



# FFS PROVIDER SPECIALTY ADDITION APPLICATION

San Diego County Mental Health Plan & Optum Public Sector  
Fee For Service (FFS) Medi-Cal Provider Network

**Please mail, fax or email (secure) complete application packet to:**

Optum Public Sector San Diego  
Attention: Provider Services  
P.O. Box 601370  
San Diego, CA 92160-1370

Fax: (877) 309-4862

Email: [sdu\\_providerserviceshelp@optum.com](mailto:sdu_providerserviceshelp@optum.com)

[Instructions and Frequently Asked Questions](#)

## CHECKLIST FOR FFS SPECIALTY ADDITION APPLICATION

Please print or type your answers to all questions. If further space is needed for you to provide complete answers, please attach additional sheets of paper and indicate on the sheet the applicable question number.

Please use the following checklist to confirm you have included the following information with your application:

<input type="checkbox"/>	<b><u>Resume/Curriculum Vitae</u></b> : It is very important that your resume be detailed including descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. Include the dates and locations of education and post-graduate training. <b>Dates of employment must include the month and year. All gaps in employment of six (6) months or more require a written explanation.</b>
<input type="checkbox"/>	<b><u>Medi-Cal Network – Clinician Specialty Requirements (pages 7-10)</u></b> : Please carefully review the experience requirements before checking an age or treatment specialty.
<input type="checkbox"/>	<b><u>Clinician Specialty Requirements – Specialty Attestation Form (page 11)</u></b> : Must be signed and dated.
<input type="checkbox"/>	<b><u>Provider Rights (page 12)</u></b> : Provider understands that as an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. <b>Please print your name on this page.</b>
<input type="checkbox"/>	<b><u>Child and Adolescent Needs and Strength Assessment (CANS)</u></b> : <ul style="list-style-type: none"> <li>• Provider must become CANS certified in order to render therapy services to clients ages 0-21.</li> <li>• Provider must be recertified every year.</li> <li>• Provider may be reimbursed for training, certification, recertification, and reports when the appropriate requirements are met.</li> </ul>

***\*All documents and copies submitted must be clear and legible.***

**FFS SPECIALTY ADDITION APPLICATION**

**San Diego County Mental Health Plan for Fee for Service (FFS) Medi-Cal Provider Network**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 License Type:  MD  DO  PhD  PsyD  LMFT  LCSW  LPCC  PNP  PA  
 License Number: \_\_\_\_\_ DEA Number (if applicable): \_\_\_\_\_  
 NPI Number: \_\_\_\_\_

**CLINICAL PROFILE**

**Cultural Competency:**

Please identify the cultures in which you meet the Cultural Competency Criteria below and are willing to treat in your practice. Delivering culturally competent clinical services means you have an understanding of: **1)** ongoing social realities (e.g., racism, immigration patterns, acculturation) that can impact the mental health of culturally and linguistically diverse populations, **2)** differences between culturally acceptable behaviors and pathological characteristics, **3)** cultural beliefs around mental illness and help-seeking patterns, and **4)** have the ability to adapt your skills to fit the cultural context of a client.

If you endorse cultural competency in the ability to deliver services to one of the groups listed below, you **must also** have experiences consistent with one or more of the statements below:

- By adopting systematic practices that align behaviors, attitudes, and policies, I have worked effectively in cross-cultural situations, showcasing cultural competence and diversity. All services provided have been tailored to meet the unique linguistic and cultural needs of our diverse clients. I honor the diversity of cultures, address the complexities within and between them, and ensure our services are accessible and relevant.
- Have completed formal training, such as a degree emphasis area, specific university courses, multiple workshops, or an internship focusing on culture and human behavior
- Have significant professional culture-based expertise (e.g., have provided cultural competence training to others and/or published peer-reviewed journal articles, book chapters, or major reports in this area)
- Have provided clinical treatment or evaluations to more than ten (10) members of the cultural group

Please check any groups from the table below for which you are competent to evaluate family dynamics and provide treatment:

<input type="checkbox"/> African American	<input type="checkbox"/> Dominican	<input type="checkbox"/> Iraqi	<input type="checkbox"/> Puerto Rican
<input type="checkbox"/> Amerasian	<input type="checkbox"/> Ethiopian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Salvadorian
<input type="checkbox"/> Arab	<input type="checkbox"/> Filipino	<input type="checkbox"/> Jewish	<input type="checkbox"/> Samoan
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Korean	<input type="checkbox"/> Somali
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Haitian	<input type="checkbox"/> Laotian	<input type="checkbox"/> Sudanese
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Hawaiian Native	<input type="checkbox"/> Mexican American/Chicano	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Hmong	<input type="checkbox"/> Native American	
<input type="checkbox"/> Cuban	<input type="checkbox"/> Iranian	<input type="checkbox"/> Pacific Islander	
<input type="checkbox"/> Other: _____			

