Membership Application

All fields must be completed to ensure timely processing of your application. All information will be kept confidential. ***Please write legibly or type.***

Name (Fist, Middle Initial, Last): _____

Group Practice or Company/Agency name (if applicable) _____

Type of Business: (Circle one) Sole Proprietorship Partnership Corporation

Practice Address: _____

City _____ State _____ Zip _____

Secondary Practice Address: _____

City _____ State _____ Zip _____

Billing Address (if different than the Practice Address):

_____

City _____ State _____ Zip _____

Office Phone _____ Cell phone _____ FAX _____

Email Address: _____

Website: _____

LICENSURE: _____

TAX ID YOU BILL UNDER (please indicate if EIN or SSN): _____

DATE OF BIRTH: _____

CAQH NUMBER: _____

INDIVIDUAL (TYPE1) NPI NUMBER: _____

GROUP (TYPE 2) NPI NUMBER (if applicable): _____

TAXONOMY NUMBER: _____

LANGUAGES SPOKEN (other than English): _____

How do you file your claims? (Circle one) Electronic Paper Both

How do you keep your records? (Circle one) Electronic Paper Both

What are your office hours? _____

What are your After-Hours/Vacation call arrangements? _____

Do you have any practice or other limitations? Please list: _____

What is your waiting time for appointments? Routine? _____ Urgent? _____

Give a description of your specializations, certifications and populations that you work with:

Describe any special services (example: evaluations prior to medical procedures) or testing your business offers:

Membership categories: (Check one)

☐ **Regular full membership ($300.00):** Applicants must hold a current professional license for independent practice in behavioral healthcare, issued by an accredited licensing board in the State of New Mexico.

License type _____ License # _____ State Issued _____ Expiration Date _____ Years in practice _____

☐ **Associate membership ($50.00):** Applicants who are not yet independently licensed in the State of New Mexico, but who are under the supervision of a qualified, fully-licensed practitioner. Associate members are not eligible for insurance contracts through the IPA. When independent license is obtained, applicant may apply for full membership.

License type _____ License # _____ State Issued _____ Expiration Date _____ Years in practice _____

Supervisor _____ Anticipated date of Independent License _____

☐ **Affiliate member annual dues: ($80.00):** Applicants must hold a current professional license for independent practice in behavioral health care, issued by an accredited licensing board in the State of New Mexico. Affiliate members have voting rights and may enjoy all privileges of membership except for participation in insurance contracts available through the organization.

License type _____ License # _____ State Issued _____ Expiration Date _____ Years in practice _____

☐ **Agency membership:** Applicants who work for an Agency, whose members bill under a single tax ID #, and hold a current professional license in behavioral healthcare, issued by an accredited licensing board in the State of New Mexico. *(All members of an Agency must complete the entire application process.)*

License type _____ License # _____ State Issued _____ Expiration Date _____ Years in practice _____

Insurance requirements

Members must carry a current malpractice insurance policy appropriate to their license.

Attestation

I hereby agree that I will abide by the Code of Ethics of my professional licensing board, and agree to review by the SWBHIPA Quality Assurance Committee, in accordance with the SWBHIPA bylaws. I further understand that falsification of information, conviction of a felony, reprimand by a licensing board, or revocation of licensure may be grounds for rejection or termination of the IPA membership and of any and all benefits resulting therefrom.

I understand that my application for membership in the SWBHIPA will be submitted to the Board for the final approval of membership. I will receive written notice from SWBHIPA within 30 days.

Signature _____ Date _____

Thank you for your interest in partnering in order to improve the quality of Behavioral Healthcare in NM, and the quality of our lives as Behavioral Healthcare providers. ***By working together, we can make a difference.***

Mail or fax application and packet to:

Southwest Behavioral Health IPA,

PO Box 3682

Albuquerque, NM 87190-3682

FAX: 505.213.8559