Provider Specialty Profile

This profile was created to capture specific information that will allow us to improve our referral process by closely matching member needs with provider services. Please note that incomplete information will be rejected.

Provider Information

Name:_____ _____ _____
First Middle Last Suffix

Licensure: _____ **State of Licensure:** **License Number:** _____
(MD, ARNP, PhD, LCSW, etc.)

SS#: _____ **DOB:** _____ **Provider e-mail:** _____

Individual Medicaid #: _____ **Individual Medicare #:** _____

Individual NPI #: _____ **Individual Taxonomy Type:**_____

Group NPI #: _____ **Group Taxonomy Type:** _____

Credentialing Information

Credentialing Contact Name: _____ **Phone:** _____

Email:_____ **Fax:** _____

Council for Affordable Quality Healthcare (CAQH) Participant? 0 Yes 0 No If yes, list CAQH#* _____

*Please be sure all information, attachments and attestations are up to date and access has been granted for MHS Health Wisconsin to view your data
*If you do not have a CAQH number, you can obtain one by going to proview.caqh.org
*MHS Health Wisconsin only accepts credentialing submissions through CAQH. For more information, visit www.caqh.org

Practice Information

Group Name/Clinic Name:_____ **Tax ID#** _____

☐ Check here if you ONLY offer home based services

Practice Address : ___ _____ _____ _____ _____
City State Zip

.

Second Practice Address:_____
City State Zip

.

Billing Office Contact Information: _____
Name Phone Email address

Billing Address: _____ _____ _____ _____ _____
City State Zip

Mailing Address:_____ _____ _____ _____
City State Zip

Provider Specialty Profile

Office Hours	
MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	
SUNDAY	

Are you currently accepting new members? ❑ Yes ❑ No

Appointment Availability: Please indicate your availability for the following appointment types: * **Routine** appointment – within 10 business days (14 calendar days) ❑ **Yes** ❑ **No**

* **Urgent** appointment – within 24 hours ❑ **Yes** ❑ **No**

* **7-day Post Hospital Discharge** appointment ❑ **Yes** ❑ **No** *Please indicate location: ❑ In home ❑ In office*

Ethnicity: Please choose the option that best describes your ethnic background (used to meet member referral requests)

❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander

❑ African America, Black ❑ Hispanic or Latino

❑ White, Non-Hispanic _____ ❑ other: _____(please specify)

Do you provide services in languages other than English? ❑ Yes ❑ No

If "Yes," what other languages? _____

Does your office staff speak languages other than English? ❑ Yes ❑ No

If "Yes," what other languages? _____

Do you offer emergency services? ❑ Yes ❑ No

If "Yes," please describe: _____

Are the following areas in your office handicapped accessible? (Check those that apply)

❑ Building ❑ Restroom ❑ Therapy Room ❑ Parking

What are your age restrictions? Youngest Age: _____ Oldest Age: _____

Do you provide services to both males and females? ❑ Yes ❑ No

If "No," please explain: _____

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Treatment Expertise/Specialties

Please select the types of services you offer, including the disorders you treat and the modalities you practice. (Check those that apply)

NOTE: Please submit evidence of certificates or transcripts that account for the associated trainings in the treatment modalities and/or disorders selected below.

