



MASSACHUSETTS

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CLINICIANS - DO NOT USE THIS FORM

# Behavioral Health for Children and Adolescents

## Site and service information for provider directory

Complete this two-page form for **EVERY SITE**. Read the instructions below carefully as you may not need to answer all the color-coded questions.

Provider's legal name  NPI

Check one status box below:

**Currently contracted** – means the site is listed on a current Blue Cross agreement. Answer the **yellow** and **blue** questions.

**Closing** – enter the closing date and answer the **yellow** questions.

**Opening** – enter the opening date and answer the **yellow, blue, and green** questions.

This site is:  Currently contracted  Closing  Opening Date

Site name				
Address				
City or town, state, ZIP				
Phone number to schedule appointments		Fax		
	Medicare #*		MassHealth #*	

\*Enter if different than Primary site of service

Let us know which services are offered at the above location. For each of the 8 services, please indicate (Yes or No) whether you provide the service and then select the ages for which you provide these services (check all ages that apply).

The information you provide will be included in the BCBSMA directory, *Find a Doctor & Estimate Costs*.

Please complete all 8 lines.

	SERVICE PROVIDED?		AGES TREATED		
	Yes	No	Age 12 & under	Age 13-19	Over age 19
1. In-Home Behavioral Services (IHBS): Behavior management monitoring and behavior management therapy	<input type="radio"/> †	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In-Home Therapy (IHT): Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support	<input type="radio"/> †	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Intensive Care Coordination (ICC)	<input type="radio"/> †	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Therapeutic Mentoring (TM)	<input type="radio"/> †	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Family Support & Training (FS&T)	<input type="radio"/> †	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Community Based Acute Treatment for Children and Adolescents (CBAT)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Intensive Community Based Treatment for Children and Adolescents (ICBAT)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Mobile Crisis Intervention (MCI)	<input type="radio"/> †	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

†A site from which you offer only these home-based services, and no other Behavioral Health for Children and Adolescents services, does not need to be listed on your license. All other credentialing requirements apply.

### Additional site of service

If the address above is your Primary site of service, you may skip the remaining questions and enter the information on the [application](#) instead.

Billing address for this site **If NPI is the same as Primary site's NPI, the billing address must also be the same.**

Same as above  Same as for Primary site  Other – enter below:

Billing company name				
Address				
City, state, ZIP				
Phone		Fax		

**Accessibility**

Does this site accept admissions, provide services, or have a coverage arrangement:  
 24 hours a day, 7 days per week?  Yes  No  
 During evening hours?  Yes  No    On weekends?  Yes  No

Which Massachusetts counties are in this site's service area?  
 Barnstable     Berkshire     Bristol     Dukes     Essex     Franklin     Hampden  
 Hampshire     Middlesex     Nantucket     Norfolk     Plymouth     Suffolk     Worcester

Is this site handicap accessible (i.e., parking, ramps, or elevator)?  Yes  No  
 Does this site have TTY/TDD services for people with hearing impairments?  Yes  No  
 If yes, please provide number

Is this site accessible by public transportation?  Yes  No  
 Are interpretation services available at this site?  Yes  No  
 Which foreign languages (including sign language) are spoken by an office interpreter at this site?

**Accreditation**    See our [Institutional Credentialing and Recredentialing Guidelines](#)

Same as for Primary site     Other – enter below:  
 Name of accreditation organization:

Confirm that you attached accreditation certificate(s) for this site

**License**

Same as for Primary site     Other – enter below:  
 License number     Confirm that you attached a copy of the license for this site

**Medical Director (if applicable)**

Same as for Primary site     Other – enter below:  
 Name   
 NPI Type 1     Confirm that you attached a copy of medical director's license

**Additional credentialing information (if applicable)**    See our [Institutional Credentialing and Recredentialing Guidelines](#)

Provide required information on a separate sheet and attach with this form.

**Insurance information**

Same as for Primary site     Other – enter below:

**Present malpractice carrier**  
 Name   
 Dates of coverage    From     To

**Present liability carrier**  
 Name   
 Dates of coverage    From     To