



Southeastern Regional Mental Health, Developmental Disabilities
and Substance Abuse Services
Performing Provider Profile

ORGANIZATION INFORMATION

Facility Name: «Organization__ Facility_Name»
Mailing Address: «Mailing_Address», «City», «State» «ZIP»
Physical Address: «Physical_Address», «Physical_City»

Special Accommodations

- Bi-lingual _____
- Hearing Impaired
- Sign Language
- Services for Blind
- Speech Impaired
- Wheelchair Accessible
- Physician Services

ENROLLMENT INFORMATION

Is your facility directly enrolled with Medicaid? Yes No
If yes, what is your Medicaid Provider Number? _____
IPRS Attending Provider Number: «AP_Number»

PERFORMING PROVIDER INFORMATION

Name: _____ *Date of Birth _____
*SSN: _____ *Age: _____ *Race: _____ *Gender _____

AGE GROUP SPECIALTY: Children Adults

TREATMENT SPECIALTIES: (Check All that Apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Dementia | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Personality Disorder |
| <input type="checkbox"/> Anti-social Personality Disorder | <input type="checkbox"/> Dissociative Disorder | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Domestic Violence Offender | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Domestic Violence Victim | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Behavioral Disorder | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Psychomatic Disorders |
| <input type="checkbox"/> Bereavement | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Severe & Persistent Mental Illness |
| <input type="checkbox"/> Borderline Personality | <input type="checkbox"/> HIV Issues | <input type="checkbox"/> Sexual Assault Offender |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Sexual Assault Victim |
| <input type="checkbox"/> Childhood Sexual Abuse Victim | <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Other _____ |

LICENSE TYPE: (Check All that Apply)

- | | |
|--|--|
| <input type="checkbox"/> Associate Professional | <input type="checkbox"/> Licensed Psychological Associates |
| <input type="checkbox"/> Certified Clinical Addiction Specialist | <input type="checkbox"/> Licensed Psychologist – Doctorate Level |
| <input type="checkbox"/> Certified Clinical Supervisor | <input type="checkbox"/> Medical Doctor |
| <input type="checkbox"/> Licensed Clinical Social Worker | <input type="checkbox"/> Para-Professional |
| <input type="checkbox"/> Licensed Clinical Social Worker – Provisional | <input type="checkbox"/> Physicians Assistant |
| <input type="checkbox"/> Licensed Marriage & Family Therapist | <input type="checkbox"/> Qualified Professional |
| <input type="checkbox"/> Licensed Professional Counselor | <input type="checkbox"/> Non-Licensed |
| <input type="checkbox"/> Nurse Practitioner Certified in Psychiatric Nursing | |
| <input type="checkbox"/> Advanced Practice Psychiatric Clinical Nurse Specialist | |
| <input type="checkbox"/> Other – Please Specify: _____ | |

License State: _____ License Number: _____ (if applicable)

UPIN Number: _____ DEA License Number: _____ (if applicable)

I hereby consent to release the above information to Southeastern Regional Mental Health, Disabilities and Substance Abuse Services for purposes of billing and consumer choice.

Performing Providers Signature _____
Date

Areas marked with an asterisk indicates optional information.
The performing provider may elect to disclose this information.
This information will be used for consumer choice / billing purposes only.
Please submit / attach copies of all license(s).