	Certifications		
	Art Therapy		Positive Behavior Support
	Center of Excellence		SBIRT
	Emergency Services Provider		Targeted Case Management (TCM) Certificate Required
	Lead Behavior Analysis Therapist		Trauma Informed Care
	Settings/Populations Treated		
	Adolescents		Homelessness
	Adults		Men
	Blind/Visually Impaired		Mobile Crisis
	Children		Nursing Home
	Community Based		Physical Disability
	Deaf/Hearing Impaired		Serious Emotional Disturbance
	Developmental Disability		Serious Mental Illness
	Emotionally Disturbed		Severe Persistent Mentally Ill
	Gay/Lesbian		School Based
	Geriatric		Telemedicine
	Hospital Based		Women
	Home Based		Young Children
	Treatment Modalities/ Approaches		
	Applied Behavioral Analysis (ABA)		Group Therapy
	Addictive Disorders		Geriatric Psychiatry
	Adolescent Psychotherapy		Gestalt
	Adolescent Sex Offender		Hypnosis
	Adolescent Psychiatry		Intensive Family Intervention
	Adoption Issues		Individual Therapy
	Alcohol/SA Treatment		Intensive Outpatient
	Anger Management		Intake Assessment
	Art Therapy		Medication Management
	Attachment Therapy		Methodone/Suboxone
	Behavioral Therapy		Mood Disorders
	Brief Therapy		Neuropsycholog ical Testing
	Biofeedback		Neuro-Linguistic Programming (NLP)
	Chemical Dependency Assessment		Outcomes Oriented Therapy
	Child Parent Psychotherapy (CCP)		Parent Child Interaction Therapy (PCIT)
	Child Psychiatry		Play Therapy
	Child Psychological Testing		Psychological Testing
	Christian Counseling		Psychoanalytic Therapy
	Client Centered Therapy		Psychodynamic Therapy
	Cognitive Rehab Therapy		Psychopharmacology
			Pain Management

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	Cognitive Therapy		Rationale Emotive Therapy
	Community Support Program		Relapse Prevention
	Community Support Program for the homeless		Relationship Disorders
	Couples Therapy		Sensory Processing/Integration
	Crisis Intervention/Stabilization		Sexual Compulsions/Addictions
	Critical Incident Debriefing		Sex Therapy
	Dialectical Behavioral Therapy		Solution Empowerment Therapy
	Developmental Evaluation		Stress Management
	Domestic Violence		Tobacco
	ECT		Tobacco Cessation
	EMDR		Trauma Focused Cognitive Behavioral Therapy
	Evaluation/Assessment		Trauma (TF-CBT) Informed Care (TIC)
	Family Therapy		Trust Based Relational Intervention (TBRI)
	Family Systems		Weight Management
	Gay/Lesbian/Bisexual		

Disorders/Issues			
	Addictive Medicine		Impulse disorders
	ADD/ADHD		Infertility
	Addictive Disorders		Inpatient Attending
	Adjustment Disorder		Inpatient Consult MD
	Adolescent Behavior Disorders		Learning Disability
	Adoption Issues		Medical Evaluation
	Adult ADD		Medical Illness/Chronic Illness
	AIDS/HIV		Men Issues
	Anger Management		Mood Disorders
	Anxiety/Panic Disorder		Marital Issues
	Attachment Disorder		Mental Retardation
	Autism/Aspergers		Obsessive Compulsive Disorder
	Bipolar Disorders		Oppositional Defiant Disorder
	Chemical Dependency		Organic Mental Disorder
	Christian/Spiritual		Parenting Issues
	Chronic Pain/Pain Management		Personality Disorders
	Crisis Stabilization		Post-Partum Disorder
	Cultural Issues		PTSD
	Child/Parent Bonding		Panic Disorder
	Co-occuring Disorders		Phobias
	Cognitive Disorder		Physical Abuse
	Concussion		Reactive Attachment Disorder
	Criminal Offenders		Relapse Prevention
	Dementia Disorders		Sexual/Physical Abuse (Adults)
	Developmental Disorder		Sexual/Physical Abuse (Children)
	Disruptive Behavior		Schizophrenia
	Dissociative Disorder		Serious/Persistent Mental Illness
	Separation/Divorce		Sexual Disorders
	Domestic Violence		Sexual Dysfunction
	Dual Diagnosis		Sexual Abuse/Incest
	Depression		Sleep Disorder

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	Disabled		Step/Blended Families
	Eating Disorders		Stress Management
	Equine Assisted Therapies		Self-Injury
	Family Dysfunction		Sexual Offender
	Feeding Disorders		Substance Abuse
	Gay/Lesbian/Bisexual		Suicide
	Gender Identity Issues		Tobacco Cessation
	Grief/Loss/Bereavement		Women Issues
	Head Trauma		Work Related Problems
	Home Visits		

Signature: **Date:**