OUT OF NETWORK PROVIDER APPLICATION

Community Behavioral Health (CBH) works to maintain a robust provider network to support the needs of our members. If an In-Network provider cannot meet the clinical needs of a member, an Out-of-Network (OON) provider may be considered. CBH will approve and reimburse OON providers for medically necessary behavioral health services provided to CBH eligible members when there is a demonstrated need for a service offered at an OON provider.

The following information is necessary for CBH to reimburse OON providers:

PROVIDER DEMOGRAPHICS

Submission Date: _____

Application Administrator
(person filling out the application)

First Name: _____ Last Name: _____

Title: _____ Phone/Ext. #: _____

Email: _____

Provider Information

Provider Status: ☐ For Profit ☐ Non-Profit

Tax ID # (TIN/FEIN/SSN): _____

Provider Legal Name: _____

D/B/A Name (if applicable): _____

Service Location Address: _____

City: _____

State: _____

ZIP Code: _____

Is your billing or mailing address different than your service location address? ☐ Yes ☐ No *If yes:*

Billing Name *(must match tax ID name on file with IRS)*: _____

Billing/Mailing Address: _____

City: _____

State: _____

ZIP Code: _____

CONTACT INFORMATION

Executive Director/CEO

First Name: _____ Last Name: _____

Title: _____ Phone/Ext. #: _____

Email: _____

Contracting/Provider Agreement

First Name: _____ Last Name: _____

Title: _____ Phone/Ext. #: _____

Email: _____

Chief Financial Officer

First Name: _____ Last Name: _____

Title: _____ Phone/Ext. #: _____

Email: _____

Utilization Review

First Name: _____ Last Name: _____

Title: _____ Phone/Ext. #: _____

Email: _____

Quality Department

First Name: _____ Last Name: _____

Title: _____ Phone/Ext. #: _____

Email: _____

Billing

First Name: _____ Last Name: _____

Title: _____ Phone/Ext. #: _____

Email: _____

ACCREDITATION, LICENSING AND ENROLLMENT

Are you accredited? ☐ Yes ☐ No If yes, which apply? ☐ Joint Commission ☐ CARF ☐ COA

☐ Other: _____

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Are you a Pennsylvania Medicaid participating provider? ☐ Yes ☐ No

If yes, PROMISe (13-digit) #: _____

If outside of PA, are you enrolled in your home State Medicaid Program? ☐ Yes ☐ No ☐ N/A

If yes, your Medicaid Provider ID: _____

If no, and you are participating in another State Medicaid Program, which State? _____

NPI for the practitioner or facility: _____

PROVIDER ATTESTATION

Please note that to be reimbursed by Community Behavioral Health (CBH) as an Out of Network (OON)/Non-Participating provider, the following conditions must be met:

1. In-state (i.e. Pennsylvania) providers must be licensed by the Pennsylvania Department of Human Services (PA DHS), Pennsylvania Department of Drug and Alcohol Programs (PA DDAP) or the Pennsylvania Department of State (PA DOS) and enrolled in the Pennsylvania Medicaid Program (i.e. PROMISe) for the date(s) of service(s) being billed.

2. Out-of-state providers must be licensed in their home state and enrolled in the home state's Medicaid program for the date(s) of service(s) being billed.

3. Individuals must be eligible for PA Medicaid benefits and be active CBH members for the date(s) of service(s) being billed. Even though an authorization may be issued to provide services, CBH cannot pay claims for a member who is not eligible for coverage by Medical Assistance at the time services were rendered. Because eligibility or enrollment status may change at any time, CBH strongly recommends that all providers enrolled in PA Medicaid check member eligibility via the Electronic Verification System (EVS) at the time of each visit. For providers who do not participate in the PA Medicaid program, the member's eligibility is verified by calling our Member Services or Psychiatric Emergency Services hotline(s) at the time of each visit.

4. For CBH members with Third Party Liability (TPL) insurance coverage, CBH is the payor of last resort. OON providers are responsible for coordinating benefits with a member's TPL carrier and obtaining a final determination Explanation of Benefits (EOB) prior to billing CBH for services.

5. CBH reimburses for behavioral health services only; physical health services provided to a CBH member must be billed to the member's Physical Health Medicaid Managed Care Organization (PH-MCO).

6. The per diem for inpatient psychiatric, drug and alcohol residential programs and residential treatment facilities includes all physician fees.

7. The OON Application must be completed in its entirety and all requested supporting documentation must be provided to support claims reimbursement. All required supporting documentation should be submitted to CBH within 15 days of completing the OON Application.

8. Claims must be submitted consistent with CBH requirements for claims submission to qualify for reimbursement. Please be advised that CBH billing procedures may differ from commercial carriers or other Medicaid Behavioral Health Managed Care Organizations (BH-MCOs). Detailed information regarding claims submission will be provided upon receipt of the completed OON Provider Application and supporting documentation. Please note that an authorization is an agreement that the care the provider wants to provide to a specific member meets medical necessity for that level of care. It is not a promise to pay a claim. All the billing aspects of the service must be correct for the claim to be paid including meeting the timely file submission guidelines.

9. CBH reimburses OON providers at CBH Standard Rates for ambulatory and community-based services. For acute psychiatric inpatient admissions (AIP), CBH will reimburse OON providers at the greater of standard CBH Network Average rates for AIP or the Medicaid fee-for-service rate established by the facility's home state Medicaid program. For all other bed-based services (i.e. D&A Rehabilitation programs, residential treatment facilities), CBH will reimburse OON providers at a rate that aligns with the established State Medicaid rate, verified Medicaid managed care rate, or current Single County Authority (SCA) rate. If a rate other than a CBH Standard Rate is being requested, please include a letter of request and the supporting documentation of the requested rate.

10. The following business documents are required when establishing an Out of Network contract with CBH and must be submitted with this form:

- License
- W9 Form
- Tax Identification Number (TIN)
- Documentation of active enrollment in Pennsylvania or Home state's Medicaid Program (Your ID Number and Active Date should be present)
- NPI Number Verification (npiregistry.cms.hhs.gov/)
- IRS Treasury Letter

Any questions regarding CBH OON/Non-Participating provider application process can be directed to the CBH OON Provider Hotline at 215-413-7660 (select Option 2) or via email at **CBHOON@phila.gov**. Please provide the facility name, contact person (including phone number and email address) when contacting CBH with questions regarding the OON Provider Application.

Please verify that the CBH OON Provider Application for your facility has been completed in its entirety and that your organization will comply with the above requirements for reimbursement as CBH OON/Non-Participating provider.

☐ Yes

For all claims inquiries, please email at **CBHClaimsOON@phila.gov**.