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.