



BEHAVIORAL HEALTHCARE OPTIONS, INC. (BHO)

a subsidiary of Sierra Health Services, Inc.

Application to PPO network

<input type="checkbox"/> YES , I am interested in participating and learning more about BHO's provider network.	
Date:	
Provider/Group Name:	
Credentials/Licensure:	<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Ph.D. <input type="checkbox"/> Psy.D. <input type="checkbox"/> Ed.D. <input type="checkbox"/> LCSW <input type="checkbox"/> LMFT <input type="checkbox"/> LPC <input type="checkbox"/> LMSW-ACP <input type="checkbox"/> LMSW <input type="checkbox"/> ACSW <input type="checkbox"/> OTHER (please specify):
Specialty(ies)/Subspecialties:	<input type="checkbox"/> Mental Health <input type="checkbox"/> Addiction <input type="checkbox"/> Both <input type="checkbox"/> Child (under 12 years) <input type="checkbox"/> Adolescent <input type="checkbox"/> Adult <input type="checkbox"/> Geriatric
Address:	
City/State/Zip:	
Telephone No.:	()
Fax No.:	()
e-mail address:	
Tax ID No.:	
Language Fluency:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Sign Language <input type="checkbox"/> Braille <input type="checkbox"/> OTHER (please specify):
Substance Abuse Provider (SAP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If a group, please list individual provider names and credentials or attach a separate sheet listing:</i>	
1.	2.
3.	4.
5.	6.
TO E-MAIL RESPONSE: lreed@sierrahealth.com TO FAX RESPONSE: (702) 242-5864	