EAP Provider Application

Instructions for Completing This Application

Before completing this application, please carefully review the Eligible Providers and Minimum Criteria outlined below. Providers must meet the minimum eligibility and credentialing requirements established by Neely EAP in order to participate in our provider network.

If you do not meet the minimum criteria, are unsure whether you qualify, or have questions regarding any of the requirements, please do not complete or submit the application until you have consulted with a Neely EAP representative.

For assistance, please contact Neely EAP:
Phone: 210-523-4200
Email: admin@neelyeap.com

Eligible Providers

The Neely EAP network of providers 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
- Associate or Provisionally Licensed Clinicians – Upon Approval

Minimum Criteria

All Neely 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.
  - Provisionally licensed clinicians – Upon Approval
- Carry minimum malpractice and liability insurance coverage of $1,000,000 per occurrence and $3,000,000 aggregate.
- Ability to provide services via tele-medicine, face to face, or telephone.

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
  - Resume or CV.
- To include a W-9 form and NPI Verification.
- To sign and date this application.

Any questions or concerns regarding this application should be directed to Neely EAP at 210-523-4200 or admin@neelyeap.com.

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 Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

Email: _____

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: _____

2. Street Address: _____

3. City: _____ County: _____

4. State: _____ Zip Code: _____

Email: _____

5. Phone Numbers:

Appointments: (____) _____- _____ext _____

Billing: (___) _____- _____ext _____

Fax: (_____) _____- _____ext _____

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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: _____

C. Graduation Date: _____

IV. Liability History

A. Complete the following information about your malpractice insurance for the last 5 years.

Include information for every carrier/workplace during last 5 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):

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

☐Older Child (6-12) ☐Adult (18-64)

B. Disorders (Check all that apply):

☐Anxiety Disorders ☐Addictions ☐HIV/AIDS

☐Mood Disorders ☐ADHD ☐Sexual/Gender Disorders

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☐Abuse-Sexual/Physical
☐Dissociative Disorders
☐Psychosomatic/Somatoform
☐Personality Disorders
☐Adjustment/Conduct
☐Eating Disorders

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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?	☐	☐

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AGREEMENT / RELEASE

I submit this application for membership in the Neely EAP provider 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 Neely 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 Neely 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 Neely EAP provider.

_____

Signature Date

I have read and agreed to the requirements outlined in the Neely EAP Provider Manual.

_____

Signature Date