Capital BLUE

Areas of Expertise Form

Please fax this completed form, along with the Behavioral Health Provider Data Form, to Capital BlueCross at 717.526.3037.

This information may be used in the referral of members to you.

1. Provider Name: ______________________________

2. Languages: Please list languages in which you are fluent and can conduct treatment.

   English (native speaker) ☐ Yes ☐ No

   Native speaker of other language(s): ______________________________

   Other(s) languages in which you can conduct treatment: ______________________________

   American Sign Language: ☐ Yes ☐ No

3. Are you accepting new members? ☐ Yes ☐ No

   If yes, how many new members can you accept per month? ______________

Insurance Benefit Appointment Availability

Do you provide routine appointments within ten (10) business days of request? ☐ Yes ☐ No

Are you available to provide urgent care within 48 hours? ☐ Yes ☐ No

Are you available to provide emergency care within six (6) hours? ☐ Yes ☐ No

Employee Assistance Program (EAP) Appointment Availability

Do you provide routine EAP appointments within three (3) business days of request? ☐ Yes ☐ No

Are you available for urgent EAP care within two (2) business days? ☐ Yes ☐ No

Are you available for nonlife-threatening emergency EAP care within six (6) hours? ☐ Yes ☐ No

4. Providing the information below is voluntary.

   The information is used for referrals and for compliance with Title VI of the 1964 Civil Rights Act. If you provide this information, you are consenting to its use and disclosure to members who request a referral to a provider of a particular gender or ethnic background and to the use of the information on websites and in provider directories published by Capital BlueCross and our customers.

   Gender: ☐ Male ☐ Female

   Ethnic background:
   ☐ Black/African American
   ☐ Asian/Pacific Islander
   ☐ Hispanic/Latino
   ☐ Declined
   ☐ Multi-Racial
   ☐ American Indian/Alaska Native American
   ☐ White/Non-Hispanic
   ☐ Other

5. Practice Information: The following information is provided to support the referral process.

a. **Please check area(s) within your scope of practice for which you have training and expertise and <u>for which you are accepting referrals</u>.** *A minimum of one (1) selection is required in the General Categories.* Please also indicate the age of patients you accept in your practice, the Start Age being the youngest and the End Age being the oldest.

General Categories		Practice Age Range	Years
☐ Mental Health		Start Age	
☐ Substance Abuse		End Age	
☐ EAP			

b. **We encourage you to also make additional selections in the specialty areas below.**

☐ ***First—Select:*** Check area(s) within your scope of practice for which you have training and expertise <u>and for which you are accepting referrals.</u> *Indicate your selections in the check box to the **left** of the practice area.*

☐ ***Then—Rank:*** Select five (5) of the areas where you've indicated particular expertise **and order** these "1" to "5," with "1" being greatest expertise of the five areas identified. *Indicate your ranking in the "Rank" column to the **right** of the practice area.*

	Rank		Rank
☐ Depressive Disorders		☐ Group Psychotherapy	
☐ Schizophrenic Disorders		☐ Mobile Crisis/Home-based	
☐ Anxiety Disorders		☐ Marriage/Family	
☐ Personality Disorders		☐ Adoption	
☐ PTSD		☐ Infertility	
☐ Bipolar Disorder		☐ Divorce/Blended Family Issues	
☐ Psychotic Disorders		☐ Medication Management	
☐ Substance Abuse Disorders		☐ Electroconvulsive Therapy (ECT)	
☐ Obsessive Compulsive Disorders		☐ Neuropsychological Testing	
☐ Eating Disorders		☐ Psychological Testing	
☐ Compulsive Gambling		☐ Neuropsychiatric Assessment	
☐ ADHD		☐ Cognitive Behavioral Therapy (CBT)	
☐ Conduct Disorders		☐ Dialectical Behavioral Therapy	
☐ Development Disorders		☐ Behavior Modification	
☐ Sexual Disorders		☐ Faith-Based Counseling: ____________________	
☐ Gay/Lesbian/Bisexual Issues		☐ Fitness-for-Duty Assessment	
☐ Transgender Issues		☐ Military/Veterans	
☐ Women's Issues		☐ Police/Fire Fighters	
☐ Men's Issues		☐ Worker's Comp/Disability	
☐ Cultural Ethnic Issues		☐ Workplace Violence	
☐ Perpetrators of Violence/Sexual Abuse		☐ Life Coaching	
☐ Victim of Violence, Abuse, Assault, Trauma		☐ Bariatric Assessments	
☐ Medical/Behavioral Comorbidity		☐ Brief Solution Focused	
☐ Obesity		*EAP only* ☐ Substance Abuse Professional (SAP/DOT)	
☐ Diabetes		*EAP only* ☐ EAP Assessment and Referral	
☐ Cardiovascular Disease		*EAP only* ☐ Short-term Resolution	
☐ Cancer		*EAP only* ☐ Management/Supervisor Consultation	
☐ Childhood Medical Conditions		*EAP only* ☐ Critical Incident Stress Management (CISM)	
☐ HIV/AIDS		*EAP only* ☐ Wellness/Supervisory Training	
☐ Asthma		*EAP only* ☐ Formal/Mandatory Referral	
☐ Chronic Pain		*EAP only* ☐ Employee Orientation	
☐ Postpartum Issues—medical comorb		*EAP only* ☐ Return to Work Consultation	
☐ Prenatal Issues—medical comorb		☐ Autism Spectrum Disorders (*see note)	
☐ End of Life Issues		☐ ICISF Trained	
☐ Workplace Crisis Response Experience		☐ Psychological First Aid Trained	
☐ Red Cross Disaster Mental Health		☐ Geriatric Medicine	
☐ Infertility			

*By selecting Autism Spectrum Disorders, you attest that you have had training in and a background in the clinical evaluation of Autism Spectrum Disorders, and that in addition, you are able to provide treatment for Autism Spectrum Disorder and continue your skills through ongoing practice and training in this area.