

**PREPARE**

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

**PERSONAL INFORMATION****Name**

First Name : **Khalia** Middle Name :  
 Last Name : **Davis** Suffix :  
 Have you used other names? **No**

**Home Address**

Street 1 : **505 Chatham Ave** Street 2 : **857**  
 City : **Orlando** State : **FL**  
 Country : Province :  
 County : Zip Code : **32801**

**Mailing Address**

Is Mailing address and Home Address Same? Yes  
 Street 1 : **505 Chatham Ave Apt 857** Street 2 :  
 City : **Orlando** State : **FL**  
 Country : Province :  
 County : Zip Code : **32801-0033**

**Primary Method of Contact**

Primary E-mail Address : **khdavis@teampbs.com** Personal E-Mail Address : **khaliadavis4@gmail.com**  
 PMOC CC Email1 :  
 PMOC CC Email2 :

**Phone Numbers**

Home Phone : Personal Cell Phone : **954-822-8035**

**Personal Identification Numbers**

Social Security Number : **673-01-0802** FNIN Country of Issue :  
 Foreign National Identification Number :  
 Do you have a Unique Physicians Identification Number (UPIN)? **No**  
 Do you have an Individual (Type 1) National Provider Identifier (NPI)? **Yes** Individual NPI : **1396493128**

**Demographics**

Gender Identity: **Female**  
 Race/Ethnicity: **Black or African American**  
 Birth Date : **3/9/1998** Birth City : **Atlanta**  
 Birth State : **GA** Birth Country : **United States**

**Languages**

Non-English languages spoken by provider :  
 provider :

**PROFESSIONAL IDENTIFICATION NUMBERS****Professional License**

License State : **FL** Do you currently practice in this state? **Yes**  
 License Number : **1-24-72059** License Type : **ABA**  
 License Status : **Active**  
 Issue Date : **03/25/2024** Expiration Date : **03/25/2026**

**DEA Registration**

Do you have a DEA Registration Certificate? **No**  
 I do not Prescribe : **Yes**  
 Reason For Not Having DEA : **I don't have a DEA due to my provider type**  
 Alternate Prescriber Name :  
 More Information :

**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? **Yes**

Medicaid Number : **105394000** State : **FL**

**ECFMG**

USMLE No. :

Exam Date :

**Workers Compensation Number**

Workers Compensation Number :

**EDUCATION**Graduate Type : **US/Canada Graduate****Professional School Information**

Country :	<b>United States</b>	State :	<b>MN</b>
County :	<b>Hennepin County</b>		
Professional School :	<b>Capella University</b>	Street 1 :	<b>225 South 6th St</b>
Street 2 :		City :	<b>Minneapolis</b>

Province :

Zip Code : **55402**

Phone Number : Fax Number :

Degree : **Master of Science (MS)**Professional School Start Date : **05/2021** Professional School End Date : **06/2022**

Area of Training / Course of Study /

Major :

Did you complete your professional education at this school? **Yes** Graduation Date : **06/30/2022****Undergraduate Education**Country : **United States** State : **AL**

School :	<b>University of Alabama</b>	Street 1 :	<b>1530 3rd Avenue South</b>
Street 2 :		City :	<b>Tuscaloosa</b>

Province :

Zip Code : **35487**Phone Number : **205-348-6010** Fax Number :Degree : **Bachelor of Arts (BA)**Start Date : **08/2016** End Date : **08/2019**

Area of Training / Course of Study /

Major :

Did you complete your Undergraduate education at this school? **Yes** Graduation Date : **08/03/2019**Certificate Received/Awarded : **June 2019****TRAINING INFORMATION****Cultural Competency Training :**Have you completed cultural competency training? **Yes**

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 : State :

County : Street 2 :

Street 1 : Province :

City :

Zip Code :

Certification Number : **1-24-72059**Initial Certification Date : **3/25/2024** Does your board certification have an expiration date? **Yes**Expiration Date : **3/25/2026** Last Recertification Date : **3/25/2024**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:

**CERTIFICATION INFORMATION**Do you have Certifications? : **Yes**

QASP - Qualified Autism Service Provider :

CPR - Cardio-Pulmonary Resuscitation : **No**Basic Life Support (BLS) : **Yes**BLS - State : **KY** BLS - Type : **American Heart Association- Basic**BLS - Certificate No : **245413795015**BLS Expiration Date : **12/2/2025** BLS - Date of Certification : **12/2/2023**

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 : **8/28/2025**  
Office Type : **Primary Practice** Providers's Start Date : **3/25/2024**  
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 : **Yes**  
Type of Service provided :  
Provide a narrative description of your clinical practice including special interests :  
Practice Name : **Positive Behavior Supports Corporation - Central Florida**  
Street 1 : **907 Outer Rd Ste B**  
Street 2 :  
City : **Orlando** Country : **United States**  
County : **Orange County** State : **FL**  
Zip Code : **32814-6601** Province :  
Can general correspondence be sent to this location? Email Address : **RrPinero@teampbs.com**  
Appointment Scheduling Website Practice Location Website : **www.teampbs.com**

**Mailing Address :**

Street1 : **7108 S KANNER HWY** Street2 :  
City : **STUART** State :  
County : **Martin County** Province :  
Country : **United States** Zip Code : **34997-7462**  
Type of Practice : **Single Specialty Group**  
Do you have an organization (Type 2 NPI)? :  
Organization (Type 2) NPI : **1700024296**

Group Medicaid Number : **017422400**

**Phone Numbers :**

Appointment Phone Number : **855-832-6727** Phone Extention :  
Fax Number : **772-675-9100**

Back Office Phone Number :

**Phone Coverage :**

Does this location provide 24hour/7day a week phone coverage?: **Yes**

Phone Coverage Type : **Voice Mail Other**

**Tax Information :**

Practice Name as it appears on the W-9 : **Positive Behavior Supports Corporation**  
Tax ID : **205268843**

Is this the primary Tax ID for this practice location? **Yes**

Group Name : **Positive Behavior Supports Corp**

**Network Denial :**

Have you closed your practice to any plans or programs ? **No**

**Office Hours :**

Monday  
Start Time : **9:00 AM** End Time : **5:00 PM**  
Tuesday  
Start Time : **9:00 AM** End Time : **5:00 PM**  
Wednesday  
Start Time : **9:00 AM** End Time : **5:00 PM**  
Thursday

Saturday

**None**

End Time :

**None**

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?

**Yes**

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.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan ?

**No****Colleagues :**

Do you have any Partners/Associate at this location ?

**No****Covering Colleagues :****Mid-Level Practitioners :**

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

**No****Office Manager or Business Staff Contact :**

First Name :	<b>Rafael</b>	Last Name :	<b>Pinero</b>
Middle Name :		Suffix :	
Phone Number :	<b>855-832-6727</b>	Fax Number :	<b>772-675-9100</b>
E-mail Address :	<b>RrPinero@teampbs.com</b>		

Is Office Manager Credentialing Contact :

**Billing Contact :**

Office Manager &amp; Billing Contact are same ?

First Name :	<b>Danielle</b>	Middle Name :	
Last Name :	<b>Sexton</b>	Street 1 :	<b>7108 S Kanner Hwy</b>
Billing Company Name :		City :	
Street 2 :		Province :	
State:	<b>FL</b>	Zip Code :	<b>34997-7462</b>
Country :	<b>United States</b>	Fax Number :	<b>772-675-9100</b>
Phone Number :	<b>855-832-6727</b>		
E-mail Address :	<b>DHunter@teampbs.com</b>		

**Payment and Remittance :**

Billing department name :	<b>PBS Corp Billing Department</b>	Check Payable to :	<b>Positive Behavior Supports Corp</b>
Electronic billing capabilities ?	<b>Yes</b>		

Office Manager &amp; 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 ?

