Step by Step Guide to Complete the Optum Facility Application

United Healthcare®

Start by going to our website: providerexpress.com

Click on "Our Network" on the top tool bar.

Click on the **Facility or Hospital Based** link to complete your facility application.

OPTUM® Provider Express

Search: [Search] [Search]

Home   Our Network   Clinical Resources   Admin Resources   Video Channel   Training   About Us   Contact Us

Optum - Provider Express Home > Our Network

Our Network

Click here for state-specific information

Autism/ABA/BCBA Providers

Optum is recruiting Board Certified Behavior Analysts (BCBA) in solo private practice and qualified agencies that provide intensive ABA services in the treatment of ASD, for our Autism/ABA provider network.

[Click here to join]

Individually-Contracted Clinicians

To apply as an individual, you must be a solo clinician or practicing within a group that does not currently have a group agreement with Optum.

[Click here to join]

Facility or Hospital-Based

To apply for Facility or Hospital-Based, your facility must offer MH or SUD Inpatient, Residential, Partial Hospitalization or Intensive Outpatient Levels of Care.

[Click here to join]

Group with Individually Credentialed Providers

To apply for group with individual credentialing, you must be part of a group that has a group agreement with Optum.

[Click here to join]

Group with Agency Credentialed Providers

To apply for Agency credentialing, your group must be designated as a Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Opioid Treatment Program (OTP), and/or other Federally or State licensed or certified entity (license or certification is at the organizational level).

[Click here to join]

Learn more about our Specialty Network Requests

[Express Access]

[virtual visits]

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Facility or Hospital Providers Required Information:

- Minimum professional liability coverage of $5 million/$5 million for acute inpatient services, and minimum professional and comprehensive liability coverage of $1 million/$3 million for non-acute inpatient services (unless state requirements vary)?

- Current State License(s)/ Certificate(s) for all behavioral health services you provide, i.e. psychiatric, substance abuse, residential, intensive outpatient, etc. A18 – include all documentation for multiple facility locations.

- Accreditation status (i.e. The Joint Commission, CARF, COA, etc.)

- Medicare or Medicaid certification letter with Medicare number (REQUIRED if applying for participation in Medicaid or Medicare networks)

- Program Description-including any specialty program descriptions and hours per day/ days per week

- Copy of completed Ownership & Disclosure Form (REQUIRED if applying for participation in Medicaid networks)

- Copy of completed Ownership & Disclosure Form (REQUIRED if applying for participation in Medicaid networks)

- Current Professional and General Liability insurance certificates showing limits, policy number(s) and expiration date(s). If self -insured, attach a copy of an independently audited financial statement which shows retention of the required amounts.

- W9 form: If multiple tax ID numbers used, one W9 must be submitted for each (NOTE: required if adding or changing tax ID or entity name)

- Staff Roster for all behavioral health staff involved with your programs. Please list their degrees, licenses and/or certificates.

- We do not need an actual copy of their licenses or certifications.

- Daily Program Schedule(s) – include an hour-by-hour schedule showing a patient's daily treatment for each level of care you provide. Include weekend scheduling, where appropriate,

- Policy and Procedure on Intake/Access Process to Behavioral Medicine

- Policy and Procedure on Intake/Access Process if done through E.R.

- Policy and Procedure on Holds/Restraints

- Policy and Procedure for Discharge Planning

Optum/OptumHealth Behavioral Solutions of California
Facility Application

IMPORTANT NOTE:

- Fields marked with are mandatory to move forward
- Please complete fully. Incomplete forms will delay the response to this inquiry.
- Please be sure to have only ONE Network Participation Request Form window open at a time for each submission. Working the same submission in multiple windows at the same time will result in errors related to incorrect data overwriting correct data during the auto-save process.
- Acceptance into the Optum/OptumHealth Behavioral Solutions of California (Optum) provider network is contingent upon the applicant Facility's meeting our credentialing standards and being approved by the Credentialing Committee. Optum collects updated credentialing documentation in order to recredential facilities approximately every 36 months. The requested information is required in order to comply with Optum's credentialing standards and continue your participation in the network.

- Optum Standard Age Ranges

Geriatric -> 65+

Adult -> 18-64

Adolescent -> 13-17

Child -> 0-12

If your facility age range differs from what is listed please indicate the ages treated in the space(s) provided.