**POPULATIONS AND SERVICES**

Please check all the Populations and Services in which you have **clinical training and experience AND are currently willing to treat in your practice.**

*\*Documentation is required for some specialties as identified on the Clinician Specialty Requirements (pages 7-10)*

<b>Populations:</b>	<b>Infants Toddlers 0 - 3</b>	<b>Preschool 3 - 5</b>	<b>Children 6 -12</b>	<b>Adolescents 13 - 17</b>	<b>Transitional Youth 18 - 22</b>	<b>Adults 23 - 59</b>	<b>Older Adults 60+</b>
Developmentally Delayed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impaired			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veterans					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visually Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Services/Modalities:</b>							
Critical Incident Stress Debriefing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ECT (MD Only, including consult)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Spravato (MD Only)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*TMS (MD Only)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Therapy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual Therapy (Non-prescriber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Evaluation & Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Neuropsychological Testing (MD/PhD/PsyD Only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Testing (PhD/PsyD Only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**AREAS OF CLINICAL EXPERTISE:**

Check areas of expertise in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

Areas of Clinical Expertise I:	Infants Toddlers 0 - 3	Preschool 3 - 5	Children 6 -12	Adolescents 13 - 17	Transitional Youth 18 - 22	Adults 23 - 59	Older Adults 60+
Anxiety Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit/Hyperactivity Disorder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar and Related Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociative Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding and Eating Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Factitious Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gender-Affirming Care		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gender Dysphoria Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive, Impulse-Control and Conduct Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paraphilic Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma and Stress - Related Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia and Other Psychotic Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somatic Symptom and Related Disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check areas below in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

*\*Documentation is required for some specialties as identified on the Clinician Specialty Requirements (page 7-10)*

Areas of Clinical Expertise II:	Infants Toddlers 0 - 3	Preschool 3 - 5	Children 6 -12	Adolescents 13 - 17	Transitional Youth 18 - 22	Adults 23 - 59	Older Adults 60+
ACA/Co-Dependency					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adoption Pre/Post Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Anger Management			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Domestic Violence Offender				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Domestic Violence Victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Co-Occurring Disorders (MH/DD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Co-Occurring Disorders (MH/Medical)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Co-Occurring Disorders (MH/SUD)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family or Relationship Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Co-Parenting					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grief/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Physical Abuse Offender			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse Non-Protecting Parent					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Political Refugee		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Abuse Victims	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
*Sexual Abuse Non-Protecting Parent					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Sexual Abuse Offender			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Survivors of Torture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

## CLINICIAN SPECIALTY REQUIREMENTS

**Important note:** Signature on the Optum Public Sector Specialty Attestation on page #11 is required of all applicants

### PHYSICIAN SPECIALTY REQUIREMENTS

#### Child/Adolescent

- Completion of an ACGME approved Child and Adolescent Fellowship **OR** recognized certification in Adolescent Psychiatry (This specialty includes Infants, Preschool, Children and Adolescents (twelve (12) years old and younger)

#### Geriatrics

- Completion of an ACGME approved Geriatric Fellowship **OR** recognized certification in Geriatric Psychiatry

#### Neuropsychological Testing

- Recognized certification in Neurology through the American Board of Psychiatry and Neurology **OR**
- Accreditation in Behavioral Neurology and Neuropsychiatry through the American Neuropsychiatric Association

#### **AND all the following criteria:**

- State medical licensure does not include provisions that prohibit neuropsychological testing service;
- Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
- Physician and supervised psychometrician adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

#### Prescribers of Psychotropic Medication for Children and Youth in Out of Home Placement

**Authorized Prescribers of Psychotropic Medication:** Because of the complex medical and psychiatric needs of children in out of home placements (which include foster, kinship, NREFM care; group homes; and the juvenile justice systems), it is recommended that psychotropic medications for children be prescribed by board certified or board eligible specialists in one of the following areas of expertise:

- Psychiatry (specialization in child and adolescent psychiatry recommended)
- Neuro-developmental pediatrics
- Developmental-Behavioral pediatrics
- Pediatric neurology
- Pediatrics or family practice with specialized training in children who are at high risk or who had in utero exposure to illicit drugs or alcohol

### PSYCHOLOGISTS, NURSES, & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS

#### Infants/Toddlers: 0 - 3 Years

- Completion of an APA approved or other accepted training/certification program in Child Psychology or Infant Mental Health

#### **AND one (1) or more of the following:**

- Fifteen (15) hours of CEU in topics relevant to Infant and Early Childhood Mental Health in the last thirty-six (36) month period
- Documented certification in treatment of infants 0-3 years
- Evidence of work experience with infants 0-3 years at an agency that provides treatment to this age group

