

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	Authorization and Reimbursement requirements
Service Excellence (Policy No. 117-A)	Behavioral Health Service Definitions
Confidentiality of Patient Info. (Policy# 500)	MD Informed Consent
Faxing/E-Mailing/Mailing PHI (Policy# 505)	Medical Necessity Criteria
Alcohol and Other Drug Abuse Policy	Clinical Forms and Documentation
Violence in the Workplace (Policy# 223-PM)	Claims process
Info. on the CCMHP Provider Network	Provider Portal
CCMHP's Affirmative Statement	
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.