



Interface EAP

PO Box 421879, Houston, TX 77242-1879

Phone (713) 781-3364 (800) 324-4327

www.ieap.com

Provider Network INDIVIDUAL PROVIDER APPLICATION

Provider name:

FIRST

MIDDLE

LAST

DEGREE

The following items **MUST** be attached in order for your application to be considered:

- | Enclosed | Previously Submitted | |
|--------------------------|--------------------------|---|
| | | Check one of the following three choices regarding liability coverage: |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Professional Liability Coverage: <i>\$1million/\$1million</i> for Master's and Doctoral level clinicians and <i>\$1million/\$3million</i> for all Physicians |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Enrolled in the Patient Compensation or Stabilization Fund |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Practice in a State that is recognized under the tort reform |
| <input type="checkbox"/> | <input type="checkbox"/> | STATE licenses or STATE certifications in Counseling Disciplines
MD's: DEA, State Substance Control, & Board Certifications |
| <input type="checkbox"/> | <input type="checkbox"/> | Current Resume or Vita (Clinicians must have 3 years post licensure experience) |
| <input type="checkbox"/> | <input type="checkbox"/> | List of hospital staff privilege status (<i>if appropriate</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Form W-9 – Taxpayer Identification Number (see attached)
Do others use this Federal EIN? <input type="checkbox"/> Yes <input type="checkbox"/> No |

I am with a group who currently has a contract with Interface EAP

Group Name: _____ Federal EIN: _____

I am currently seeing an Interface Participant OUT OF NETWORK Yes No

If yes, include client's IEAP case number: _____

I agree to see this referral for Interface EAP (IEAP). I have received, read and understand the policies and forms sent to me by IEAP. I agree to follow said policies and utilize the forms. I understand this agreement will allow me to see up to 2 more referrals prior to signing the full IEAP agreement. I also understand IEAP is available for any questions or help with procedures associated with this referral.

Provider Signature _____

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Individual Provider Application – Demographic Information

Provider Name: _____			
FIRST	MIDDLE	LAST	DEGREE
Date of Birth: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: _____ <small>(Optional)</small>	
Bilingual: <input type="checkbox"/> Yes <input type="checkbox"/> No	Languages: _____		
Practice Name: _____			
Mailing Address: _____			
City: _____	State: _____	Zip: _____	County: _____
Service Address: _____			
City: _____	State: _____	Zip: _____	County: _____
Primary Phone: _____	AnsSvc/Pager: _____	Fax: _____	
Billing Contact: _____	Phone : _____		
E-mail address (optional): _____	Web Site: _____		
Hours: M _____ T _____ W _____ TH _____ F _____ Sat _____ Sun _____			
Handicapped Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a personal residence? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate areas that you are qualified to assess & counsel potential referrals.			
Specialized Populations	Specialized Knowledge	Specialty Areas	
Adolescents _____	Christian Counselor _____	ADHD _____	Marital/Family _____
Adults _____	CISD _____	Anger Mgmt _____	MPD _____
Children 6-12 _____	Clergy Peer Hotline _____	Anxiety Dis _____	Parenting Issue _____
Children < 6 _____	Developmental Dis _____	Bipolar _____	Perpetrators _____
Geriatrics _____	ECT _____	Career Counsel _____	Personality _____
Specialized Modalities	Employer Mandated _____	Chemical Dep. _____	Phobias _____
Biofeedback _____	Fit For Duty _____	Chronic Pain _____	Psychosis _____
Conj/Family _____	Gay/Lesbian Issues _____	Depression _____	PTSD _____
Forensic _____	Men's Issues _____	Eating Disorder _____	Sexual Dis _____
Group _____	Pharmacy Intervention _____	EMDR _____	Sleep Disorder _____
Hypnosis _____	SAP (DOT) _____	Gambling _____	Smoking Cess. _____
Neuro-Psych Test _____	Veterans _____	Grief/Loss _____	Somatic _____
Play Therapy _____	Wellness Seminar _____	Impulse Control _____	Stress Mgmt _____
Psych Testing _____	Women's Issues _____	Learning Dis _____	Victim Issue _____
	Workplace Violence _____		
Where do you refer your clients for:			
Psychiatric Assessments? _____			
Psychological Testing? _____			
Chemical Dependency Treatment? _____			
Inpatient Psychiatric Treatment? _____			

