HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

2740 South Jones Blvd, Las Vegas, NV 89146
Phone (702) 248-8866 Ext. 210
Fax (702) 248-9640 • www.hbinetwork.com

OUTPATIENT FACILITY LETTER OF INTENT

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? ☐ Yes ☐ No **Submit copy of policy*		DO YOU HAVE A CLINICAL POLICY IN PLACE? ☐ Yes ☐ No **Submit copy of policy*	
MEDICARE PROVIDER ☐ Yes ☐ No	MEDICAID PROVIDER ☐ Yes ☐ No	PROVIDER 14 ☐ Yes ☐ No	PROVIDER 82 ☐ Yes ☐ No

Submit this completed form and any required documentation to HBI Provider Services
Fax: (702) 248-9640 or E-mail: credentialing@hbinetwork.com

NOTE: This is <u>ONLY</u> 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