

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services 910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org

Physical and Behavioral Health Single Case Agreement (SCA) Application
\*For Ongoing Patient-Specific Care by Out of Network Providers or Non-Contracted Patient-Specific BH/SUD/IDD Service Code(s) for Contracted Behavioral Health Providers

| Date of Request:  |                         |          |       |                        |            |                             |     |  |  |
|---|-------------------------|----------|-------|------------------------|------------|-----------------------------|-----|--|--|
| <b>Funding Requested:</b>   | Medicaid IPI            | RS/State |       | <b>Enrolled Provid</b> | er: Y      | es                          | No  |  |  |
| Provider Type   |                         |          |       |                        |            |                             |     |  |  |
| Agency  | Residential<br>Provider | Solo LIP |       | Group Practice         |            | Physical Health<br>Provider |     |  |  |
| Provider Name (as list  |                         |          |       |                        |            |                             |     |  |  |
| DBA Name (if applicable):   |                         |          |       |                        |            |                             |     |  |  |
| Federal Tax ID:   |                         |          |       |                        |            |                             |     |  |  |
| Corporate Address:  |                         |          |       |                        |            |                             |     |  |  |
| Agency Mailing Address (if different from corporate address):                             |                         |          |       |                        |            |                             |     |  |  |
| Agency Billing Address:   |                         |          |       |                        |            |                             |     |  |  |
| A CENICK CONT A OT INFORM ATION   |                         |          |       |                        |            |                             |     |  |  |
| AGENCY CONTACT INFORMATION  NAME TITLE PHONE E-MAIL                                       |                         |          |       |                        |            |                             |     |  |  |
| CEO/Director/Owner  | NAME                    |          | HILLE | PHO                    | ONE        | E-IVI                       | AIL |  |  |
| (Person authorized to   |                         |          |       |                        |            |                             |     |  |  |
| sign contract)  |                         |          |       |                        |            |                             |     |  |  |
| Primary Contact   |                         |          |       |                        |            |                             |     |  |  |
| Primary Clinical  |                         |          |       |                        |            |                             |     |  |  |
| Contact   |                         |          |       |                        |            |                             |     |  |  |
| Billing Contact   |                         |          |       |                        |            |                             |     |  |  |
|   |                         |          |       |                        | <u>l</u> _ |                             |     |  |  |
| Is national accreditation required for the service being requested? Yes No                |                         |          |       |                        |            | 0                           |     |  |  |
| If yes, list accrediting body/number of years accredited & accreditation expiration date: |                         |          |       |                        |            |                             |     |  |  |
|   |                         |          |       |                        |            |                             |     |  |  |
|   |                         |          |       |                        |            |                             |     |  |  |
| SERVICE LOCATION INFORMATION  |                         |          |       |                        |            |                             |     |  |  |
| <b>Site Address:</b>  |                         |          |       |                        |            |                             |     |  |  |
| Street  |                         | City     | State | Zip+4                  | County     |                             |     |  |  |
| Site License Type, if applicable:   |                         |          |       |                        |            |                             |     |  |  |
| NPI Number(s) linked with site:   |                         |          |       |                        |            |                             |     |  |  |
|   |                         |          |       |                        |            |                             |     |  |  |
|   |                         |          |       |                        |            |                             |     |  |  |







| PATIENT INFORMATION   |                         |  |  |  |  |  |  |
|---|-------------------------|--|--|--|--|--|--|
| Patient Name:   |                         |  |  |  |  |  |  |
| Patient Date of Birth:  | Member Medicaid Number: |  |  |  |  |  |  |
| Requested Service Start Date (should match date on SAR):  |                         |  |  |  |  |  |  |
| Service name(s) with code(s) (should match information on SAR):   |                         |  |  |  |  |  |  |
| Is this Single Case Agreement being requested due to the member's change of Medicaid from another PIHP/BH/IDD TP to Sandhills Center? Y N |                         |  |  |  |  |  |  |
|   |                         |  |  |  |  |  |  |
| CLINICAL / LIP INFORMATION (if applicable)  |                         |  |  |  |  |  |  |
| Legal name of LIP:  |                         |  |  |  |  |  |  |
| Address:  |                         |  |  |  |  |  |  |
| Street City   | State Zip+4 County      |  |  |  |  |  |  |
| Phone Number:   |                         |  |  |  |  |  |  |
| LIP NPI Number:   |                         |  |  |  |  |  |  |
| Identification of all on-call designee(s) who must have credentials the same as the LIP or higher including phone number & email address: |                         |  |  |  |  |  |  |
|   |                         |  |  |  |  |  |  |
| THIS SECTION TO BE COMPLETED BY SANDHILLS CENTER PIHP/BH/IDD TAILORED PLAN  |                         |  |  |  |  |  |  |
| Sandhills Center Approved Service Start Date:   |                         |  |  |  |  |  |  |
| REQUIRED ATTACHMENTS  |                         |  |  |  |  |  |  |
| □EFT Agreement  |                         |  |  |  |  |  |  |
| ☐ Trading Partner Agreement   |                         |  |  |  |  |  |  |
| ☐SAR and other clinical documentation   |                         |  |  |  |  |  |  |

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