**Yes**

Does this office provide handicapped accessibility ?

**Yes****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 &amp; Stretchers

No

Portable Lifts

No

Restroom

Yes

Other Handicapped Access :

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:

**Yes**

Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)?

**Yes**

Telehealth Service Type:

Audio :

**Yes**

Audio/Video :

**Yes**

Online Adaptive Interviews :

**No**

Secure Text Messaging :

**Yes**

Remote Monitoring :

**Yes**

Store-and-Forward :

**Yes**

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?

**No**

Physical Therapy? :

**No**

Treadmill?

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****General Information :**

Confirmed Date :

**8/28/2025**

Office Type :

**Other Practice**

Providers's Start Date :

**3/24/2025**

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 :

**Behavior Analyst**

Subspecialty :

Specialty :

**Yes**

Will you continue to practice at this location

Type of Service provided :

Provide a narrative description of your clinical practice including special

Street 2 : Orlando  
 City : Orange County  
 County : 32801-2381  
 Zip Code :  
 Can general correspondence be sent to this location?

Country : United States  
 State : FL  
 Province :  
 Email Address : office@behaviorapple.com  
 Practice Location Website : www.behaviorapple.com

## Appointment Scheduling Website

**Mailing Address :**

Street1 :  
 City :  
 County :  
 Country :  
 Street2 :  
 State :  
 Province :  
 Zip Code :

Type of Practice : **Group**  
 Do you have an organization (Type 2) **Yes**

Organization (Type 2) NPI : **1528869534**

NPI? :  
 Group Medicaid Number :

Group Medicare Number :

**Phone Numbers :**  
 Appointment Phone Number : **407-640-8807**

Phone Extension :

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 : **Behavior Apple LLC**

:  
 Tax ID : **332290588**

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  
 Start Time : **9:00 AM** End Time : **5:00 PM**  
 Tuesday  
 Start Time : **9:00 AM** End Time : **5:00 PM**  
 Wednesday  
 Start Time : **9:00 AM** End Time : **5:00 PM**  
 Thursday  
 Start Time : **9:00 AM** End Time : **5:00 PM**  
 Friday  
 Start Time : **9:00 AM** End Time : **5:00 PM**  
 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? **No**  
 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.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan ? **No**

**Colleagues :**

Do you have any Partners/Associate at this location ? **No**

at this location?

**Office Manager or Business Staff Contact :**

First Name :	<b>Khalia</b>	Last Name :	<b>Davis</b>
Middle Name :		Suffix :	
Phone Number :	<b>407-640-8807</b>	Fax Number :	
E-mail Address :	<b>office@behaviorapple.com</b>		
Is Office Manager Credentialing Contact	<b>Yes</b>		
:			

**Billing Contact :**

Office Manager & Billing Contact are same ?	<b>Yes</b>	Middle Name :	
First Name :	<b>Khalia</b>	Street 1 :	<b>111 north orange avenue</b>
Last Name :	<b>Davis</b>	City :	<b>orlando</b>
Billing Company Name :		Province :	
Street 2 :	<b>suite 800</b>	Zip Code :	<b>32801</b>
State:	<b>FL</b>	Fax Number :	
Country :	<b>United States</b>		
Phone Number :	<b>407-640-8807</b>		
E-mail Address :	<b>office@behaviorapple.com</b>		

**Payment and Remittance :**

Billing department name :		Check Payable to :	
Electronic billing capabilities ?	<b>Yes</b>		
Office Manager & Payee Contact are same ?	<b>No</b>		

**Practice Limitations and Patient Populations :**

Are there any Practice Limitations ?	<b>No</b>	Yes
Gender Limitations :		
Are there any Age Limitations? :	<b>No</b>	
Only Native Americans:		
Only Enrolled Students:		
Other Limitations :		
<b>Accessibility :</b>		
Does this office meet ADA accessibility requirements ?		<b>Yes</b>
Does this office provide handicapped accessibility ?		<b>Yes</b>

