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Specialty Supplemental Application — Psychiatry

IMPORTANT NOTICE
This is a SUPPPLMENT to an MIEC application. This document alone is insufficient to apply for and be approved for coverage with MIEC. Be sure to submit this along with your complete signed and dated MIEC application.

APPLICANT

Entity or Last name, first name

PSYCHIATRY SUPPLEMENTAL APPLICATION — ANSWERS A-I

A. Do you have a specialty area?
- ☐ Addiction
- ☐ Child and adolescent
- ☐ Forensic
- ☐ Geriatric
- ☐ Pain Management
- ☐ Clinical Neurophysiology

B. Do you work in conjunction with any of the following professionals? (Check all that apply)
- ☐ Psychologists
- ☐ Social workers
- ☐ Nurse practitioners
- ☐ None

C. Does your practice involve any of the following? (Check all that apply)
- ☐ Sex Therapy that involves touching?
- ☐ Hypnosis?
- ☐ Electroconvulsive therapy (ECT)?

D. Does your practice prescribe medications? ☐Yes ☐No **If yes,** please answer the following questions:
- For refills, do you require an in-person follow up? ☐Yes ☐No
- Do you prescribe Ketamine? ☐Yes ☐No
- Do you prescribe other medications, other than Ketamine, for off-label usage? ☐Yes ☐No
  - **If yes,** what medication and for what purpose? _____

E. Have you ever had an intimate relationship with a patient including former patients? ☐Yes ☐No

F. Have you ordered any diagnostics tests for patients within the last 3 years? (Diagnostic tests may include CT scans, MRI's, EEG's, PET scans or other similar tests) ☐Yes ☐No
- **If yes,** what tests? _____

G. Have you had to terminate any patients within the last 3 years? ☐Yes ☐No
- **If yes,** what was the reason? _____

H. How can patients contact you during non-business hours? (Check all that apply)
- ☐ Call group
- ☐ Private/cell telephone
- ☐ Answering service
- ☐ Other: _____

I. Do you provide services via telemedicine? ☐Yes ☐No (**If no,** you can skip questions J-Q and go to the signature)
- **If yes,** please answer the following questions:
  - What technology mediums/platforms do you use? (Check all that apply)
    - ☐ Email
    - ☐ Telephone
    - ☐ Text Messaging
    - ☐ Videoconference (Is it asychronus or what? Please describe) _____
    - ☐ Other (please specify) _____

PSYCHIATRY SUPPLEMENTAL APPLICATION — ANSWERS J-Q

J. What type of patients do you see via telemedicine? (Check all that apply)

- ☐ New patients
- ☐ Established patients
- ☐ Referrals/consultations
- ☐ Other: _____

K. Do you see patients in the following controlled environments? (Check all that apply)

- ☐ Prisons/jails
- ☐ Emergency Department
- ☐ Nursing home/Assisted Living
- ☐ Schools

L. Do patients have the option to opt out of telemedicine? ☐ Yes ☐ No

If yes, and the patient opts out, what are the next steps? _____

M. Will any clinical staff be physically present or be nearby to assist the patient during the telemedicine sessions? ☐ Yes ☐ No

N. What is the average duration of each telemedicine session? _____

O. Do you require an in-person visit/session after a set number of telemedicine visits? ☐ Yes ☐ No

If yes, how many visits/sessions? _____

P. What is your protocol for managing acute situations and/or crisis related to your telemedicine patients?

_____

Q. Are there conditions you will not treat via telemedicine? ☐ Yes ☐ No

If yes, please describe: _____

SIGNATURE

SIGNATURE

_____

Print Name

_____ _____

Signature Date