



# Interface EAP

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[www.ieap.com](http://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

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <b>1) Submit one copy if all providers are covered under the same policy</b><br>1. Professional Liability Coverage: <i>\$1million/\$1million</i> for Master's and Doctoral level clinicians and <i>\$1million/\$3million</i> for all Physicians or Enrolled in the Patient Compensation or Stabilization Fund |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>2) STATE licenses or STATE certifications in Counseling Disciplines MD's:</b><br>DEA, State Substance Control, & Board Certifications  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>3) Current Resume or Vita (Clinicians must have 3 years post licensure experience)</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>4) List of hospital staff privilege status (<i>if appropriate</i>)</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>5) Form W-9 – Taxpayer Identification Number (see attached)</b><br>Do others use this Federal EIN? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>6) NPI # (National Provider Identification Number)</b>   |

### 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 \_\_\_\_\_

# Interface EAP

## Individual Provider Application – Demographic Information

<b>Provider Name:</b>					
FIRST	MIDDLE	LAST	DEGREE		
<b>Date of Birth:</b>				<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Ethnicity:</b>
<i>(Optional)</i>					
<b>Bilingual:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Languages:</b>		
<b>National Provider Identification # (NPI#):</b>	<input type="checkbox"/>	<input type="checkbox"/>			
	Individual	Group			
<b>Practice Name:</b>					
<b>Service Address:</b>					
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	<b>County:</b>		
<b>Mailing Address:</b>					
<b>City:</b>	<b>State:</b>	<b>Zip:</b>			
<b>Primary Phone:</b>	<b>AnsSvc/Pager:</b>	<b>Fax:</b>			
<b>Billing Contact:</b>	<b>Phone :</b>				
<b>E-mail address (optional):</b>	<b>Web Site:</b>				
<b>Hours:</b>	<b>M</b>	<b>T</b>	<b>W</b>	<b>TH</b>	<b>F</b>
					<b>Sat</b>
					<b>Su</b>
					<b>n</b>
<b>Handicapped Accessible:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Is this a personal residence?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Please indicate areas that you are qualified to assess &amp; counsel potential referrals.</i>					
<b>Specialized Populations</b>		<b>Specialized Knowledge</b>		<b>Specialty Areas</b>	
Geriatrics		Christian Counselor	ADHD	Learning Dis	
Adults		CISD	Adoption Issues	MPD	
Adolescent 14-17		Clergy Peer Hotline	Alcohol	Parenting Issue	
Pre-Teen 10-13		Developmental Dis	Anger Mgmt	Perpetrators	
Children 7-9		ECT	Anxiety Dis	Personality	
Children 4-6		Employer Mandated	Autism Spec Dis	Phobias	
Infant/Todd 0-3		Fit For Duty	Bari/Gastric Eval	Psychosis	
<b>Specialized Modalities</b>		Gay/Lesbian Issues	Bipolar	PTSD	
App Beh Analysis		Mediation	Career Counsel	Rape Issues	
Biofeedback		Men's Issues	Chemical Dep	Rx Drugs	
Conj/Family		Pharmacy Intervention	Chronic Pain	Separation/Divorce	
EMDR		SAP (DOT)	Couple/Marriage	Sexual Dis	
Forensic		Veterans	Death/Dying	Sleep Disorder	
Group		Wellness Seminar	Depression	Smoking Cess	
Hypnosis		Women's Issues	Domestic Violence	Somatic	
Home Visitations		Workplace Violence	Eating Disorder	Stress Mgmt	
Neuro-Psych Test			Family Counseling	Victim Issues	
Online Counseling			Gambling		
Play Therapy			Gang/Cult		
Psych Testing			Grief/Loss		
Tele-Health			Impulse Control		
Web Debriefing					
Web Training					

# Interface EAP

## Individual Provider Application – Waiver

Provider name:

