

NARBHA PM Form 3.20.3
Initial/Re-Credentialing Application for Agencies



1300 S. Yale Street
Flagstaff, Arizona 86001
Telephone (928) 774-7128
Facsimile (928) 774-5665

General Instructions

⇒ Complete this application in FULL. Responses may be neatly hand written or typed.
⇒ For clarification of any portion of this application, please contact the Credentialing Department at NARBHA at 928-774-7128.

Initial **Re-Credentialing**

_____ **Date of Application**

Agency Information

Agency Name: _____

Other Names Known By: _____

(Example: Parent Company, dba names)

Email address: _____ (If Applicable)

Tax ID: _____

Contact Name/Number: _____ **Fax #:** _____

Administration Address: _____

City State Zip

Administration Phone: (____) _____

CEO Name: _____

Clinical Director: _____

MIS Director: _____

QM Director: _____

HR Director: _____

Medical Director: _____

Finance Director: _____

Other Contracted RBHAs/TRBHAs: _____

This space for office use only

Initial/Re-Credentialing Application for Agencies

NARBHA Contracted Agency Site Information

Please fill out the following information for each **contracted** NARBHA site. Use additional sheets of paper if necessary.

Level I Level I RTC Level II Level III Level IV Outpatient Clinic HCTC

Site Name: _____

Address: _____

_____ City _____ State _____ Zip _____

Program Director: _____ Phone #: _____

NPI: _____ AHCCCS ID#: _____ OBHL License #: _____

Accreditation (if applicable): JCAHO CARF Other _____ Expiration Date: _____

Population(s) Served : _____ Language(s) Spoken: _____

Hours (outpatient only): Monday _____ Tuesday _____ Wednesday _____ Thursday _____

Friday _____ Saturday/Sunday _____

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Agency Liability Insurance Information

Liability Carrier: _____

Address: _____

_____ City _____ State _____ Zip

Email Address: _____ (If Applicable) Phone: (____) _____

Policy Number: _____ Dates of Coverage: _____ to _____

Worker's Comp Carrier: _____

Address: _____

_____ City _____ State _____ Zip

Email Address: _____ (If Applicable) Phone: (____) _____

Policy Number: _____ Dates of Coverage: _____ to _____

PLEASE ATTACH A COPY OF YOUR ACORD CERTIFICATE AS WELL AS THE WORKER'S COMPENSATION CERTIFICATE. (INITIAL APPLICATIONS ONLY)

Release and Attestation

**NORTHERN ARIZONA REGIONAL BEHAVIORAL HEALTH AUTHORITY, INC.
APPLICATION FOR CREDENTIALING
RELEASE AND ATTESTATION**

Name: _____

BY SIGNING AND SUBMITTING THIS APPLICATION, I HEREBY ATTEST THAT ALL INFORMATION AND DOCUMENTATION PROVIDED IS COMPLETE AND CORRECT. I UNDERSTAND AND AGREE TO UPDATE ANY CHANGES IN THE INFORMATION PROVIDED IN MY APPLICATION.

I ACKNOWLEDGE THAT ANY MATERIAL, MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION MAY CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION FOR STAFF MEMBERSHIP OR PARTICIPATION.

Print Name

Signature

Date

Please attach the following required documents:

- Completed W-9 (Initial only)
- OBHL licenses for each site
- ACORD Liability Certificate (Initial only)
- Worker's Compensation Certificate (Initial only)
- JCAHO, CARF or other accreditation

Failure to submit the required documentation will delay the processing of your application.

NARBHA ensures that the credentialing/re-credentialing information is kept confidential.

The provider has a right to be informed of the status of their application upon request.

Providers have the right to appeal credentialing decisions as per credentialing policy Section 3.20 of NARBHA's Provider Manual, Credentialing and Re-credentialing.