**Please specify how this location meets handicapped accessibility requirements:**

Exterior Building	<b>No</b>
Interior Building	<b>Yes</b>
Wheelchair access to exam room	<b>No</b>
Exam table/scale/chair	<b>No</b>
Gurneys & Stretchers	<b>No</b>
Portable Lifts	<b>No</b>
Radiologic Equipment	<b>No</b>
Signage & documents	<b>No</b>
Parking	<b>No</b>
Restroom	<b>Yes</b>
Other Handicapped Access :	

Does this office have other services for the disabled ?	<b>No</b>
<b>Please specify other services for the disabled:</b>	

Text Telephony (TTL) :	<b>No</b>
American Sign Language :	<b>No</b>
Mental/Physical Impairment Services :	<b>No</b>
Other Disability Services :	

Is this office accessible by public transportation ?	<b>Yes</b>
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**Please specify how this office is accessible by public transportation:**

Bus Transportation:	<b>Yes</b>
Subway :	<b>No</b>
Regional Train :	<b>No</b>
Other Transportation :	

Does this Location Provide Child Care Services?	<b>No</b>
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Does this office meet all state and local fire, safety and sanitation requirements?	<b>Yes</b>
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Do you have TDD(hearing impaired device) available :	<b>No</b>
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Do you accept Workers' Compensation Patients?	<b>No</b>
---	-----------

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?	<b>No</b>
---	-----------

Modified or alternative duty is actively evaluated for each Workers' Compensation claimant?	<b>No</b>
---	-----------

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	<b>No</b>
---	-----------

Staff are available and willing to provide compensation representatives information regarding a claimant's care.	<b>No</b>
--	-----------

**Telehealth :**

I provide telehealth services at this location:	<b>Yes</b>
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Do you use a telehealth application or platform that is compliant with the Health	<b>Yes</b>
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Online Adaptive Interviews :

**No**

Secure Text Messaging :

**No**

Remote Monitoring :

**No**

Store-and-Forward :

**No**Are you willing and able to support family  
caregivers?**Yes****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?

**No**

Physical Therapy?

**No**

Treadmill?

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****General Information :**

Confirmed Date :

**8/28/2025**

Office Type :

**Other Practice**

Providers's Start Date :

**7/25/2025**

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 :

**Specialist**

Specialty :

**Behavior Analyst**

Subspecialty :

**Behavior Analyst**Will you continue to practice at this  
location**Yes**

Type of Service provided :

Provide a narrative description of your  
clinical practice including special  
interests :**Allied Health Professional**

Practice Name :

**Tilly FL**

Street 1 :

**6303 Waterford District Dr Ste 400**

Street 2 :

Country :

**United States**

City :

**Miami****FL**

County :

**Miami-Dade County**

State :

Zip Code :

**33126-6040**

Province :

Can general correspondence be sent to  
this location?

Email Address :

**care@tillytherapy.com**

Appointment Scheduling Website

Practice Location Website

**https://tillytherapy.com/****Mailing Address :**

Street1 :

**19 W 24th Street**

Street2 :

**4th Floor**

City :

**New York****NY**

County :

**New York County**

Province :

Country :

**United States**

Zip Code :

**10010**

Type of Practice :

**Multi-Specialty Group**Do you have an organization (Type 2)  
NPI? :**Yes**

Organization (Type 2) NPI :

**1881222040**

Group Medicaid Number :

**106689000**

Group Medicare Number :

**Phone Numbers :**

Appointment Phone Number :

**833-458-0386**

Phone Extention :

Fax Number :

**855-461-3542**

Back Office Phone Number :

**Phone Coverage :**Does this location provide 24hour/7day a  
week phone coverage?:**Voice Mail To Answering Service**

Phone Coverage Type :

**Tax Information :**

Practice Name as it appears on the W-9

**FL MC Sprout 1 LLC**

:

Tax ID :

**850563425**

Type of Tax ID :

**Group**

Is this the primary Tax ID for this practice

**Yes**

Have you closed your practice to any plans or programs ?