FIRST

MIDDLE

LAST

DEGREE

**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: \_\_\_\_\_

# Interface EAP

## Individual Provider Application – Managed Care Services

Provider Name: \_\_\_\_\_

FIRST

MIDDLE

LAST

DEGREE

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

PSYCHIATRISTS				PSYCHOLOGISTS			
CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE	CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE
*99201	New patient (10 Minutes)		27	*90791	New Pt w/o Medical Services		125
*99202	New patient (20 Minutes)		51	*90792	New Pt w/Med Services ( <b>Med Psych Only</b> )		145
*99203	New patient (30 Minutes)		79	*90832	Psychotherapy 30 Min		45
*99204	New Patient – Moderate		161	*90834	Psychotherapy 45-50 Min		90
*99205	New Patient – Severe		200	*90837	Psychotherapy 60 Min		118
*99211	Est. Patient – 5 Min		20	*90846-7	Family w/ & w/o Patient		90
*99212	Est. Patient – 10 Min		43	*90853	Group Therapy		35
*99213	Est. Patient – 15 Min		60	*90863	Med Mgmt ( <b>Med Psych Only</b> )		60
*99214	Est. Patient – 25 Min		104	*90901	Biofeedback		90
*99215	Est. Patient – 40 Min		140	*90839	Psychotherapy-Crisis 30-74 Min		135
<b>Add-on Codes for E/M Services Only</b>				*90840	Psychotherapy Crisis Add-On for each addl 30 Min		45
*90833	Psychotherapy 30 Min		35	*90785	Interactive Complexity		4
*90836	Psychotherapy 45 Min		56	*96130	Psych Testing Eval by Physician or QHP – first hour		90
				*96131			
				*96136			
				*96137			
*90838	Psychotherapy 60 Min		90	*96138	Psych or Neuro test admin and scoring		25
				*96139	Two or more tests, any method each additional 30 minutes		
*90792	Psychiatric Evaluation w/ (medical services)		145	*96146	Psych <b>or Neuro</b> Testing by Computer {w/ single automated, standardized instrument via electronic platform, w/ automated result only}		45
*99221-3	Initial Hospital		140	*96132	Neuro Psych Testing {by physician or other QHP , first hour}		90
				*96133	By Physician or other QHP each additional hour		
*99251-5	Initial Inpatient Consultation		140				
*99231-3	Subsequent Hosp		100				
*90870	ECT		100				
*99271-5	Confirmatory Consultation		100				
*99238-9	Discharge Day		100				
*90846-7	Family w/ & w/o Patient		100				
*90853	Group Therapy		40				
*90875	Interactive Complexity		4				

APRN				MASTERS			
CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE	CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE
*99201	New patient (10 Minutes)		27	*90791	New Patient w/o Medical Services		115
*99202	New patient (20 Minutes)		51	*90832	Psychotherapy 30 Min		40
*99203	New patient (30 Minutes)		79	*90834	Psychotherapy 45-50 Min		80
*99204	New Patient – Moderate		121	*90837	Psychotherapy 60 Min		108
*99205	New Patient – Severe		150	*90846-7	Psychotherapy w/ & w/o Patient		80
*99212	Est. Patient – 10 Min		32	*90853	Group Therapy		30
*99213	Est. Patient – 15 Min		53	*90839	Psychotherapy for Crisis 30-74 Min		120
*99214	Est. Patient – 25 Min		78	*90840	Psychotherapy for Crisis Add-on		40
*99215	Est. Patient - 40		105	*90785	Interactive Complexity		4
<b>Add-on Codes for E/M Services Only</b>							
*90833	Psychotherapy 30 Min		35				
*90836	Psychotherapy 45 Min		56				
*90838	Psychotherapy 60 Min		90				
*90792	Psychiatric Evaluation w/ (Medical Service)		145				
*90846-7	Family w/ & w/o Patient		80				
*90853	Group Therapy		30				
*90875	Interactive Complexity		4				

## Interface EAP

Individual Provider Application – EAP and On-Site Services

Provider name: \_\_\_\_\_

FIRST

MIDDLE

LAST

DEGREE

### Applies **ONLY** to **Psychologists** and **Masters Level Clinicians**.

**\$60.00 EAP:**

- IEAP will include this EAP rate on all network agreements
- 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.

Applies **ONLY** to **Psychologists** and **Masters Level Clinicians** that conduct these services.

#### CISD

\$100 per Hr + \$50 Flat Fee for travel

#### Grief Debriefing

\$100 per Hr + \$50 Flat Fee for travel

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 \$ \_\_\_\_\_