

**Preferred EAP
National Network
EAP Provider Application**

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

Before completing this *Application* please review the Eligible Providers and Minimum Criteria information below. If you do not meet the minimum criteria or are otherwise not an eligible provider, do not complete this *Application* before consulting with the Preferred EAP Counselor, Jenny Reilly, at 610-477-9856.

Eligible Providers

The Preferred EAP National Network includes:

- Licensed doctoral and masters level psychologists
- Licensed masters level social workers
- Licensed masters level psychiatric nurses
- Licensed masters level professional counselors
- Licensed or certified addictions counselors

Minimum Criteria

All National Network EAP Providers must meet the following criteria:

- Currently engaged in active clinical practice.
- As eligible, hold a current unrestricted license or certification in their specialty.
- Carry minimum malpractice and liability insurance coverage of \$1,000,000 per occurrence and \$3,000,000 aggregate.

When completing the *Application*, please be sure:

- To include **up-to-date** copies of all required documents, including
 - Malpractice and Professional Liability Insurance Face Sheet.
 - Professional License.
- To include a W-9 form and NPI Verification.
- To sign and date the *Application*.

Any question concerning this *Application* should be directed to Jenny Reilly, LPC,CADC Preferred EAP Counselor, 610-477-9856 or jenny.reilly@lvhn.org

Please type or print

I. Provider Identification

- A. Name _____ Male Female
 LAST FIRST M.I.
- B. Date of Birth _____ C. Social Security Number _____

II. Billing and Practice Information

Please provide practice information for each office in which you see patients and billing information for each tax identification number under which you currently bill.

A. Primary Practice Address

1. Group or Facility Name: _____

Street: _____

City: _____ County: _____

State: _____ Zip Code: _____

e-mail: _____@_____

2. Phone Numbers:

Appointments: (____) _____ - _____ ext _____

Billing: (____) _____ - _____ ext _____

Fax: (____) _____ - _____ ext _____

3. Is this address your (check all that apply):

Practice address Mailing address Remittance address

Tax ID# _____(Please submit a W-9 form.)

NPI # _____

B. Second Practice Address

1. Group or Facility Name: _____

Street: _____

City: _____ County: _____

State: _____ Zip Code: _____

e-mail: _____@_____

2. Phone Numbers:

Appointments: (____) _____ - _____ ext _____

Billing: (____) _____ - _____ ext _____

Fax: (____) _____ - _____ ext _____

III. Credentialing

A. Highest Professional degree: _____

B. Name of graduate school which corresponds with the highest professional degree checked above.

College or University: _____

Address: _____

City/State/Zip: _____

Graduation Date: _____

IV. Liability History

A. Complete the following information about your malpractice insurance for the past Five (5) years. Include information for every carrier/workplace during past five years. Attach additional sheets if necessary.

Current Carrier: _____

Expiration Date: _____

Address: _____

City: _____ State: _____

Zip Code: _____

Levels: \$ _____ per occurrence \$ _____ per aggregate

If Group/Organization policy, please list name below.

Group Name: _____

Phone: (____) _____ - _____ Contact Person: _____

V. Practice Patterns

A. Client Population: (Check the age ranges for which you offer services):

- | | | |
|---|---|--|
| <input type="checkbox"/> Young Child (0-5) | <input type="checkbox"/> Adolescent (13-17) | <input type="checkbox"/> Older Adult (65+) |
| <input type="checkbox"/> Older Child (6-12) | | <input type="checkbox"/> Adult (18-24) |

B. Disorders (Check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Addictions | <input type="checkbox"/> HIV/Aid |
| <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> ADHD | <input type="checkbox"/> Sexual/Gender Disorders |
| <input type="checkbox"/> Abuse-Sexual/Physical | <input type="checkbox"/> Personality Disorders | |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Adjustment/Conduct | |
| <input type="checkbox"/> Psychosomatic/Somatoform | <input type="checkbox"/> Eating Disorders | |

VI. Attestations

If you answer “Yes” to any of the following questions, please attach a complete written explanation. If you have been named in a malpractice action, please include a complete copy of the original complaint and the order of settlement.

	Yes	No
1. Have you ever been named in a malpractice action?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had any professional liability cases pending, any settlements made, or any judgments entered against you?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been denied malpractice insurance coverage by any carrier as a result of previous malpractice liability experience?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your license or certification to practice in any jurisdiction ever been denied, limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action, nor renewed or otherwise acted upon in an adverse manner?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been suspended, fined, disciplined, or otherwise sanctioned or excluded from receiving payment under Medicaid or Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been subjected to disciplinary action by any medical organization, public agency, MCO, HMO or other provider network or organization?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has any hospital or facility ever dismissed you from its staff?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been convicted of a criminal offense other than a minor traffic violation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you presently using illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have an impairment which, even with reasonable accommodation, would interfere with your ability to provide professional services?	<input type="checkbox"/>	<input type="checkbox"/>

AGREEMENT / RELEASE

I submit this application for membership in Preferred EAP National Network and understand that my application will be reviewed based on the information I have provided here. I certify that the information contained in this form is true and accurate, and that information found to be false could result in denial or subsequent termination of network membership.

I understand that my answers to the questions in this Application constitute factual representations upon which Preferred EAP may rely for purposes of entering into a Professional Services Contractor Agreement with me.

By this authorization, I hereby forever release from any and all liability whatsoever all representatives, agents, and officials of Preferred EAP for any action performed or statements made in connection with evaluating my credentials.

Also, I hereby authorize an individual and/or organization from whom information is requested to provide any and all information, records and documents in their possession, or their control and will forever release such individuals from any liability when this information is used to facilitate assessment of this application for performing as a Preferred EAP National Network Provider.

Signature

Date