**No**

**Office Hours :**

Monday

**9:00 AM**

End Time :

**9:00 PM**

Tuesday

**9:00 AM**

End Time :

**9:00 PM**

Wednesday

**9:00 AM**

End Time :

**9:00 PM**

Thursday

**9:00 AM**

End Time :

**9:00 PM**

Start Time :

**9:00 AM**

End Time :

**9:00 PM**

Friday

**9:00 AM**

End Time :

**9:00 PM**

Saturday

**9:00 AM**

End Time :

**9:00 PM**

Sunday

**9:00 AM**

End Time :

**9:00 PM**

Start Time :

**9:00 AM**

End Time :

**9:00 PM**

**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.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

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 : **Liezl**

Last Name :

**Parohinog**

Middle Name :

Suffix :

Phone Number : **833-458-0386**

Fax Number :

E-mail Address : **credentialing@tillytherapy.com**

Is Office Manager Credentialing Contact

**Yes**

:

**Billing Contact :**

Office Manager & Billing Contact are same ?

**Payment and Remittance :**

Billing department name : **Tilly**

Check Payable to :

**FL MC Sprout 1 LLC**

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**

Portable Lifts

No

Radiologic Equipment

No

Signage &amp; documents

No

Parking

No

Restroom

No

Other Handicapped Access :

**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 :

**No**

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?

**Yes**

Does this office meet all state and local fire, safety and sanitation requirements?

**Yes**

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

Staff are available and willing to provide compensation representatives information regarding a claimant's care.

No

**Telehealth :**

I provide telehealth services at this location:

**Yes**

Do you use a telehealth application or platform that is compliant with the Health

**Yes**

Insurance Portability and Accountability Act (HIPAA)?

Telehealth Service Type:

Audio :	<b>Yes</b>	Audio/Video :	<b>Yes</b>
Online Adaptive Interviews :	<b>No</b>	Secure Text Messaging :	<b>Yes</b>
Remote Monitoring :	<b>No</b>	Store-and-Forward :	<b>No</b>

Are you willing and able to support family Yes  
caregivers?**Services :**

Does this location provide any of the following services:

Laboratory Services? :	<b>No</b>	Accrediting/Certifying Program :	
Radiology Services :	<b>No</b>	X-ray?	<b>No</b>
X-Ray Certification Type :		EKG Services?	<b>No</b>

Care of Minor Lacerations? :	<b>No</b>	Pulmonary Function testing?	<b>No</b>
Allergy Injections :	<b>No</b>	Allergy Skin Testing :	<b>No</b>

Office Gynecology?	<b>No</b>	Age Appropriate Immunizations?	<b>No</b>
Drawing Blood?	<b>No</b>	Tympanometry/Audiometry Screening ?	<b>No</b>

Asthma Treatment?	<b>No</b>	IV Hydration treatment?	<b>No</b>
Flexible Sigmoidoscopy?	<b>No</b>	Physical Therapy?	<b>No</b>

Osteopathic Manipulation?	<b>No</b>	What class/category of anesthesia is used ?	
Cardiac Stress Test?	<b>No</b>	Anesthesia Administered by Last Name :	

Treadmill?			
Is anesthesia administered in your office ?	<b>No</b>		

Anesthesia Administered by First Name :			
Other Services :	<b>ABA Therapy</b>	Special Skills By The Practitioner :	

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?	<b>No</b>		

**Archived Locations****General Information :**

Confirmed Date :	<b>3/29/2025</b>	Providers's Start Date :	<b>7/30/2024</b>
Office Type :	<b>Other Practice</b>		
Do you practice at this location?:	<b>No, I do not practice here</b>		
Please Explain:	<b>I no longer practice at this location</b>		

Will you continue to practice at this location?

