



# HUMAN BEHAVIOR INSTITUTE

Full Service Behavioral Health

## INDIVIDUAL PROVIDER 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

NAME		DATE:	
TIN		NPI	TITLE/CREDENTIALS:
MAILING ADDRESS			
CITY, STATE, ZIP			
PRACTICE ADDRESS (If different from above)			
CITY, STATE, ZIP			
TEL. NO.	FAX NO.	E-MAIL	
EDUCATIONAL BACKGROUND			
UNIVERSITY	DEGREE	YEAR GRADUATED	YEAR COMPLETED RESIDENCY/INTERNSHIP
CURRENT LICENSES			
DISCIPLINE OF PRACTICE (Check all that apply)	LICENSE		
	STATE	NUMBER	EXP. DATE
<input type="checkbox"/> Psychiatrist			
<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Board Cert			
<input type="checkbox"/> Clinical Psychologist			
<input type="checkbox"/> Licensed Clinical Social Worker			
<input type="checkbox"/> Licensed Marriage and Family Therapist			
<input type="checkbox"/> Licensed Alcohol and Drug Counselor			
<input type="checkbox"/> Certified Case Manager			
<input type="checkbox"/> Licensed Mental Health Counselor			
<input type="checkbox"/> Advanced Psychiatric Nurse			
<input type="checkbox"/> Other			
CURRENT PRACTICE INFORMATION			
GROUP AFFILIATION			
PSYCHIATRIC FACILITY/HOSPITAL PRIVILEGES			
PATIENTS SERVED (Check all that apply) <i>*Must submit proof of education, training, and experience in treatment of children</i>			
<input type="checkbox"/> *Children (below) 7yo <input type="checkbox"/> *Children 7-12yo <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults <input type="checkbox"/> Geriatrics <input type="checkbox"/> Couples/Family <input type="checkbox"/> Groups			
LANGUAGES SPOKEN (Other than English)			
SPECIALIZATION (List areas of expertise)			
MEDICARE PROVIDER <input type="checkbox"/> Yes <input type="checkbox"/> No		MEDICAID PROVIDER <input type="checkbox"/> Yes <input type="checkbox"/> No	

Submit this completed form and any required documentation to HBI Provider Services

Fax: (702) 248-1339 or E-mail: [credentialing@hbinetwork.com](mailto: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.**

PROVIDER/AUTHORIZED SIGNATURE

PRINT NAME & TITLE OF AUTHORIZED PERSON