CAQH Data Summary Date 8/28/2025
Diaz Sotelo, Stefany Applied Behavioral Analyst
CAQH Provider ID : 16589001

Last Reattestation Date: 8/21/2025 6:17:00 PM

PREPARE

NUCC Grouping:	**Behavioral Health & Social Service Providers**		
Provider Type:	**Applied Behavioral Analyst**	Practice Setting:	**Inpatient/Outpatient or Outpatient Only**
Primary Practice State:	**FL**		
Other Practice State(s):			

PERSONAL INFORMATION

Name

First Name :	**Stefany**	Middle Name :	
Last Name :	**Diaz Sotelo**	Suffix :	
Have you used other names?	**No**		

Home Address

Street 1 :	**16135 SW 147th ST**	Street 2 :	
City :	**Miami**	State :	**FL**
Country :		Province :	
County :		Zip Code :	**33196**

Mailing Address

Is Mailing address and Home Address Same?	No		
Street 1 :		Street 2 :	
City :		State :	
Country :		Province :	
County :		Zip Code :	

Primary Method of Contact

Primary E-mail Address :	**stefanyrds27@gmail.com**	Personal E-Mail Address :	
PMOC CC Email1 :		PMOC CC Email2 :	

Phone Numbers

Home Phone :		Personal Cell Phone :	
Personal Fax :			

Personal Identification Numbers

Social Security Number :	**772-68-5981**		
Foreign National Identification Number :		FNIN Country of Issue :	
Do you have a Unique Physicians Identification Number (UPIN)?	**No**		
Do you have an Individual (Type 1) National Provider Identifier (NPI)?	**Yes**	Individual NPI :	**1972190379**

Demographics

Gender Identity:	**Female**		
Race/Ethnicity :	**Hispanic or Latino**		
Birth Date :	**11/11/1997**	Birth City :	**Ica**
Birth State :		Birth Country :	**Peru**

Languages

Non-English languages spoken by provider :	**Spanish**		

PROFESSIONAL IDENTIFICATION NUMBERS

Professional License

License State :	**FL**	Do you currently practice in this state?	**Yes**
License Number :	**1-25-81916**	License Type :	**ABA**
License Status :	**Active**		
Issue Date :	**06/11/2025**	Expiration Date :	**06/11/2027**

DEA Registration

Do you have a DEA Registration Certificate?	**No**

Controlled Dangerous Substance (CDS) Registration

Do you have a CDS Registration Certificate?	**No**

Medicare

Are you a participating Medicare provider?	**No**

Medicaid

Are you a participating Medicaid provider?	**No**

ECFMG

Do you have a Educational Commission for Foreign Medical Graduates (ECFMG) Number?	**No**

USMLE

USMLE No. :		Exam Date :	

Workers Compensation Number

Professional School Information

Country :	**United States**	State :	**FL**
County :			
Professional School :	**NOVA Southeastern University, College of Optometry**	Street 1 :	**3200 S. University Dr.**
Street 2 :		City :	**Fort Lauderdale**
Province :			
Zip Code :	**33328**		
Phone Number :	**800-541-6682**	Fax Number :	
Degree :	**Master in Counseling (MC)**		
Professional School Start Date :	**08/2021**	Professional School End Date :	**12/2023**
Area of Training / Course of Study / Major :			
Did you complete your professional education at this school?	**Yes**	Graduation Date :	**12/31/2023**

Undergraduate Education

Country :	**United States**	State :	**PA**
School :	**University of Pennsylvania**	Street 1 :	**36th St And Hamilton Walk**
Street 2 :		City :	**Philadelphia**
Province :			
Zip Code :	**19104**		
Phone Number :		Fax Number :	
Degree :	**Bachelor of Arts (BA)**		
Start Date :	**08/2016**	End Date :	**05/2020**
Area of Training / Course of Study / Major :	**Biology**		
Did you complete your Undergraduate education at this school?	**Yes**	Graduation Date :	**05/31/2020**
Certificate Received/Awarded :			

TRAINING INFORMATION

Cultural Competency Training :

Have you completed cultural competency training?	No
Please select which program(s) you have completed:	

SPECIALTY INFORMATION

Primary Specialty

Primary Specialty :	**Behavior Analyst (103K00000X)**		
Board Certified?	**Yes**		
Name of Certifying Board :	**Behavior Analyst Certification Board**		
Country :	**United States**	State :	**FL**
County :	**Miami-Dade County**		
Street 1 :		Street 2 :	
City :		Province :	
Zip Code :			
Certification Number :			
Initial Certification Date :	**6/11/2025**	Does your board certification have an expiration date?	**Yes**
Expiration Date :	**6/11/2027**	Last Recertification Date :	**6/11/2025**
Do you wish to be listed in the directory under this primary specialty? By HMO		**Yes**	
Do you wish to be listed in the directory under this primary specialty? By PPO		**Yes**	
Do you wish to be listed in the directory under this primary specialty? By POS		**Yes**	