**No**

If no, last date of employment

3/28/2025

Type of Service provided :

Provide a narrative description of your clinical practice including special interests :

Practice Name :

**Bright Behavioral Health****18001 Old Cutler Rd Ste 550**

Street 1 :

Street 2 :

City :

County :

Zip Code :

Can general correspondence be sent to this location?

**Palmetto Bay****Miami-Dade County****33157-6439**

Country :

State :

Province :

Email Address :

Practice Location Website

**United States****FL**

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:

**1518743582**

Group Medicaid Number :

Group Medicare Number :

**Phone Numbers :**

Appointment Phone Number :

**786-380-4932**

Phone Extention :

**104**

Fax Number :

**786-619-1902**

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

:

Tax ID : **932094108**

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

**None**

End Time :

**None**

Tuesday

**None**

End Time :

**None**

Wednesday

**None**

End Time :

**None**

Thursday

**None**

End Time :

**None**

Friday

**None**

End Time :

**None**

Saturday

**None**

End Time :

**None**

Sunday

**None**

End Time :

**None**

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?

**Yes**

Do you accept new patients from physician referrals (i.e., referring letter) at this location?

**Yes**

What questions should we ask a patient, to help determine the appropriateness of the referral?

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 : **Gloria**

Last Name :

**Patino Cuna**

Middle Name :

Suffix :

Phone Number :

Fax Number :

E-mail Address : **gpatino@brightbehavioralhealth.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**

Parking

**No**

Restroom

**No**

Other Handicapped Access :

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 :

**No**

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

**No**

and provide care/services with an active return to work philosophy?

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 :**

## Telehealth Service Type:

Audio : **No**  
 Online Adaptive Interviews : **No**  
 Remote Monitoring : **No**  
 Are you willing and able to support family caregivers? **No**

**Services :**

Does this location provide any of the following services:

Laboratory Services? :	<b>No</b>	Accrediting/Certifying Program :	
Radiology Services :	<b>No</b>	X-ray?	<b>No</b>
X-Ray Certification Type :		EKG Services?	<b>No</b>
Care of Minor Lacerations?	<b>No</b>	Pulmonary Function testing?	<b>No</b>
Allergy Injections :	<b>No</b>	Allergy Skin Testing :	<b>No</b>
Office Gynecology?	<b>No</b>		
Drawing Blood?	<b>No</b>		
Asthma Treatment?	<b>No</b>	Age Appropriate Immunizations?	<b>No</b>
Flexible Sigmoidoscopy?	<b>No</b>	Tympanometry/Audiometry Screening ?	<b>No</b>
Osteopathic Manipulation?	<b>No</b>	IV Hydration treatment?	<b>No</b>
Cardiac Stress Test?	<b>No</b>	Physical Therapy?	<b>No</b>
Treadmill?			

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 :

Non-English language spoken by office personnel :

## Employee Type :

Do you have any interpreters at this location? **No**

Special Skills By The Staff :

