

ATTACHMENT 38



Offeror’s Proposed Provider Network Files - RFP entitled: “Healthcare Program Administrative Services Only (ASO)”

File Layout Specifications for the Offeror's Proposed Hospital, Medical Practitioner, MHA Practitioner and MHA Facility Network Files

Instructions: The Offeror must submit network files for Hospitals, Medical Practitioners, MHA practitioners , and MHA facilities. These files must include each provider and facility with whom you have an executed contract. The providers and facilities listed in this file must be included in the Network implemented for the Program in 2021 in accordance with the Healthcare Program Administrative Services Only (ASO) Request for Proposal. Please reference, **Section 5.12 "Provider Network- – Ancillary Networks"** for additional instruction. The files need to be submitted on USB storage device using Microsoft Excel. Please do not submit paper.

Medical Practitioner File

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10	Column 11	Column 12	Column 13	Column 14
Provider Tax ID	National Provider Identifier (if available)	Provider First Name	Provider Middle Initial	Provider Last Name	Provider Office Address 1	Provider Office Address 2	Provider Office City	Provider Office State	Provider Office 5-Digit Zip Code	PCP or Specialist	Specialty (Provider Type)*	Board Certification**	Practitioner License Number

Include all Medical Practitioners in the proposed Network for each of the specified provider types in the Medical Practitioner File.

***In Column 12**, for Specialty Provider Type enter as follows: **Primary Care Physician:** **FP** Family Practice, **GP** General Practice, **IM** Doctor of Internal Medicine, **PD** Pediatrician, **OBG** Obstetrician/Gynecologist, **PT** Physical Therapist, **CHI** Chiropractor, **OCC** Occupational Therapist, **Specialists:** **A** Allergy, **AN** Anesthesiology, **C** Cardiology, **DER** Dermatology, **EM** Emergency Medicine, **GAS** Gastroenterology, **GS** General Surgeon, **HMO** Hematology/Oncology, **N** Neurology, **OPH** Ophthalmology, **ORS** Orthopedic Surgery, **OTL** Otolaryngology, **PUL** Pulmonary Medicine, **RAD** Radiology, **RHE** Rheumatology, and **UR** Urologist

****In Column 13**, enter "Y" for Yes if the Practitioner is Board Certified and "N" for No if the Practitioner is not Board Certified.

ATTACHMENT 38



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Hospital File

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9
Provider Tax ID	National Provider Identifier (if available)	Facility Name	Facility Address 1	Facility Address 2	Facility City	Facility State	Facility 5-Digit Zip Code	Facility Type*

Include all Hospitals in the proposed Network; reporting for in-network Hospitals providing MHSA services should be reported in the MHSA Facility File.

*In Column 9, for Hospitals enter as follows: **TR** Trauma Center Hospital, **ACT** Acute Hospital, **AMB** Ambulatory Surgery Center, **CHL** Children's Hospital, **CL** Clinic, **LT** Long-Term Hospital, **RHB** Rehabilitation Hospital, and **SPC** Specialty Hospital.

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**MHSA
Practitioner
File**

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10	Column 11	Column 12	Column 13	Column 14
Provider Tax ID	National Provider Identifier (if available)	Provider First Name	Provider Middle Initial	Provider Last Name	Provider Office Address 1	Provider Office Address 2	Provider Office City	Provider Office State	Provider Office 5-Digit Zip Code	Specialty (Provider Type)*	Board Certification**	Practitioner License Number	MLC and MHAPO Subcategory***

Include the following Practitioner types in this file: a. psychiatrist b. psychologist c. A licensed clinical social worker who qualifies for the "R" certification in New York State. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body. d. A Registered Nurse Clinical Specialist or Psychiatric Nurse/Clinical Specialist: advanced practice Nurses hold a master's or doctoral degree in a specialized area of psychiatric nursing. e. A Registered Nurse Practitioner: a nurse with a master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided. Nurse Practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty of practice. This must be done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols. f. A Certified Behavioral Analyst who provides covered services solely limited to diagnosed autism spectrum disorders. g. Applied behavioral analysis or ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a certified behavioral analyst.

*In Column 11, for Specialty (Provider Type) please enter the following: **PSYI** Licensed Psychiatrist, **PSYCH** Licensed Psychologist, **MLC** Licensed Clinical Social Worker who qualifies for the "R" designation in NYS, Master's Level Clinician with the highest level of licensure in other states, **CBA** Certified Behavioral Analyst Provider, **MHSAP** Mental Health/Substance Abuse Practitioner - Other Prescriber, and **PA** Physician Assistant.

**In Column 12, enter "Y" for Yes if the Practitioner is Board Certified and "N" for No if the Practitioner is not Board Certified.

***In Column 14, for any Practitioner listed as MLC or MHAPO, enter the Practitioner's license subcategory, (i.e. **LCSW-R**, **LCSW**, **APRN**, **NP**, **LMHC**, **LMFT**, etc.)

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**MHSA
Facilities**

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10	Column 11
Provider Tax ID	National Provider Identifier (if available)	Facility Name	Facility Address 1	Facility Address 2	Facility City	Facility State	Facility 5-Digit Zip Code	Facility Type (Category)*	Does this facility provide inpatient care?*	Does this facility provide ALOC?***

Include all Facilities, Alternate Levels of Care and Outpatient Clinics in this file. Alternate Level of Care (ALOC) means residential treatment centers, halfway houses, group homes, partial hospitalization programs or continuing treatment programs which satisfy the requirements of an approved facility.

***In Column 9**, for Facility Type (Category) enter as follows: **MHF** Mental Health Facility, **SAF** Substance Abuse Facility, **MHSAF** Mental Health and Substance Abuse Facility, **MH - OCG** Mental Health Outpatient Clinic Group, **SA - OCG** Substance Abuse Outpatient Clinic Group

****In Column 10**, please answer "Y" for Yes or "N" for No if the facility provides inpatient care.

*****In Column 11**, please answer "Y" for Yes or "N" for No if the facility provides Alternate Levels of Care (ALOC).