CONTRA COSTA
HEALTH

PROVIDER ORIENTATION

I hereby acknowledge I have received, read and understand the information from the Contra Costa Mental Health Plan (CCMHP) which I have initialed below.

(Please place you initials in the spaces provided to indicate you have read and understand each policy/information.)

_____Beneficiary Protection Training

_____Service Excellence (Policy No. 117-A)

_____Confidentiality of Patient Info. (Policy# 500)

_____Faxing/E-Mailing/Mailing PHI (Policy# 505)

_____Alcohol and Other Drug Abuse Policy

_____Violence in the Workplace (Policy# 223-PM)

_____Info. on the CCMHP Provider Network

_____CCMHP's Affirmative Statement

_____Authorization and Reimbursement requirements

_____Behavioral Health Service Definitions

_____MD Informed Consent

_____Medical Necessity Criteria

_____Clinical Forms and Documentation

_____Claims process

_____Provider Portal

I hereby agree that my participation as a CCMHP Network Provider obligates me to comply with all policies and procedures regarding the aforementioned topics. These policies and procedures have been outlined in the Contra Costa Mental Health Plan Provider's Manual; which is on the website: ***https://cchealth.org/mentalhealth/network-provider/***

I understand that if I violate any provision of these policies, I will be subject to disciplinary action up to and including termination of my contract.

Please return by email to CMUProvider.Services@cchealth.org or fax to (925) 372-4410.

Group Name: _____

Print Name: _____

Signature: _____

Date: _____

Resources – Online Provider Directory Website and CCLink Web Portal Access and more on our website located at https://cchealth.org/mentalhealth.

1/24/2020 RG