Behavioral Provider Self-Introduction Form

This form has been designed to help you develop your self-introduction for posting on Evernorth Behavioral Health's provider directory. The directory assists customers in their search to select a behavioral providers participating in their network.

Please complete the Behavioral Provider Self-Introduction Form below, save it to your computer, and email it to Evernorth Behavioral Health's Credentialing Team at Behav-Onboarding@Evernorth.com. Note: If you would like to add your photo to your profile, please attach it to the email submission.

What to include:

+ Describe your office setting (e.g., handicapped accessible, private entrance, etc.)
+ Share your practice style (e.g., goal-oriented, family therapy-based, etc.)
+ Any unique office hours (e.g., weekends, late evenings, etc.)
+ Give customers an idea of what to expect at their initial visit
+ Your photo

What to avoid:

+ Group or clinic introductions (unless otherwise discussed) - introductions should be for individual providers
+ Resumes/curriculum vitae cannot be accepted as a substitute for the provider self-introduction
+ Clinical and/or professional jargon (avoid if possible)
+ Lengthy introductions (limit to 300 word maximum)

Please note:

Evernorth Behavioral Health retains the right to review and edit your self-introduction. Privileged specialties/ populations will be removed from profiles where the provider has not attested to meeting criteria. Photos will be reviewed prior to being uploaded on our website.

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For suggestions and guidelines of what to include in your self-introduction, please refer to page one of this form. To help avoid processing errors, we highly recommend that you type your self-introduction into the fillable space below and send it to Evernorth Behavioral Health's Credentialing Team by using the "Submit" button.

Graduate School: _____ Year of Graduation: _____

Behavioral Health Provider Survey Form

EVERNORTH℠

(Providing this information is optional)

In the care management process, individuals often request that their health care providers have certain personal orientations or cultural backgrounds. Therefore, we would like to be able to refer participants to providers who meet the participants' orientation or cultural requests.

Please note that any information provided by you will be used only to meet the referral requests of the participants and will not be used to determine participation in the network.

We <u>do not</u> discriminate on the basis of any of this information.

Would you like to complete this optional survey? ☐ **Yes** ☐ **No**

Name:	Phone Number:
	( )
Street Address:	

City:	State:	Zip Code:

1. Do you consider yourself to be:
   ☐ African American ☐ Asian American ☐ Cuban American ☐ Mexican American ☐ Puerto Rican American
   ☐ Other Latina/Latino American *Specify*: _____ ☐ Native American
   ☐ Pacific Island Descent ☐ Caucasian/European ☐ Other - *Specify*: _____

2. Are you willing to identify your sexual orientation to your patients? If yes, is your sexual orientation: ☐ Gay/Lesbian ☐ Heterosexual ☐ Bisexual	☐ Yes ☐ No
3. Are you willing to identify if you are a recovering alcoholic/addict to your patients? If yes, are you a recovering person? ☐ Yes ☐ No	☐ Yes ☐ No
4. Do you utilize a clinical philosophy that emphasizes your religious beliefs? Your religious beliefs: ☐ Christian ☐ Jewish ☐ Other - *Specify*: _____	☐ Yes ☐ No
5. Are you a U.S. military veteran?	☐ Yes ☐ No
6. Are you a Vietnam era veteran?	☐ Yes ☐ No
7. Do you have a physical disability? If yes, what type? *Specify*: _____	☐ Yes ☐ No