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*. Please contact Preferred EAP at 610-433-8550 or preferred_eap@lvhn.org to be connected with a Counselor for further assistance.

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
- To sign and date the *Application*

Any question concerning this *Application* should be directed to 610-433-8550 or preferred_eap@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 _____

D. License 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. Practice Patterns

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

☐ Young Child (0-5) ☐ Adolescent (13-17) ☐ Older Adult (65+)

☐ Older Child (6-12) ☐ Adult (18-24)

B. Disorders (Check all that apply):

☐ Anxiety Disorders ☐ Addictions ☐ HIV/Aid

☐ Mood Disorders ☐ ADHD ☐ Sexual/Gender Disorders

☐ Abuse-Sexual/Physical ☐ Personality Disorders

☐ Dissociative Disorders ☐ Adjustment/Conduct

☐ Psychosomatic/Somatoform ☐ Eating Disorders

C. Services (Check all that apply):

☐ Drug & Alcohol Assessments ☐ SAP Qualified ☐ Critical Incident Debriefing

☐ Threat Assessment ☐ Wellness Workshops: Please list:_____

_____

D. Practice Information:

☐ PM Hours ☐ Telehealth

☐ Weekend Hours ☐ In Person

E. Insurances Accepted: _____

_____

F. Specialties/Certifications:_____

_____

G. Languages Spoken: _____

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?	☐	☐
2.	Have you ever had any professional liability cases pending, any settlements made, or any judgments entered against you?	☐	☐
3.	Have you ever been denied malpractice insurance coverage by any carrier as a result of previous malpractice liability experience?	☐	☐
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?	☐	☐
5.	Have you ever been suspended, fined, disciplined, or otherwise sanctioned or excluded from receiving payment under Medicaid or Medicare?	☐	☐
6.	Have you ever been subjected to disciplinary action by any medical organization, public agency, MCO, HMO or other provider network or organization?	☐	☐
7.	Has any hospital or facility ever dismissed you from its staff?	☐	☐
8.	Have you ever been convicted of a criminal offense other than a minor traffic violation?	☐	☐
9.	Are you presently using illegal drugs?	☐	☐
10.	Do you have an impairment which, even with reasonable accommodation, would interfere with your ability to provide professional services?	☐	☐

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 relay 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