STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families

Form 2617R
October 2016

CERTIFICATION RENEWAL - PRIVATE BEHAVIORAL HEALTH SERVICES PROVIDERS

Provider Type	
☐ **Alcohol/Drug Abuse Counseling - Individual**	☐ **Family Counseling**
☐ **Alcohol/Drug Abuse Counseling - Group**	☐ **Outpatient Counseling - Individual**
☐ **Diagnostic Evaluations**	☐ **Outpatient Counseling - Group**

PART A: IDENTIFYING INFORMATION

Name of Provider: _____ Federal Taxpayer ID Number (TIN): _____

Telephone: _____ **or**

Fax Number: _____ Social Security Number (SSN): _____

Physical Address: Street: _____ Email: _____

City / Town: _____ State: _____ Zip Code: _____

Mailing Address *(if different)*: _____

Languages in which you are proficient: _____

NH Medicaid Number: _____ National Provider Identification Number (NPI): _____

If you work for an agency Please complete this section:

Name of Agency: _____ Federal Taxpayer Id Number (TIN): _____

Physical Address: _____

Billing Address: _____ Telephone: _____

City/Town: _____ State: _____ Zip Code: _____ Fax Number: _____

Name of Billing Contact Person: _____ Telephone # of Billing Contact: _____

Agency Website Address: _____

NH Medicaid Number: _____ National Provider Identification Number (NPI): _____

PART B: INSURANCE INFORMATION

Do you have General and Professional Liability Insurance? Yes ☐ No ☐

Please indicate all insurance companies and/or managed care organizations that you participate with.

☐ Aetna	☐ Medicaid	☐ Value Option
☐ Anthem	☐ MVP	☐ NH Healthy Families *(Medicaid Managed Care Organization)*
☐ CBA	☐ Northeast Community Care *(aka Arcadian)*	☐ Well Sense Heath Plan *(Medicaid Managed Care Organization)*
☐ CIGNA	☐ PacifiCare	☐ Other: _____
☐ Harvard-Pilgrim	☐ Tri Care	☐ Other: _____
☐ Humana	☐ Tufts	☐ Other: _____
☐ Medicare	☐ United Behavioral Health	☐ Other: _____

PART C: INDIVIDUAL PROVIDER INFORMATION

Name of Provider: _____ **List Current Licenses:** _____

License Expiration Date: _____

All individuals must answer the following questions. If any question is answered **"yes"** provide specific information to include: **by whom, reasons, dates, details, and results** on a separate sheet and submit it with the application.

HAVE YOU EVER:	**YES**	**NO**
1. Had membership on any hospital, medical or allied health provider staff revoked?	☐	☐
2. Had provider status with any group or health maintenance organization revoked?	☐	☐
3. Had clinical privileges revoked?	☐	☐
4. Had academic appointment terminated?	☐	☐
5. Had professional or general liability insurance cancelled for disciplinary purposes?	☐	☐
6. Had any judgments or settlements made against you in a professional liability case or are there any pending law suits?	☐	☐
7. Been subject to disciplinary action by a licensing body or professional society?	☐	☐
8. Been found civilly liable for professional misconduct?	☐	☐
9. Been found to have committed an ethical violation by a state or national professional association or any state's regulatory board?	☐	☐
10. Been convicted of a felony or any crimes against a person?	☐	☐
11. Been in the past or currently are listed in any state registry of founded child or elder abuse and neglect?	☐	☐

☐ **I declare that all the information contained above is true, correct and complete to the best of my knowledge and belief. I acknowledge that the provision of false information in the application is a basis for denial of the application.**

_____ _____

Signature of Provider Date

STATEMENT OF AFFIRMATION

"I have reviewed Administrative Rule He-C 6344 and will adhere to the rules as an enrolled provider. I understand that DCYF has the right to verify information contained in this application";

"I will notify DCYF in writing within 10 business days of any change to the information contained in this application";

"I understand and agree that any individual whom provides services or agency that I subcontract with will have a current and valid license for the service being provided"; and

"The information contained in this application is correct to the best of my knowledge."

Signature of Provider _____ Date _____

Printed Name of Provider _____

Return Completed Application to:	NH Department of Health and Human Services or Division for Children, Youth and Families Provider Relations 129 Pleasant St Concord, NH 03301-3857

*Below mentioned items **MUST** be submitted in order for renewal to occur.*

☐ License to Practice or Operate
☐ Alternate W-9

FOR DCYF OFFICE USE ONLY

Enrollment Valid: From: _____ *To:* _____ *NH Bridges Provider Number:* _____

Approved for Initial Enrollment ☐ _____

Approved for Enrollment Renewal: ☐ _____ Provider Relations: _____
Signature