To select multiple values for fields that may require more than one selection, please hit "Ctrl" on your keyboard and select the values needed.

Organizational Facility Identification Information

Facility Legal Name

Sample Record

Administrative Fax

Parent Company/Health System Name (if applicable)

Administrative Email

Submit For Review   Save & Exit

DBA(Identifying) Name

Website

Administrative Address (Line 1)

Tax Identification Number (Please enter 9 numbers. No special characters)

999999999

Administrative Address (Line 2)

NPI Primary Number (Please enter 10 numbers. No special characters)

Administrative City

NPI Secondary Number (Please enter 10 numbers. No special characters)

Administrative State

--None--

Billing/Remit Address (Line 1)

Administrative Zip

Billing/Remit Address (Line 2)

Administrative County

Billing/Remit City

Administrative Phone

Billing/Remit State

--None--

Billing/Remit Zip

Level(s) of Care Facility Desires to Contract

⌄ For Geriatrics

Substance Use Disorder Level(s) of Care Facility Desires to Contract for Geriatrics

⌄ For Adolescents

Substance Use Disorder Level(s) of Care Facility Desires to Contract for Adolescents

Submit For Review   Save & Exit

N/A
Medically Managed Intensive Inpatient Services ASAM 4 LOCATION: Acute Care Hospita
Medically Monitored intensive Inpatient Services ASAM 3.7 WM LOCATION: Acute Care
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7 LOCATION:
Residential ASAM 3.7 LOCATION: Acute Care or Freestanding healthcare setting
Clinically Managed High-Intensity Residential Services(SUD Residential) ASAM 3.5 LOC
Partial Hospitalization (PHP) ASAM 2.5
SUD Intensive Outpatient (IOP) ASAM 2.1
Ambulatory Detox (Drug or Alcohol) ASAM 1 WM

N/A
Medically Managed Intensive Inpatient Services ASAM 4 LOCATION: Acute Care Hospita
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM LOCATION: Acute Care
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7 LOCATION:
Residential ASAM 3.7 LOCATION: Acute Care or Freestanding healthcare setting
Clinically Managed High-Intensity Residential Services(SUD Residential) ASAM 3.5 LOCA
Partial Hospitalization (PHP) ASAM 2.5
SUD Intensive Outpatient (IOP) ASAM 2.1
Ambulatory Detox (Drug or Alcohol) ASAM 1 WM

Mental Health Level(s) of Care Facility Desires to Contract for Geriatrics

N/A
I/P Locked
I/P Open
Residential
Partial Hospitalization (PHP)
MH Intensive Outpatient (IOP)
Crisis Services
ECT
Other

Mental Health Level(s) of Care Facility Desires to Contract for Adolescents

N/A
I/P Locked
I/P Open
Residential
Partial Hospitalization (PHP)
MH Intensive Outpatient (IOP)
Crisis Services
ECT
Other

For Adults

For Children

Substance Use Disorder Level(s) of Care Facility Desires to Contract for Adults

N/A
Medically Managed Intensive Inpatient Services ASAM 4 LOCATION: Acute Care Hospita
Medically Monitored Intensive Inpatient Services ASAM 3.7 WM LOCATION: Acute Care
Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7 LOCATION:
Residential ASAM 3.7 LOCATION: Acute Care or Freestanding healthcare setting
Clinically Managed High-Intensity Residential Services(SUD Residential) ASAM 3.5 LOC
Partial Hospitalization (PHP) ASAM 2.5
SUD Intensive Outpatient (IOP) ASAM 2.1
Ambulatory Detox (Drug or Alcohol) ASAM 1 WM

Mental Health Level(s) of Care Facility Desires to Contract for Children

N/A
I/P Locked
I/P Open
Residential
Partial Hospitalization (PHP)
MH Intensive Outpatient (IOP)
Crisis Services
ECT

Other

Mental Health Level(s) of Care Facility Desires to Contract for Adults

N/A
I/P Locked
I/P Open
Residential
Partial Hospitalization (PHP)
MH Intensive Outpatient (IOP)
Crisis Services
ECT
Other

Is your facility a CMS approved facility and do you hold a CLIA (Clinical Laboratory Improvement Amendments) waiver?

