treatment (OBAT) to patients with an addiction diagnosis must provide a completed copy of our MAT/OBAT and Navigator Attestation form to attest that services are provided in compliance with guidelines established by the NJ Division of Medical Assistance and Health Services and the Division of Mental Health and Addiction Services.

TELEMEDICINE SERVICES

If you provide telemedicine services to patients as part of your practice, you are required to comply with the guidelines of Horizon BCBSNJ's Telemedicine Services reimbursement policy and/or Horizon NJ Health's Telemedicine and Telehealth reimbursement policy.

The guidelines of these policies include, but are not limited to, the requirement that telemedicine services are conducted for the purpose of diagnosis, consultation, and/or treatment and are conducted using a HIPAA compliant and secure interactive, real-time, two-way audio-video communication technology.

☐ I do not provide telemedicine services as part of my practice.

☐ I comply with the guidelines of Horizon BCBSNJ's Telemedicine Services policy and/or Horizon NJ Health's Telemedicine and Telehealth reimbursement policy in the delivery of services to my patients.

Please note that our Telemedicine Services *and* Telemedicine and Telehealth *reimbursement policies are temporarily amended to consider additional technologies/services for reimbursement during the COVID-19 pandemic. The temporary policy addenda only apply for the duration of this pandemic.*

ATTESTATION

By signing and dating below, I, attest that the information provided on this form is accurate and complete.

Name ______________________________

Telephone ______________________________

Position/Role ______________________________

Email Address ______________________________

Signature ______________________________

Date ______________________________

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