## CLINICIAN SPECIALTY REQUIREMENTS

### PSYCHOLOGISTS, NURSES, & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS - *Continued*

#### Preschool: 3 - 5 Years

- Completion of an APA approved or other accepted training program in Child Psychology

#### AND one (1) or more of the following:

- Fifteen (15) hours of CEU in topics relevant to Child Development in the last thirty-six (36) month period
- Evidence of practice experience in treating preschool aged children

#### Children: 6 - 12 Years

- Completion of an APA approved or other accepted training program in Child Psychology

#### AND one (1) or more of the following:

- Fifteen (15) hours of CEU in topics relevant to Child Development in the last thirty-six (36) month period
- Evidence of practice experience in treating children

#### Adolescents: 13 - 17 Years

- Completion of an APA approved or other accepted training program in Adolescent Psychology

#### AND one (1) or more of the following:

- Fifteen (15) hours of CEU in topics relevant to Child Development in the last thirty-six (36) month period
- Evidence of practice experience in treating adolescents

#### Older Adults: 60+ Years

- Completion of an APA approved or other accepted training program in Geriatric Psychology

#### AND one (1) or more of the following:

- Fifteen (15) hours of CEU in topics relevant to Older Adults in the last thirty-six (36) month period
- Evidence of practice experience in treating older adult

#### Neuropsychological Testing (Psychologists Only)

- Member of the American Board of Clinical Neuropsychology OR the American Board of Professional Neuropsychology

#### OR

- Completion of courses in Neuropsychology including: Neuroanatomy, Neuropsychological testing, Neuropathology, or Neuropharmacology
- Completion of an internship, fellowship, or practicum in Neuropsychological Assessment at an accredited institution

#### AND

- Two (2) years of supervised professional experience in Neuropsychological Assessment

#### Domestic Violence Treatment - Victim

- Documented completion of an approved (40) hour training program in Domestic Violence that fulfills California State's requirement for domestic violence victim counselors

#### AND both of the following:

- Fifteen (15) hours CEU in Domestic Violence Victim training in the last thirty-six (36) month months
- Evidence of recent practice experience in Domestic Violence Victim treatment

#### Domestic Violence Treatment - Offender

- Documented completion of the forty (40) hour basic domestic violence training from a Facilitator Training Committee (FTC) approved provider
- Evidence of recent practice experience in Domestic Violence Batterers treatment

## CLINICIAN SPECIALTY REQUIREMENTS

### PSYCHOLOGISTS, NURSES, & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS - *Continued*

#### Sexual Offender and Sexual Abuse Non-Protecting Parent Treatment

- **Must be approved by CA State Sex Offender Management Board (CASOMB) <https://www.casomb.org>** and continue to meet CASOMB requirements.

#### Psychiatric Nurse Practitioners Requesting Prescriptive Authority Must:

- Possess a currently valid license as a Registered Nurse in California
- Be authorized for prescriptive authority in California
- Meet California specific mandates regarding DEA and/or Furnishing license and physician supervision
- Attest that you meet California's collaborative or supervisory agreement requirements
- Specifically request prescriptive privileges on the Optum Public Sector application below

#### Psychiatric Physician Assistants Requesting Prescriptive Authority Must:

- Possess a currently valid license as a Registered Nurse in California
- Be authorized for prescriptive authority in California
- Meet California specific mandates regarding DEA and physician supervision
- Attest that you meet California's collaborative or supervisory agreement requirements
- Specifically request prescriptive privileges on the Optum Public Sector application below

## CLINICIAN SPECIALTY REQUIREMENTS

### Optum Public Sector San Diego Specialty Attestation

**You must sign this document even if you are not requesting any of these specialty designations in your provider record.** Additional training, experience, requirements, and/or outside agency approval is required for the following populations, professional certifications, and specialties. **Please review the Clinician Specialty Requirements on pages 7-10.**

If you are not requesting a specialty designation, please check the “No Specialties” box at the bottom of the list to indicate you have read this form and acknowledge that you have not requested these specialties.

*I have reviewed the Optum Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, I meet Optum’s requirements for that treatment area.*