Secondary Specialty

Do you have a Secondary Specialty? **No**

Special Experience, Skills, and Training

Please select one or more special experience, skills, and training that apply from the list below:

Patient Age Groups

Toddlers (2-5), Children (6-12), Adolescents (13-18)

Patient Gender Identities

Male, Female

Special Patient Populations

Developmentally Disabled, Intellectually Disabled

Patient Racial/Ethnic Groups

African American, American, Cuban

Issues Treated

Attention Deficit/Hyperactive Disorder (ADHD), Autism Spectrum, Behavioral Issues, Education and Learning Disabilities, Intellectual Disabilities

Types of Therapies

Applied Behavioral Analysis (ABA)

CERTIFICATION INFORMATION

Do you have Certifications? : **Yes**

QASP - Qualified Autism Service

			Child/Infant/Adult
CPR - Certificate No :	**C35032F86**	CPR - Date of Certification :	**12/4/2024**
CPR Expiration Date :	**12/4/2026**		
Basic Life Support (BLS) :	**No**		
Advanced Cardiac Life Support (ACLS) :	**No**		
Advanced Life Support in OB(ALSO) :	**No**		
Health Care Provider (CoreC) :	**No**		
Advanced Trauma Life Support (ATLS) :	No		
Neonatal Advanced Life Support (NALS) :	**No**		
Neonatal Resuscitation Program (NRP) :	**No**		
Pediatric Advanced Life Support (PALS) :	**No**		
Other :	**No**		
Anesthesia Permit :	**No**		
Therapeutics Classification Number (Optometrists only) :			
Other Interests :			

PRACTICE LOCATIONS

Active Locations

General Information :			
Confirmed Date :			
Office Type :	**Primary Practice**	Providers's Start Date :	**8/5/2025**
Do you practice at this location?:	**Yes, I practice at this location**		
Please Explain:	**I see patients by appointment at least one day per week on a regular basis**		
Provider Directory Classification :			
Specialty :	**Behavior Analyst**	Subspecialty :	
Will you continue to practice at this location			
Type of Service provided :			
Provide a narrative description of your clinical practice including special interests :			
Practice Name :	**NeuroDverse LLC**		
Street 1 :	**2500 NW 79th Ave Ste 180**		
Street 2 :		Country :	**United States**
City :	**Doral**	State :	**FL**
County :		Province :	
Zip Code :	**33122-1083**	Email Address :	
Can general correspondence be sent to this location?		Practice Location Website	
Appointment Scheduling Website			
Mailing Address :			
Street1 :		Street2 :	
City :		State :	
County :		Province :	
Country :		Zip Code :	
Type of Practice :			
Do you have an organization (Type 2) NPI? :	**Yes**	Organization (Type 2) NPI :	**1912615873**
Group Medicaid Number :		Group Medicare Number :	
Phone Numbers :			
Appointment Phone Number :	**786-882-5437**	Phone Extention :	
Fax Number :			
Back Office Phone Number :			
Phone Coverage :			
Does this location provide 24hour/7day a week phone coverage?:			
Phone Coverage Type :			
Tax Information :			
Practice Name as it appears on the W-9 :	**NeuroDverse LLC**		
Tax ID :	**883710970**	Type of Tax ID :	**Group**
Is this the primary Tax ID for this practice location?	**Yes**		
Group Name :			
Network Denial :			
Have you closed your practice to any plans or programs ?		**No**	
Office Hours :			
Monday			

Wednesday			
Start Time :	**None**	End Time :	**None**
Thursday			
Start Time :	**None**	End Time :	**None**
Friday			
Start Time :	**None**	End Time :	**None**
Saturday			
Start Time :	**None**	End Time :	**None**
Sunday			
Start Time :	**None**	End Time :	**None**

Patients :

Do you accept new patients at this practice location?	**Yes**
Do you accept existing patients with change of payor at this location?	**Yes**
Do you accept all new patients at this location?	**Yes**
Do you accept new Medicare patients at this location?	**No**
Do you accept new Medicaid patients at this location?	**Yes**
Do you accept new CHIP patients at this location?	**No**
Do you accept new patients from physician referrals (i.e., referring letter) at this location?	**Yes**
Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.	**ASD Diagnosis**
What questions should we ask a patient, to help determine the appropriateness of the referral?	**Do you have an ASD diagnosis by a clinical psychologist or physician?**
Does this information vary by health plan ?	**No**

Colleagues :

Do you have any Partners/Associate at this location ?

Covering Colleagues :

Mid-Level Practitioners :

Do you have any mid-level practitioners at this location?

