Credentialing Initiation Form
LP Mecklenburg-Orange only

Name (First, Middle-No Initial, Last, Maiden): _____

Name of Practice: _____ **Provider License Type (MD, LCSW, LMFT etc.):** _____

CAQH ID#: _____

NPI: _____ **TAXONOMY CODE:** _____

Clinician Email address: _____ **Phone Number:** _____

Date of Birth: ____/____/____

Mailing Address: _____

(Street Name and Number no PO Box) (City) (State) (Zip+4)

Associate Licensed LP: Provide a copy of your current supervision contract and the name/contact information of your clinical supervisor. Include an attestation from the clinical supervisor stating that you are receiving supervision.

Clinical Supervisor	Phone	Email	Address	City	State	Zip

Employment Gaps: Explain any gaps longer than 6 months _____

Insurance: Amount of $1 million / $3 million? ☐Yes ☐No

Accessibility: Handicapped accessible? ☐Yes ☐No If no, how would you accommodate a handicapped consumer?

_____

Accepting new patients? ☐Yes ☐No

Signature (of the practitioner for whom the application is being submitted):

_____ Date: _____

Alliance Health

All Offices: (919) 651-8401

Online: AllianceHealthPlan.org

Clinician Site and Specialties Information Sheet

One form to be completed per Provider and Per Site Location
(Submit multiple forms if working at more than one site location)

Help us to communicate to consumers, staff and others what they need to know about you. Credentialing cannot be initiated without receipt of this form. Check below all that apply to your scope of practice/expertise (proof may be requested). One form per site.

Group/Agency Name			
Physical Site Address (***list multiple addresses if all the specialties are applicable to each of the sites***)			
Specialties & Applied Approaches			
◯ ADD	◯ Persian	◯ EMDR/Bio-Feedback	◯ Eating Disorders
◯ American Indian/Alaska Native	◯ Physically Aggressive Youth	◯ Medicare	◯ Impulse Control
◯ American Sign Language	◯ Play Therapy	◯ Amnestic Disorder	◯ Incest
◯ Applied Behavioral Analysis	◯ Portuguese	◯ Autism Spectrum Disorders	◯ Intellectually Developmentally Delayed
◯ Arabic	◯ Russian	◯ Conduct Disorders	◯ Men's Needs
◯ Armenian	◯ Sex Abuse Treatment	◯ Dementia Disorder	◯ Mood Disorders
◯ Asian/Pacific Islander	◯ Sexual Behavior Problems	◯ Depression	◯ Parent Training
◯ Co-Occurring MH/IDD Needs	◯ Spanish	◯ Factitious Disorders	◯ Perinatal Mood Disorders
◯ Co-Occurring MH/IDD/SU Needs	◯ Special Population- Mute	◯ Obsessive-Compulsive Disorder	◯ Post-Traumatic Stress Disorder (PTSD)
◯ Co-Occurring MH/SU Needs	◯ Specialized Population- Developmental Delayed	◯ Personality Disorders	◯ Psychoanalysis
◯ Co-Occurring SU/IDD Needs	◯ Specialized Population- Intellectual Disability	◯ Rape	◯ Sex Offender Treatment
◯ Domestic Violence Offenders	◯ Specialized Population- non verbal	◯ Schizophrenia and other Psychotic Disorders	◯ Sexual Aggressive Youth
◯ Family Systems	◯ SU and Other Drug Abuse	◯ Sleep Disorders	◯ Stress Management
◯ Farsi	◯ Tele Psychiatry	◯ Somatoform Disorders	◯ Trauma Focused CBT

◯ Foreign Language Line Interpreter	◯ Teletypewriter (TTY)	◯ Traumatic Brain Injury	◯ Visually Impaired
◯ Gang Involved	◯ Vietnamese	◯ Abuse and Neglect	◯ Women's Needs
◯ Gender Identity Issues	◯ Women with Children	◯ ADD/ADHD	◯ Dutch
◯ Group Therapy	◯ All Ages	◯ Adolescents	◯ English
◯ Hindi	◯ Children (0-3)	◯ Adoption	◯ French
◯ In Home Therapy	◯ Geriatrics (55+)	◯ Affective Disorders	◯ German
◯ Italian	◯ Career/Vocational Counseling	◯ Anxiety Disorder	◯ Hmong
◯ Japanese	◯ Co-Occurring MH/SA Issues	◯ At risk youth	◯ Polish
◯ Johnston	◯ Dialectical Behavior Therapy	◯ Attachment Needs	◯ Adults (18+)
◯ Korean	◯ Disability and Chronic Illness	◯ Bipolar Disorder	◯ Gay / Lesbian / Bisexual / Transgender / Questioning
◯ Mandarin	◯ Faith Based Counseling	◯ Body Image	◯ HIV/AIDS
◯ Medicare	◯ Forensic Screening/Evaluations	◯ Couple and Family Counseling	◯ Learning Disorders
◯ NC HealthChoice	◯ Grief and Loss Therapy	◯ Court Ordered	◯ Hispanic or Latin
◯ Neurodegenerative Disorders	◯ Relaxation/Meditation-Hypnotherapy	◯ Crisis Intervention	
◯ Parent Child Interaction Therapy	◯ Anger Management	◯ Deaf &Hard of Hearing	

Languages in which you are able to communicate fluently:

◯ Arabic	◯ Dutch	◯ Italian	◯ Persian	◯ Spanish	◯ English	◯ Hindi
◯ Farsi	◯ German	◯ Korean	◯ Portuguese	◯ American	◯ French	◯ Japanese
◯ Mandarin	◯ Polish	◯ Vietnamese	◯ Other (specify)_____		◯ Available Interpreter Types _____	

All Offices:
(919) 651-8401

Online:
AllianceHealthPlan.org

Attestation Statement – LP

This Application is to be signed by each
individual provider submitting an application.

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in **Alliance Health**, I signify my willingness to appear for interview in regard to my application. I authorize **Alliance Health** to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to **Alliance Health** materials pertaining to my qualifications and competence, including materials relating to complaints filed, any disciplinary actions, suspension, or action to curtail my medical-surgical privileges. I further to consent to the inspection by representatives of **Alliance Health** of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of **Alliance Health** for their acts performed in good faith and without malice in connection with evaluating my applications and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to **Alliance Health** in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to **Alliance Health**.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, **Alliance Health** may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event that I am accepted for participation in **Alliance Health**, I hereby consent to **Alliance Health** for inspection of my patient records relating to **Alliance Health** enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation. I further agree to notify **Alliance Health** in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER **DATE**