None ⌄

Compensation

Submit For Review

Save & Exit

⌄ Compensation for Selected Substance Use Disorder Level(s) of Care Facility Desires to Contract for Geriatrics

⌄ Compensation for Selected Mental Health Level(s) of Care Facility Desires to Contract for Geriatrics

⌄ Compensation for Substance Use Disorder Level(s) of Care Facility Desires to Contract for Adults

⌄ Compensation for Selected Mental Health Level(s) of Care Facility Desires to Contract for Adults

⌄ Compensation for Selected Substance Use Disorder Level(s) of Care Facility Desires to Contract for Adolescents

⌄ Compensation for Selected Mental Health Level(s) of Care Facility Desires to Contract for Adolescents

⌄ Compensation for Selected Mental Health Level(s) of Care Facility Desires to Contract for Children

Facility Location(s) and Levels of Care

How many Practice Location(s) need to be Contracted

| --None-- ⌄ |

STAFFING

*Enter "N/A" if program is not applicable to your facility.

Are services by psychiatrist restricted to staff / faculty psychiatrists?

| --None-- ⌄ |

Number of board certified psychiatrist on staff

Number of Psychiatrist visits per week for IP Acute

Number of IP Acute cases required in Facility bylaws or policy per week

Number of Psychiatrist visits per week for Medically Managed Intensive Inpatient Services ASAM 4

Number of Medically Managed Intensive Inpatient Services ASAM 4 cases required in Facility bylaws or policy per week

Submit For Review   Save & Exit

Number of Psychiatrist visits per week for MH IOP

Number of MH IOP cases required in Facility bylaws or policy per week

Number of Psychiatrist visits per week for Medically Monitored Intensive Inpatient Services ASAM 3.7 WM

Number of Medically Monitored Intensive Inpatient Services ASAM 3.7 WM cases required in Facility bylaws or policy per week

Number of Psychiatrist visits per week for Intentive Outpatient Services ASAM 2.1

Number of Intentive Outpatient Services ASAM 2.1 cases required in Facility bylaws or policy per week

Number of Psychiatrist visits per week for Clinically Managed High Intensity Residential Services(SUD Residential) ASAM 3.5

Number of MH Residential cases required in Facility bylaws or policy per week

Number of Psychiatrist visits per week for MH Residential

Number of Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7 cases required in Facility bylaws or policy per week

Number of Psychiatrist visits per week for Partial Hospitalization ASAM 2.5

Number of Partial Hospitalization ASAM 2.5 required in Facility bylaws or policy per week

Number of Psychiatrist visits per week for MH PHP

Number of required Clinically Managed High Intensity Residential Services(SUD Residential) ASAM 3.5 in Facility bylaws or policy per week

Number of Psychiatrist visits per week for Medically Monitored Intensive Inpatient Services (SUD Inpatient) ASAM 3.7

Number of required MH PHP in Facility bylaws or policy per week

Identify your Average Length of Stay (ALOS) for each program

*Enter "N/A" if program is not applicable to your facility.

⌄ Mental Health Services

⌄ Substance Use Disorder Services

ALOS for Locked Program

ALOS for Medically Managed Intensive Inpatient Services (ASAM 4)

