



# HUMAN BEHAVIOR INSTITUTE

Full Service Behavioral Health

## OUTPATIENT FACILITY LETTER OF INTENT

2740 South Jones Blvd, Las Vegas, NV 89146

Phone (702) 248-8866 / (800) 441-4483

Fax (702) 248-1339 / (866) 766-7652

www.hbinetwork.com

DATE: \_\_\_\_\_

NAME OF AGENCY \_\_\_\_\_

TIN \_\_\_\_\_ NPI \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PRACTICE ADDRESS (If different from above) \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

TEL. NO. \_\_\_\_\_ FAX NO. \_\_\_\_\_ E-MAIL \_\_\_\_\_

### CLINICIANS PROVIDING SERVICES

List all the clinicians in your facility. Use another sheet if form is not enough

NAME & TITLE	EDUCATION				LICENSE		
	DEGREE	UNIVERSITY	YEAR GRADUATED	YEAR INTERNSHIP/ RESIDENCY COMPLETED	STATE	NUMBER	EXP. DATE
1. MEDICAL DIRECTOR:							
2. CLINICAL DIRECTOR:							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

### CURRENT PRACTICE INFORMATION

PSYCHIATRIC HOSPITAL ADMITTING PRIVILEGES \_\_\_\_\_

PATIENTS SERVED (Check all that apply) *\*Must submit proof of education, training, and experience in treatment of children*  
 \*Children (below) 7yo     \*Children 7-12yo     Adolescents     Adults     Geriatrics     Couples/Family     Groups

LANGUAGES SPOKEN (Other than English) \_\_\_\_\_

SPECIALIZATION (List areas of expertise) \_\_\_\_\_

SPECIAL LICENSES/CREDENTIALS/ACCREDITATION \_\_\_\_\_

DO YOU HAVE A QM POLICY IN PLACE?    DO YOU HAVE A CLINICAL POLICY IN PLACE?  
 Yes    No   *\*Submit copy of policy*     Yes    No   *\*Submit copy of policy*

MEDICARE PROVIDER    MEDICAID PROVIDER    PROVIDER 14    PROVIDER 82  
 Yes    No     Yes    No     Yes    No     Yes    No

**Submit this completed form and any required documentation to HBI Provider Services  
Fax: (702) 248-1339 or E-mail: credentialing@hbinetwork.com**

**NOTE: This is ONLY a Letter of Intent and does not entitle you as a network provider. Our Provider Services Department will send you an application packet that you are required to complete in order to become a fully credentialed provider.**

\_\_\_\_\_  
FACILITY REPRESENTATIVE SIGNATURE

\_\_\_\_\_  
PRINT NAME & TITLE OF AUTHORIZED PERSON