Physician Specialties	Non-Physician Specialties
<input type="checkbox"/> Child /Adolescent (Please specify all the ages that you treat) <ul style="list-style-type: none"> <li><input type="checkbox"/> Infant Mental Health (0 – 3)</li> <li><input type="checkbox"/> Preschool (3 - 5)</li> <li><input type="checkbox"/> Children (6 – 12)</li> <li><input type="checkbox"/> Adolescents (13 - 17)</li> </ul> <input type="checkbox"/> Children and youth in out of home placements <input type="checkbox"/> Geriatrics (60+) <input type="checkbox"/> Neuropsychological Testing <input type="checkbox"/> Spravato Treatment ( <b>Proof of certification required</b> ) <input type="checkbox"/> Transcranial Magnetic Stimulation (TMS)	<input type="checkbox"/> Child /Adolescent (Please specify all the ages that you treat) <ul style="list-style-type: none"> <li><input type="checkbox"/> Infant Mental Health (0 – 3)</li> <li><input type="checkbox"/> Preschool (3 - 5)</li> <li><input type="checkbox"/> Children (6 – 12)</li> <li><input type="checkbox"/> Adolescents (13 - 17)</li> </ul> <input type="checkbox"/> DBT ( <b>Submit copy of certification. Certification attests the ability to provide individual/group services.</b> ) <input type="checkbox"/> Domestic Violence Offender – ( <b>Submit proof of 40 hr. DV Training from a Facilitator Training {FTC} approved provider.</b> ) <input type="checkbox"/> Domestic Violence Victim – ( <b>Submit proof of 40 hr. CA approved DV Training</b> ) <input type="checkbox"/> Neuropsychological Testing – <i>Psychologist Only</i> <input type="checkbox"/> Psychiatric Nurses – Prescriptive Privileges ( <b>Submit ANCC certificate, Prescriptive Authority, DEA Certificate and/or Controlled Substance certificate, based on CA State requirements.</b> ) <input type="checkbox"/> Sexual Offender AND Sexual Abuse Non-Protecting Parent ( <b>Must be approved by CA State Sex Offender Management Board (CASOMB) <a href="https://www.casomb.org">https://www.casomb.org</a> and continue to meet CASOMB requirements.</b> ) <input type="checkbox"/> Spravato Treatment ( <b>Proof of certification required</b> ) <input type="checkbox"/> Transcranial Magnetic Stimulation (TMS) - <i>Psychiatric Nurse Practitioners and Physician Assistants Only</i>
<input type="checkbox"/> <b>No Specialties (Must be checked if none of the above specialties are being designated)</b>	

**CLINICIAN SPECIALTY REQUIREMENTS**

**Optum Public Sector San Diego Specialty Attestation**

I understand that Optum may require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. I will cooperate with an Optum documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the Optum network.

**Please note that standard credentialing criteria must be met before specialty designation can be considered.**

**All clinicians must sign this form whether specialties are applicable or not. Failure to sign this form may cause a delay in the processing of your initial credentialing file.**

**Printed Name of Applicant:** \_\_\_\_\_

**Signature of Applicant:** \_\_\_\_\_  
*(Electronic Signatures and Signature Stamps are not accepted)*

**Date:** \_\_\_\_\_

## PROVIDER RIGHTS

### I. RIGHT TO REVIEW

As an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., Malpractice insurance carriers, state licensing boards, National Practitioner Data Bank) but does not extend to review of information, references, or recommendations protected by law from disclosure. You may request to review such information at any time by sending a written request via email at [sdu\\_providerserviceshelp@optum.com](mailto:sdu_providerserviceshelp@optum.com) to the Provider Services (PS) Manager. The PS Manager, or designee, will notify you within 72 hours of the date and time when such information will be available at the OPTUM Credentialing Department located in San Diego, California.

### II. RIGHT, UPON REQUEST, TO BE INFORMED OF STATUS OF CREDENTIALING/RE-CREDENTIALING APPLICATION

You have the right to be informed, upon request, of the status of your credentialing and/or re-credentialing application. You may request such information by sending a written request via email to the Credentialing Manager at the above cited email address. You will be notified in writing and within no more than ten (10) working days of receiving your fax or letter, by return fax or letter, of the current status of your application with respect to outstanding information required to complete the application process.

### III. NOTIFICATION OF DESCREPNENCY

Practitioners will be notified when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certification, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been reported by the practitioner on his/her application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

### CORRECTION OF ERRONEOUS INFORMATION

If a practitioner believes that erroneous information has been supplied to OPTUM by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Manager. Practitioners must submit a written notice along with a detailed explanation to the Manager of Credentialing at [sdu\\_providerserviceshelp@optum.com](mailto:sdu_providerserviceshelp@optum.com). Notification to OPTUM must occur within 48 hours of OPTUM notification to the practitioner of a discrepancy as provided in Section II or within 24 hours of a practitioner's review of his/her credential file as provided in Section I.

Upon receipt of notification from the practitioner, OPTUM will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credential file. If, upon re-review, primary source information remains inconsistent with practitioner's notification, Credentialing Manager will so notify the practitioner via fax or letter. The practitioner may then provide proof of correction by the primary source body to OPTUM Director of Medical Services via fax or letter at the email address above within ten (10) working days. The Credentialing Manager will re-verify primary source information if such documentation is provided. If, after ten (10) working days, primary source information remains in dispute, the practitioner will be subject to Adverse Action, up to administrative denial/termination.

**Printed Name of Applicant:** \_\_\_\_\_

**Date:** \_\_\_\_\_