Office Manager or Business Staff Contact :

First Name :	**Gretel**	Last Name :	**Debasa**
Middle Name :		Suffix :	
Phone Number :		Fax Number :	
E-mail Address :	**gretel.debasa@neurodverse.com**		
Is Office Manager Credentialing Contact :			

Billing Contact :

Office Manager & Billing Contact are same ?

Payment and Remittance :

Billing department name :	Check Payable to :
Electronic billing capabilities ?	
Office Manager & Payee Contact are same ?	

Practice Limitations and Patient Populations :

Are there any Practice Limitations ?	**No**
Gender Limitations :	
Are there any Age Limitations? :	
Only Native Americans:	
Only Enrolled Students:	
Other Limitations :	

Accessibility :

Does this office meet ADA accessibility requirements ?	**No**
Does this office provide handicapped accessibility ?	No

Please specify how this location meets handicapped accessibility requirements:

Exterior Building	No
Interior Building	No
Wheelchair access to exam room	No
Exam table/scale/chair	No
Gurneys & Stretchers	No
Portable Lifts	No
Radiologic Equipment	No
Signage & documents	No

Does this office have other services for the disabled ?	**No**
Please specify other services for the disabled:	
Text Telephony (TTL) :	No
American Sign Language :	No
Mental/Physical Impairment Services :	No
Other Disability Services :	
Is this office accessible by public transportation ?	**No**
Please specify how this office is accessible by public transportation:	
Bus Transportation:	No
Subway :	No
Regional Train :	No
Other Transportation :	
Does this Location Provide Child Care Services?	No
Does this office meet all state and local fire, safety and sanitation requirements?	No
Do you have TDD(hearing impaired device) available :	No
Do you accept Workers' Compensation Patients?	No
Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy?	No
Modified or alternative duty is actively evaluated for each Workers' Compensation claimant?	No
Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible	No
Staff are available and willing to provide compensation representatives information regarding a claimant's care.	No

Telehealth :

I provide telehealth services at this location:	
Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)?	
Telehealth Service Type:	

Audio :	**No**	Audio/Video :	**No**
Online Adaptive Interviews :	**No**	Secure Text Messaging :	**No**
Remote Monitoring :	**No**	Store-and-Forward :	**No**
Are you willing and able to support family caregivers?	No		

Services :

Does this location provide any of the following services:			
Laboratory Services? :	**No**	Accrediting/Certifying Program :	
Radiology Services :	**No**	X-ray?	**No**
X-Ray Certification Type :		EKG Services?	**No**
Care of Minor Lacerations?	**No**	Pulmonary Function testing?	**No**
Allergy Injections :	**No**	Allergy Skin Testing :	**No**
Office Gynecology?	**No**		
Drawing Blood?	**No**		
Asthma Treatment?	**No**	Age Appropriate Immunizations?	**No**
Flexible Sigmoidoscopy?	**No**	Tympanometry/Audiometry Screening ?	**No**
Osteopathic Manipulation?	**No**	IV Hydration treatment?	**No**
Cardiac Stress Test? Treadmill?	**No**	Physical Therapy?	**No**
Is anesthesia administered in your office ?	**No**	What class/category of anesthesia is used ?	
Anesthesia Administered by First Name :		Anesthesia Administered by Last Name :	
Other Services :			
Special Skills By The Practitioner :		Special Skills By The Staff :	
Non-English language spoken by office personnel :			
Employee Type :			
Do you have any interpreters at this location?	**No**		

Archived Locations

***THERE IS NO DATA ON RECORD FOR THIS SECTION**

HOSPITAL AFFILIATIONS

General :

Do you have admitting privileges at one or more hospitals?	**No**
Do you have an admitting arrangement where another provider admits for you?	**No**
Do you have any non-admitting hospital affiliations?	

CREDENTIALING INFORMATION

*** THERE IS NO DATA ON RECORD FOR THIS SECTION**

INSURANCE INFORMATION

Policy Number :	**AR122184**

Current Expiration Date :	**01/29/2026**		
Carrier/Self Insured Name :	**Philadelphia Indemnity Insurance Company**		
Street 1 :	**One Bala Plaza, Suite 100**	Street 2 :	
City :	**Bala Cynwyd**	Province :	
State :	**PA**	Country :	**United States**
Zip Code :	**19004**	Phone Number :	
Phone Extension :		Fax Number :	
Do you have unlimited coverage with this insurance carrier?	**No**		
Type of coverage :			
Amount of coverage per occurrence :	**$1,000,000.00**	Amount of coverage aggregate :	**$3,000,000.00**
If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?			
Individual Coverage :	**Yes**		
Self-Insured?	**Yes**		