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Individual Provider Application – Waiver

YES NO Please respond to the following questions:

- Has your professional license/certification ever been revoked, suspended, or limited?
- Have you ever voluntarily surrendered your license or certification?
- Have you ever been denied privileges, were they ever limited, suspended, or renewal denied?
- Have you ever resigned from the staff of any hospital or professional organization because of problems regarding privileges or credentials?
- Have you ever been denied professional liability insurance, or has your insurance ever been canceled or refused renewal?
- Have you ever been the plaintiff or defendant in any lawsuit involving a hospital, a professional association or an organization?
- Have you ever been convicted of or plead guilty to a felony crime?
- Have you or your professional association ever sought bankruptcy protection?
- Have you ever incurred a malpractice claim?
- Has your DEA number ever been revoked or otherwise limited?
- Have you ever been suspended from receiving payment from Medicare or Medicaid?

If you answered “YES” to any of the above questions you must attach a statement with full details.

WAIVER STATEMENT

I hereby release from liability all representatives of Interface EAP, for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby consent to the release and exchange of information to Interface EAP, relating to any disciplinary action, suspension or curtailment of privileges, or professional malpractice claims whether or not settled or in judgment.

I understand and agree that I, as an applicant, have the burden of providing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I understand that Interface EAP may verify all or any of the information contained herein.

I certify that the information provided herein, including attachments, represents full and truthful disclosures of the matters to which they pertain. I understand that omission or falsification of data may invalidate any agreements in place with Interface EAP.

A photocopy of this document shall be considered as valid as the original when so presented.

Provider Signature _____ Date: _____

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Individual Provider Application – Contract Information

Provider Name: _____

FIRST

MIDDLE

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Your PPO network service agreement will be sent at the indicated IEAP rate. You must include your usual (published) rate.

CPT CODE	DESCRIPTION	Psychiatrist USUAL FEE	IEAP Psychiatrist RATE	RN-APRN USUAL FEE	RN-APRN RATE	Doctorate L. Psy USUAL FEE	IEAP Doctorate L. Psy RATE	MA License USUAL FEE	IEAP MA License RATE
99221-3	Initial HX & Exam	_____	140.00						
99231-3	Sbsqnt Hosp Care	_____	100.00						
99238	Discharge	_____	100.00						
90862	Med. Management	_____	60.00	_____	60.00				
90870/71	ECT	_____	100.00						
90801	Evaluation Interview	_____	140.00	_____	80.00	_____	90.00	_____	80.00
90804-5	Indiv 20-30m	_____	65.00	_____	65.00	_____	45.00	_____	40.00
90806-7	Indiv 45-50m	_____	100.00	_____	80.00	_____	90.00	_____	80.00
90846-7	Family	_____	100.00	_____	80.00	_____	90.00	_____	80.00
90853	Group	_____	40.00	_____	30.00	_____	35.00	_____	30.00
90901/11	Biofeedback 45-50 m	_____	100.00			_____	90.00	_____	80.00
96101/02	Psych Testing					_____	90.00		
96118/19	Neuro-Psych Testing					_____	90.00		

\$50.00 EAP:

- IEAP will include this EAP rate on all network agreements for **psychologists and master's level clinicians**.
- EAP sessions are for Assessment and brief resolution therapy.
- There are a limited number of EAP sessions available to each participant.
- EAP sessions are not filed under insurance.
- EAP sessions are FREE to participant and paid at 100% by IEAP when authorized by IEAP.

EAP rate is acceptable as Wellness Seminar rate? Yes No

If no, requested Wellness Seminar rate \$_____

Does Wellness Seminar rate include Travel rate? Yes No

If no, requested Travel rate \$_____