ALOS for Acute Program

ALOS for Medically Monitored Intensive Inpatient Service (ASAM 3.7 WM)
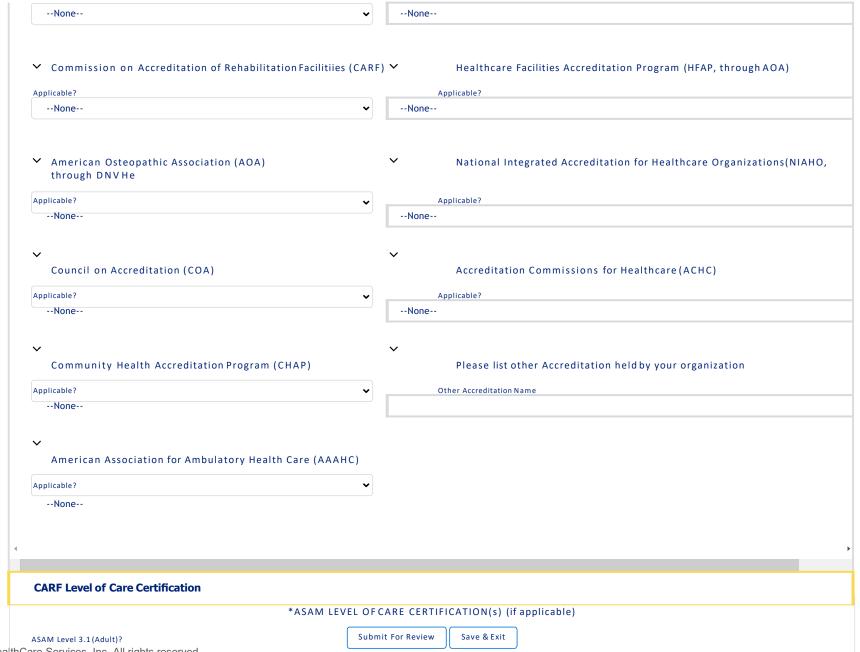
Submit For Review   Save & Exit

ALOS for Residential

ALOS for Medically Monitored Intensive Inpatient Svcs.(SUD Residential(ASAM 3.7))

ALOS for Partial Hospitalization

ALOS for Clinically Managed High-Intensity Residential Services (ASAM 3.5)

ALOS for Intensive Outpatient

ALOS for Partial Hospitalization (ASAM 2.5)

OTHER MENTAL HEALTH SERVICE   **ALOS FOR OTHER MENTAL HEALTH SERVICE**

ALOS for Intensive Outpatient (ASAM 2.1)

Save Other Mental Health Services

ALOS for Ambulatory Detox/Withdrawl Managemet Services (ASAM 1 WM)

Are there any programs/departments within the facility managed by external organizations?

--None--

Organizational Provider Contact Information

∨ Primary Contact

∨ Business Office Manager

Primary Contact Name

Business Office Manager Name

Primary Contact Phone

Business Office Manager Phone

Primary Contact E-mail Address

Business Office Manager E-mail Address

∨ Signatory Contact

∨ Director of Clinical Services

Signatory Contact Name

Director of Clinical Services Name

Submit For Review   Save & Exit

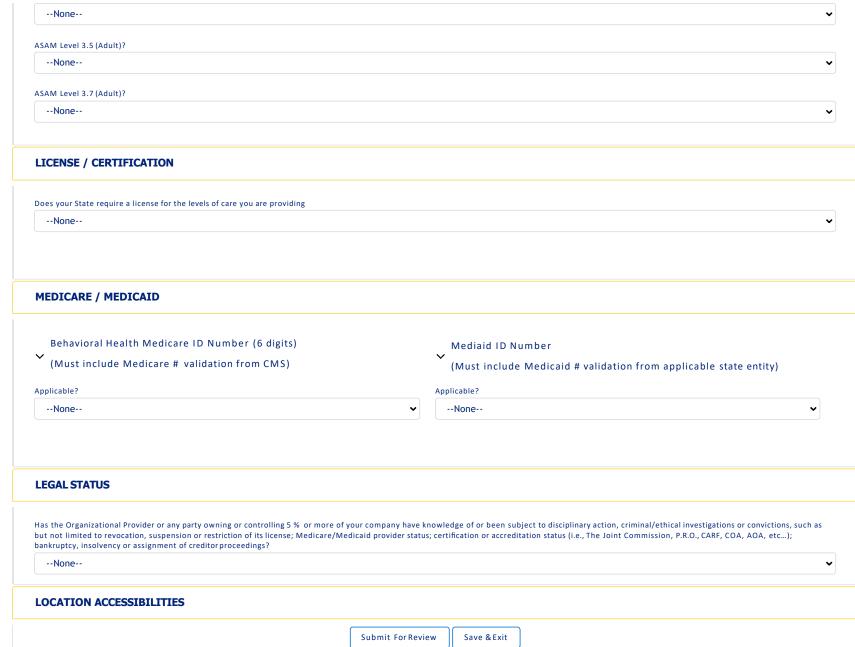[   ]   [   ]

Signatory Contact Phone   Director of Clinical Services Phone

[   ]   [   ]

Signatory Contact E-mail Address   Director of Clinical Services E-mail Address

[   ]   [   ]