WORK HISTORY INFORMATION

Employment Information Record

Practice/Employer Name :	**NeuroDverse**	Department :	
Street 1 :	**2500 NW 79th Ave Suite 180**	Street 2 :	
Country :	**United States**		
City :	**Doral**	State :	**FL**
Province :		Zip Code :	**33122**
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	**08/2025**		
Is this your current employer?	**Yes**		
Practice/Employer Name :	**Baudhuin Preschool**	Department :	
Street 1 :	**7600 SW 36th ST**	Street 2 :	
Country :	**United States**		
City :	**Davie**	State :	**FL**
Province :		Zip Code :	**33328**
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	**02/2021**		
Is this your current employer?	**No**		
End Date :	**06/2021**	Reason for departure :	**Transitioning to full-time RBT role**
Practice/Employer Name :	**Behavior Analysis Inc**	Department :	**Applied Behavior Analysis**
Street 1 :	**8001 SW 36th ST #9**	Street 2 :	
Country :	**United States**		
City :	**Davie**	State :	**FL**
Province :		Zip Code :	**33328**
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	**01/2021**		
Is this your current employer?	**Yes**		
Practice/Employer Name :	**Keller Williams International Lifestyles**	Department :	
Street 1 :	**10900 NW 25th ST #200**	Street 2 :	
Country :	**United States**		
City :	**Miami**	State :	**FL**
Province :		Zip Code :	**33172**
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	**10/2020**		
Is this your current employer?	**No**		
End Date :	**01/2021**	Reason for departure :	**Transitioning from receptionist role to RBT and ESE Teacher's Aide roles**
Practice/Employer Name :	**University of Pennsylvania's Van Pelt Library**	Department :	
Street 1 :	**3420 Walnut Street**	Street 2 :	
Country :	**United States**		
City :	**Philadelphia**	State :	**PA**
Province :		Zip Code :	**19104**
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	**09/2016**		
Is this your current employer?	**No**		
End Date :	**05/2017**	Reason for departure :	**Transitioning to an administrative assistant role at the Finance Office**
Practice/Employer Name :	**University of Pennsylvania SAS Finance and Administrative Office**	Department :	

City :	**Philadelphia**	State :	**PA**
Province :		Zip Code :	**19104**
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	**09/2016**		
Is this your current employer?	**No**		
End Date :	**05/2020**	Reason for departure :	**Moved from Philadelphia to Miami due to COVID-19 pandemic**

Employment Gap Record :

Start Date:	**01/2021**	End Date:	**02/2021**
Gap Explanation:	**Medical leave, Other (please specify)**	Reason:	**I was diagnosed with COVID-19 before the vaccine had been created. I had to quarantine for about 30 days in my bedroom to avoid contaminating my family members. Once I confirmed that I no longer had COVID-19, I returned to work.**
Start Date:	**05/2020**	End Date:	**10/2020**
Gap Explanation:	**Job search, Other (please specify)**	Reason:	**During spring break of my senior year of college, the COVID-19 pandemic shut down my school and place of work. I was able to finish my last semester of senior year and last months of work virtually through zoom, but was never able to return to Philadelphia thereafter. After graduation, my job search was prolonged due to most workplaces being shutdown due to the COVID-19 pandemic.**
Start Date:	**08/2021**	End Date:	**12/2023**
Gap Explanation:	**Academic/Training leave**		
Start Date:	**08/2016**	End Date:	**05/2020**
Gap Explanation:	**Academic/Training leave**		

Military :

Are you currently on active military duty?	**No**	Are you currently in the Reserves or National Guard?	**No**

REFERENCES INFORMATION

*** THERE IS NO DATA ON RECORD FOR THIS SECTION**

DISCLOSURE INFORMATION

CAQH :

Licensure :

1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?	**No**
2. Has there been any challenge to your licensure, registration or certification?	**No**

Hospital Privileges and Other Affiliations :

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	**No**
4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	**No**
5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	**No**

Education, Training and Board Certification :

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	**No**
7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	**No**
8. Have any of your board certifications or eligibility ever been revoked?	**No**
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	**No**

DEA or CDS :

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?	**No**

Medicare, Medicaid or other Governmental Program Participation :

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	**No**

Other Sanctions or Investigations :

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child	**No**

14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	**No**
15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?	**No**
16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?	**No**

Professional Liability Insurance Information and Claims History :

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	**No**
18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?	**No**

Malpractice Claims History :

19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case.	**No**

Criminal/Civil History :

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?	**No**
21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?	**No**
22. Have you ever been court-martialed for actions related to your duties as a medical professional?	**No**

Ability to Perform Job :

23. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. Illegal use of drugs refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the controlled Substances Act or other provision of Federal law. The term does include, however, the unlawful use of prescription controlled substances.)	**No**
24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	**No**
25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?	**No**
26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?	**No**