Outpatient Behavioral Health Facility Questionnaire/Attestation

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Please complete a separate form for each outpatient facility location.
All fields are required.

1. Complete the following facility information fields:			
Facility's Legal Name (as on file with the AZ Corporation Commission)		Entity ID Number (AZ Corporation Commission)	
Facility's DBA Name(s) (if different from above)		Formation Date (as on file with the AZ Corporation Commission)	
Facility Tax ID	Organization NPI	Date Facility Opened	
		/ /	
Please note: Blue Cross Blue Shield Association licensure requirements specify that AZ Blue network providers must have a physical address for delivery of healthcare services that is located within Arizona. Providers consistently working out of another state must be contracted with the local BCBS Plan in that service area.			
Facility Address (where in-person services are delivered)		City	State / ZIP
Executive Officers' Names and Titles (CEO, COO, CFO, CMO)		Owners' Names (if not a corporation)	

2. Do you, the facility, or anyone associated with the facility [i.e., any healthcare professional identified on this form; the facility's owner(s); the facility's executive officers (CEO, CFO, COO); if applicable, the facility's board members and the facility's managing members listed on corporate documents filed with the state corporation commission where the facility is domiciled] own any other behavioral health facility? ☐ Yes ☐ No If yes, please list the facility name(s) below.

3. What type of patient does your facility accept?		
Adult, Child/Adolescent	Age Group	Male, Female, Transgender

4. Maximum number of patients you're licensed to serve (if applicable)?	Number you can serve based on facility size and staffing?

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5. Services your facility offers (in person and/or via telehealth):

	Service Type	In-Person Only	In-Person %	Virtual Only	Virtual %	Reason(s) for Virtual
☐	Substance Abuse Treatment	☐ Yes		☐ Yes		
☐	Eating Disorder Treatment	☐ Yes		☐ Yes		
☐	Intensive Outpatient Programs	☐ Yes		☐ Yes		
☐	Partial Hospitalization Programs	☐ Yes		☐ Yes		
☐	Individual Therapy Services	☐ Yes		☐ Yes		
☐	Group Therapy Services	☐ Yes		☐ Yes		
☐	Psychiatric/Mental Health Treatment	☐ Yes		☐ Yes		
Other Services (please describe)						
☐		☐ Yes		☐ Yes		
☐		☐ Yes		☐ Yes		

6. What is your patient to licensed staff ratio? *Note: Behavioral health technicians are not eligible providers under AZ Blue benefit plans (do not include them in the ratio).* _____ : _____

7. Do you have (at all times) a sufficient number of independently licensed behavioral health professionals to provide appropriate treatment and supervision of associate licensed behavioral health professionals? ☐ Yes ☐ No

Enter name, *NPI, degree, and license number for each licensed behavioral health professional. Attach additional page(s) as needed.*

Full Name	Degree (LCSW, LMFT, etc.)	NPI Number	License Number

8. Are all professional services rendered by an individual who would qualify as an eligible provider if delivering service outside of an outpatient facility setting? ☐ Yes ☐ No

Additional Comments

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Attestation

Blue Cross® Blue Shield® of Arizona (AZ Blue) requires outpatient behavioral health facilities that service AZ Blue members to adhere to the standards of care stated here. All outpatient behavioral health facility providers must:

1. Have a physical location within Arizona at which providers deliver in-person healthcare services.
2. Be licensed by the state of Arizona to provide outpatient behavioral health treatment.
3. Offer substance abuse treatment, mental health treatment, therapeutic services, educational services, or eating disorder treatment.
4. Ensure that all professional services offered are rendered by an individual who is appropriately licensed, certified, or credentialed for the service, and who would qualify as an eligible provider if delivering the service outside of an outpatient facility setting.
5. Ensure that the facility's services are not primarily for custodial, recreational, educational, reentry program, or the Giving Insurance Freely for Transition (G.I.F.T.) program.
6. Bill claims on a UB04 claim form that names the rendering provider in the attending provider field.

Authorized Electronic Signature

I am [name] _____, [title] _____

for [facility name ("Facility")] _____.

By entering my name in the electronic signature field below, I attest: (i) I am authorized to make the representations in this form on behalf of the Facility; and (ii) I have reviewed the information provided in this form and verify that it is accurate and complete. On behalf of the Facility, I acknowledge and agree that any misstatements or omissions on this form or failure to comply with the above listed requirements may result in any one or more of the following actions: denial of participation in the AZ Blue provider network, denial of claims (ineligible for coverage), recoupment of claims, and termination of the Facility's participation agreement.

/s/ _____ ____ / ____ / _____

Authorized Electronic Signature — Date (mm/dd/yyyy)

Sign, save, and email your completed form (be sure to attach required documentation) to **ProvNet@azblue.com** or fax to AZ Blue Provider Partnerships at **602-864-3142.**

Questions? Call **602-864-4231** or **800-232-2345, ext. 4231**