∨ Facility Contracting Contact   ∨ Medical Director

Facility Contracting Contact Name   Medical Director Name

[   ]   [   ]

Facility Contracting Contact Phone   Medical Director Phone

[   ]   [   ]

Facility Contracting Contact E-mail Address   Medical Director E-mail Address

[   ]   [   ]

∨ Administrator/Roster Contact   ∨ Chief Executive Officer

Administrator / Roster Contact Name   Chief Executive Officer Name

[   ]   [   ]

Administrator / Roster Contact Phone   Chief Executive Officer Phone

[   ]   [   ]

Administrator / Roster Contact E-mail Address   Chief Executive Officer E-mail Address

[   ]   [   ]

Accreditations

*If you do not have accreditation, a site visit will be required.

The Joint Commission   Critical Access Hospitals (CAH)

∨   [Submit for Review]   [Save & Exit]
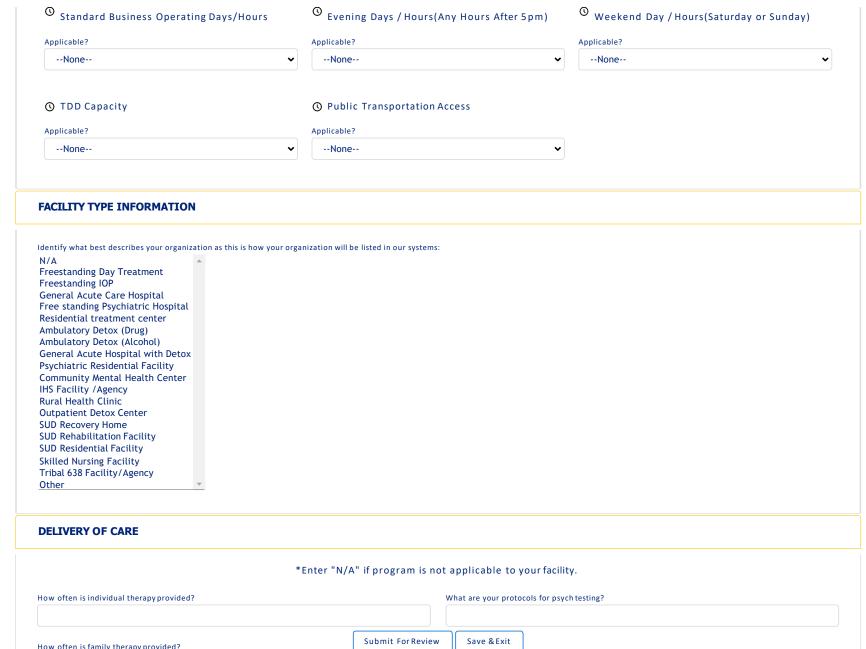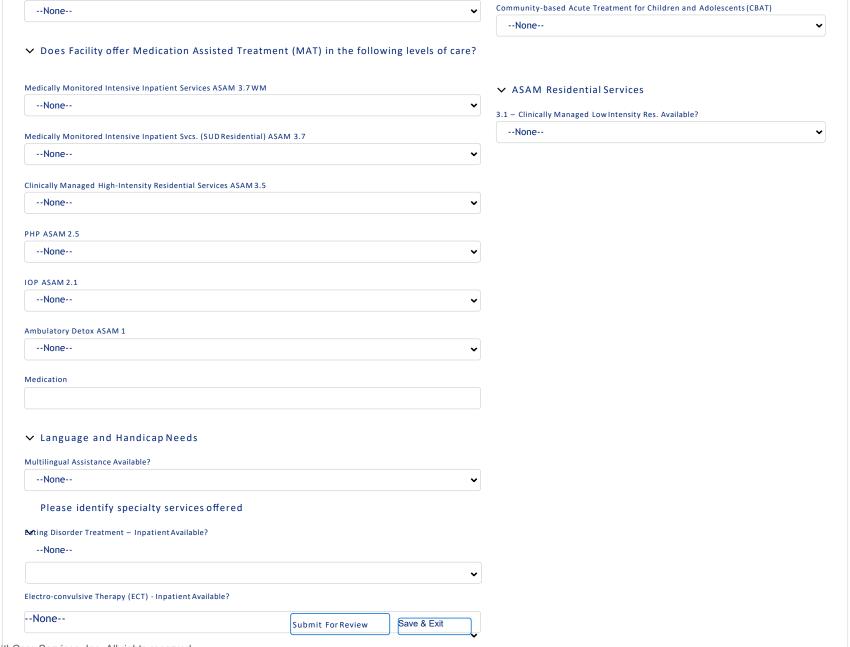
Applicable?   ∨

