

Requests are ONLY accepted by email and ONLY with this form completely filled out.

Please send to: [LSletterofinterest@humana.com](mailto:LSletterofinterest@humana.com)

<b>Humana Behavioral Health Provider Interest Form</b>			
<b>Please Print</b>			
<b>Date:</b>	<b>Contact Person:</b>		
<b>Provider Name:</b>	<b>Email Address:</b>		
<b>Telephone Number:</b>	<b>Tax ID:</b>		
<b>Fax Number:</b>	<b>National Provider Identifier:</b>		
<b>State:</b>	<b>Desired Role:</b> <input type="checkbox"/> MD <input type="checkbox"/> BCBA Other (List License):		
<b>County:</b>	<b>CAQH Number:</b>		
<b>Provider's Physical Address:</b>	<b>Provider's Mailing Address (if different from physical address):</b>		
<b>New Group?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group Name:	Group Tax ID Number:		
<b>Are you <u>joining</u> an existing group of providers who are currently participating with Humana Behavioral Health?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Group Name:	Group Tax ID Number:		
<b>Are you <u>leaving</u> an existing group of providers who are currently participating with Humana Behavioral Health?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Group Name:	Group Tax ID Number:		
<b>Does provider take Medicare patients?</b>	<b>Provider's Medicare Number:</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b><u>Specialties:</u></b> So that we can make proper referrals, please check the specialties listed below that represent at least 20% of your practice. Do not select more than six specialties, or you will be classified as a general practitioner.			
<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Mood Disorders/Depression	<input type="checkbox"/> Postpartum	<input type="checkbox"/> Disease Mgmt.
<input type="checkbox"/> Brief Psychotherapy	<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Violence/Trauma (rape, all abuse)	<input type="checkbox"/> Stress Mgmt.
<input type="checkbox"/> Child Abuse/Neglect	<input type="checkbox"/> Neuropsychological Testing	<input type="checkbox"/> Gay/Lesbian Issues	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Community Resource Svs.	<input type="checkbox"/> Sexuality	<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Critical Incident/Debriefing	<input type="checkbox"/> Personality Disorders	<input type="checkbox"/> Anger Mgmt.
<input type="checkbox"/> Grief/Death/Dying	<input type="checkbox"/> Anxiety/Phobic Disorders	<input type="checkbox"/> Psychiatric Disability	<input type="checkbox"/> Autism
<input type="checkbox"/> Play Therapy	<input type="checkbox"/> Religious Emphasis	<input type="checkbox"/> Marital Therapy	<input type="checkbox"/> Nursing Home

Once form is submitted via email, a decision will be rendered within 120 business days. (For Missouri providers, we will review your information and make a decision to approve or deny your completed credentialing application within 60 business days of the date we receive it.) Determinations are based on network need and current availability of services. **Please Note:** Requesting, obtaining or submitting a profile form does not guarantee or imply that you will be accepted to participate in the Humana Behavioral Health network, nor does it entitle you to payment of services rendered to a Humana Behavioral Health member prior to receiving written confirmation of an effective date and meeting any and all applicable authorization requirements. All providers are subject to Humana Behavioral Health credentialing requirements and applicable state and federal guidelines as set forth in the Humana Behavioral Health participating provider agreement.