**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**

First Name :	<b>Khalia</b>	Middle Name :	
Last Name :	<b>Davis</b>	Street 1 :	<b>111 north orange avenue</b>
Street 2 :	<b>suite 800</b>	City :	<b>Orlando</b>
State :	<b>FL</b>	Zip Code :	<b>32801</b>
Country :	<b>United States</b>	Province :	
Phone Number :	<b>407-640-8807</b>	Fax Number :	
Email Address :	<b><a href="mailto:office@behaviorapple.com">office@behaviorapple.com</a></b>		
Primary Credentialing Contact :	<b>Yes</b>	Location :	<b>Behavior Apple</b>
Location Type :	<b>PracticeLocation</b>	Middle Name :	
First Name :	<b>Christian</b>	Street 1 :	<b>7108 S KANNER HWY</b>
Last Name :	<b>Helenius</b>	City :	<b>STUART</b>
Street 2 :		Zip Code :	<b>34997-7462</b>
State :	<b>FL</b>	Province :	
Country :	<b>United States</b>	Fax Number :	<b>772-675-9100</b>
Phone Number :	<b>855-832-6727</b>		
Email Address :	<b><a href="mailto:chelenius@teampbs.com">chelenius@teampbs.com</a></b>		
Primary Credentialing Contact :	<b>No</b>	Location :	<b>Positive Behavior Supports Corporation - Central Florida</b>
Location Type :	<b>PracticeLocation</b>	Middle Name :	
First Name :	<b>Liezl</b>	Street 1 :	<b>19 W 24th Street</b>
Last Name :	<b>Parohinog</b>	City :	<b>New York</b>
Street 2 :	<b>4th Floor</b>	Zip Code :	<b>10010-3229</b>
State :	<b>NY</b>	Province :	
Country :	<b>United States</b>	Fax Number :	<b>855-461-3542</b>
Phone Number :	<b>833-458-0386</b>		
Email Address :	<b><a href="mailto:credentialing@tillytherapy.com">credentialing@tillytherapy.com</a></b>		
Primary Credentialing Contact :	<b>No</b>	Location :	<b>Tilly FL</b>
Location Type :	<b>PracticeLocation</b>		

**INSURANCE INFORMATION**Policy Number : **HC7CAC8V5F001**Covered Practice Locations : **Tilly FL**

Original Effective Date :

Current Effective Date : **03/16/2025**

City : **New York**  
 State : **NY**  
 Zip Code :  
 Phone Extension :  
 Do you have unlimited coverage with this insurance carrier? **No**  
 Type of coverage : **Individual**  
 Amount of coverage per occurrence : **\$1,000,000.00**  
 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? **No**  
 Policy Number : **AR413262**  
 Covered Practice Locations : **Behavior Apple**  
 Original Effective Date : **02/12/2025**  
 Current Effective Date : **02/12/2025**  
 Current Expiration Date : **02/12/2026**  
 Carrier/Self Insured Name : **Cph and Associates**  
 Street 1 : **711 South Dearborn Street**  
 City : **Chicago**  
 State : **IL**  
 Zip Code :  
 Phone Extension :  
 Do you have unlimited coverage with this insurance carrier? **No**  
 Type of coverage : **Occurrence**  
 Amount of coverage per occurrence : **\$1,000,000.00**  
 If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?  
 Individual Coverage : **No**  
 Self-Insured? **No**  
 Policy Number : **6799172**  
 Covered Practice Locations : **Positive Behavior Supports Corporation - Central Florida**  
 Original Effective Date :  
 Current Effective Date : **01/31/2025**  
 Current Expiration Date : **01/31/2026**  
 Carrier/Self Insured Name : **Lexington Insurance Company**  
 Street 1 : **99 High Street**  
 City : **Boston**  
 State : **MA**  
 Zip Code : **02110**  
 Phone Extension :  
 Do you have unlimited coverage with this insurance carrier? **No**  
 Type of coverage : **Occurrence**  
 Amount of coverage per occurrence : **\$1,000,000.00**  
 If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?  
 Individual Coverage : **No**  
 Self-Insured? **No**

#### WORK HISTORY INFORMATION

##### Employment Information Record

Practice/Employer Name : **Positive Behavior Support Corporation**  
 Street 1 : **907 Outer Rd**  
 Country : **United States**  
 City : **Orlando**  
 Province :  
 Phone Number :  
 Fax Number :  
 Start Date : **11/2019**  
 Is this your current employer? **Yes**  
**Employment Gap Record :**

Start Date:	<b>05/2021</b>	End Date:	<b>06/2022</b>
Gap Explanation:	<b>Academic/Training leave</b>		
Start Date:	<b>08/2016</b>	End Date:	<b>08/2019</b>
Gap Explanation:	<b>Academic/Training leave</b>		
<b>Military :</b>			
Are you currently on active military duty?	<b>No</b>	Are you currently in the Reserves or National Guard?	

#### REFERENCES 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 abuse or a sexual offence or sexual misconduct? **No**

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? **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**