| --None-- ▼ | --None-- ▼ |

∨ Commission on Accreditation of Rehabilitation Facilitiies (CARF) **∨** Healthcare Facilities Accreditation Program (HFAP, through AOA)

Applicable?

| --None-- ▼ |

Applicable?

| --None-- ▼ |

∨ American Osteopathic Association (AOA) through DNVHe

Applicable?

| --None-- ▼ |

--None--

∨ National Integrated Accreditation for Healthcare Organizations(NIAHO,

Applicable?

| --None-- ▼ |

--None--

∨

Council on Accreditation (COA)

Applicable?

| --None-- ▼ |

--None--

∨

Accreditation Commissions for Healthcare (ACHC)

Applicable?

| --None-- ▼ |

--None--

∨

Community Health Accreditation Program (CHAP)

Applicable?

| --None-- ▼ |

--None--

∨

Please list other Accreditation held by your organization

Other Accreditation Name

∨

American Association for Ambulatory Health Care (AAAHC)

Applicable?

| --None-- ▼ |

--None--

◄ ►

CARF Level of Care Certification

*ASAM LEVEL OF CARE CERTIFICATION(s) (if applicable)

ASAM Level 3.1 (Adult)?

| Submit For Review | Save & Exit |

| --None-- | ▾ |

ASAM Level 3.5 (Adult)?

| --None-- | ▾ |

ASAM Level 3.7 (Adult)?

| --None-- | ▾ |

LICENSE / CERTIFICATION

Does your State require a license for the levels of care you are providing

| --None-- | ▾ |

MEDICARE / MEDICAID

| ▾ | Behavioral Health Medicare ID Number (6 digits) | ▾ | Mediaid ID Number |
| | (Must include Medicare # validation from CMS) | | (Must include Medicaid # validation from applicable state entity) |

Applicable?

| --None-- | ▾ |

Applicable?

| --None-- | ▾ |

LEGAL STATUS

Has the Organizational Provider or any party owning or controlling 5 % or more of your company have knowledge of or been subject to disciplinary action, criminal/ethical investigations or convictions, such as but not limited to revocation, suspension or restriction of its license; Medicare/Medicaid provider status; certification or accreditation status (i.e., The Joint Commission, P.R.O., CARF, COA, AOA, etc…); bankruptcy, insolvency or assignment of creditor proceedings?

| --None-- | ▾ |

LOCATION ACCESSIBILITIES

| Submit For Review | Save & Exit |

🕐 Standard Business Operating Days/Hours	🕐 Evening Days / Hours(Any Hours After 5pm)	🕐 Weekend Day / Hours(Saturday or Sunday)
Applicable?	Applicable?	Applicable?
--None--	--None--	--None--

🕐 TDD Capacity	🕐 Public Transportation Access
Applicable?	Applicable?
--None--	--None--

FACILITY TYPE INFORMATION

Identify what best describes your organization as this is how your organization will be listed in our systems:

N/A
Freestanding Day Treatment
Freestanding IOP
General Acute Care Hospital
Free standing Psychiatric Hospital
Residential treatment center
Ambulatory Detox (Drug)
Ambulatory Detox (Alcohol)
General Acute Hospital with Detox
Psychiatric Residential Facility
Community Mental Health Center
IHS Facility /Agency
Rural Health Clinic
Outpatient Detox Center
SUD Recovery Home
SUD Rehabilitation Facility
SUD Residential Facility
Skilled Nursing Facility
Tribal 638 Facility/Agency
Other

DELIVERY OF CARE

*Enter "N/A" if program is not applicable to your facility.

How often is individual therapy provided?

What are your protocols for psych testing?

How often is family therapy provided?

Submit For Review   Save & Exit

[   ]

For the partial hospital and IOP services, does the program serve as a step down or are patients directly admitted?

[   ]

What is the patient to staff ratio?

[   ]

Does your Partial Hospital or IOP program align with ASAM, LOCUS, CASII and/or ECSII, as applicable?

[--None-- ▼]

What is the staff position responsible for discharge planning?

[   ]

What percentage of patients are directly admitted to the partial and IOP programs?

[   ]

Describe your discharge planning procedures

[   ]

What components are present in your Substance Use Disorder programs?

```
N/A
No SUD services offered
Education is directed to drug of choice
Relapse prevention is part of program
Program meets Department of Transportation requirements
There is criteria for drug/alcohol urine screens
```

What percentage of patients are referred for follow up care?

[   ]

SERVICE DELIVERY / SPECIALTY SERVICES

*Enter "N/A" if program is not applicable to your facility.

If Medically Managed Intensive Inpatient (ASAM 4) is offered at Facility, please identify the physical location of detoxification beds

```
N/A
Bed located on a medical floor/unit
Bed located on a behavioral health unit
```

Medication Assisted Treatment (MAT) – available in requested levels of care

[--None-- ▼]

Number of Hours of Treatment Per Day for Partial Hospitalization Program

[   ]

Sober Living / Halfway House

[--None-- ▼]

Number of Days of Treatment Per Week for Partial Hospitalization Program

[   ]

Group Home Available?

[--None-- ▼]

Number of Hours of Treatment Per Day for Intensive Outpatient Program

[   ]

Therapeutic Foster Care Available?

[--None-- ▼]

Number of Days of Treatment Per Week for Intensive Outpatient Program

[   ]

Intensive Community-based Acute Treatment for Children and Adolescents (ICBAT)

[--None-- ▼]

If Factility offers both ASAM 3.5 and ASAM 3.7, is Facility aware of the differences in the clinical requirements between the two levels of care?

[Submit For Review] [Save & Exit]

--None--

Community-based Acute Treatment for Children and Adolescents (CBAT)

--None--

∨ Does Facility offer Medication Assisted Treatment (MAT) in the following levels of care?

Medically Monitored Intensive Inpatient Services ASAM 3.7 WM

--None--

∨ ASAM Residential Services

Medically Monitored Intensive Inpatient Svcs. (SUD Residential) ASAM 3.7

--None--

3.1 – Clinically Managed Low Intensity Res. Available?

--None--

Clinically Managed High-Intensity Residential Services ASAM 3.5

--None--

PHP ASAM 2.5

--None--

IOP ASAM 2.1

--None--

Ambulatory Detox ASAM 1

--None--

Medication

∨ Language and Handicap Needs

Multilingual Assistance Available?

--None--

Please identify specialty services offered

Eating Disorder Treatment – Inpatient Available?

--None--

Electro-convulsive Therapy (ECT) - Inpatient Available?

--None--

Submit For Review

Save & Exit

Electro-convulsive Therapy (ECT) - Outpatient Available?

--None-- ⌄

Dual Diagnosis Services Available?

--None-- ⌄

Continuing Day Treatment Available?

--None-- ⌄

LGBTQ Services Available?

--None-- ⌄

Domiciliary Services in an IOP or PHP Setting (program must be formally approved by Optum) Available?

--None-- ⌄

Chronically Mentally Ill Services (CMI) / Severely Mentally Ill Services (SMI) Available?

--None-- ⌄

Respite Care Services Available?

--None-- ⌄

Emergency Room Services (assessment only) Available?

--None-- ⌄

Twenty-three (23) Hour Crisis Observation Available?

--None-- ⌄

Medicare Opioid Treatment Program Available?

--None-- ⌄

Mobile Crisis Stabilization Available?

--None--

Submit for Review   Save & Exit

⌄

MHSA Outpatient Clinics in a Hospital Available?

--None--

GENERAL / PROFESSIONAL LIABILITY

Please attach current certificates for two types of liability insurance information. Optum insurance requirements are as follows:
- For facilities/programs with an acute inpatient component: Professional/general liability $5,000,000/$5,000,000 minimum coverage.
- For facilities/programs without an acute inpatient component: Professional liability $1,000,000/$3,000,000 minimum coverage Comprehensive general liability $1,000,000/$3,000,000 minimum coverage
- If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts stated above

Documents To Be Attached (Required)

FILE DESCRIPTION	SELECT FILE	
Current State License(s)/ Certificate(s) for all behavioral health services you provide	Choose File	No file chosen
Accreditation status (i.e. The Joint Commission, CARF, COA, etc.)	Choose File	No file chosen
Medicare Certification Letter with Medicare Number	Choose File	No file chosen
Medicaid Certification Letter with Medicaid Number	Choose File	No file chosen
Clinical Program Description-including any specialty program descriptions and hours per day/ days per week	Choose File	No file chosen
Staff Roster for all behavioral health staff involved with your programs.	Choose File	No file chosen
Daily Program Schedule(s) – include an hour-by-hour schedule showing a patient's daily treatment for each level of care you provide.	Choose File	No file chosen
Copy of completed Ownership and Disclosure Form (REQUIRED if applying for participation in Medicaid networks)	Choose File	No file chosen
Professional and General liability insurance certificates showing limits, policy number(s) and expiration date(s).	Choose File	No file chosen
Controlled Substance DEA for Facility	Choose File	No file chosen

Submit For Review   Save & Exit

FILE DESCRIPTION	SELECT FILE
Substance Abuse License or Opiod Abuse License for Facility	Choose File No file chosen
Controlled Substance DEA for Individual Provider(s) MAT Waiver for	Choose File No file chosen No
Individual Provider(s)	Choose File file chosen No file
CLIA Waiver	Choose File chosen No file
Completed State Site Audit	Choose File chosen No file
W9 form: If multiple tax ID numbers used, one W9 must be submitted for each	Choose File chosen

Policies and Procedures (ONLY NEEDED FOR NEW FACILITY APPLICANTS)

FILE DESCRIPTION	SELECT FILE
Policy and Procedure on Intake/Access Process to Behavioral Medicine	Choose File No file chosen
Policy and Procedure on Intake/Access Process if done through E.R.	Choose File No file chosen
Policy and Procedure on Holds/Restraints	Choose File No file chosen
Policy and Procedure for Discharge Planning	Choose File No file chosen

Save Files

Attached Documents

(Refresh page to see attached documents)

NAME	DESCRIPTION

Acknowledge and Certify

☐

I hereby certify that all of the responses and information provided pursuant in this application are complete, true and correct to the best of my knowledge and belief. I further warrant that facility's applicable license(s) is current and free of sanction or limitation.

I understand that facility is responsible for adherence to Optum's credentialing plan, clinical guidelines, and other processes and procedures as outlined at providerexpress.com. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in representative capacity. I warrant that I (or my designee) have reviewed and will consistently review the level of care guidelines associated with services being credentialed. The level of care guidelines can be found at providerexpress.com

Submit for Review   Save & Exit

Attesting Individual Name (Submitter)

Submitter Title

Date

[__5/27/2021__

Submit for Review   Save & Exit

System Generated Emails

OPTUM

Incomplete Facility Application
2nd Notice

This message is being sent to provide you with a link to the incomplete Facility Application started for {!FNRF__c.Facility_Legal_Name__c}

You can access the link below at any time to continue with application request.

{!FNRF__c.Incomplete_Application__c}

You can also get to this application by accessing the request link just like you did initially and from the "Summary Information" page click on "view" next to this request under the "Incomplete Requests" section for the incomplete form to display. You can continue with form submission after the form displays.

Please note failure to complete the application by {!FNRF__c.Final_reminder_date__c} will require a new application to be submitted.

Reference Number for this Request is {!FNRF__c.Name}

Optum Behavioral Network Services

OPTUM

Incomplete Facility Application
Final Notice

This message is being sent to provide you with a link to the incomplete Facility Application started for {!FNRF__c.Facility_Legal_Name__c}

You can access the link below at any time to continue with application request.

{!FNRF__c.Incomplete_Application__c}

You can also get to this application by accessing the request link just like you did initially and from the "Summary Information" page click on "view" next to this request under the "Incomplete Requests" section for the incomplete form to display. You can continue with form submission after the form displays.

Please note failure to complete the application by {!FNRF__c.Final_reminder_date__c} will require a new application to be submitted.

Reference Number for this Request is {!FNRF__c.Name}

Optum Behavioral Network Services