

Provider Application/Update

The primary objective of the IMPACT Solutions Employee Assistance & Work/Life Program is to provide our clients with a comprehensive assessment, non-medical short-term solution focused counseling, support, strategies to address immediate needs and stressors, and to help them develop an action plan with recommendations for further intervention, when appropriate.

*This completed form will be processed within 7 business days of receipt unless we contact you otherwise.

Please complete this form in its entirety

Preferred Provider (impact office use only) _____

_____ New Applicant _____ Provider update only _____ Add this provider to our group

***New applicants, please send a copy of current resume with this application.**

Please indicate below the type of practice

_____ Private Practice _____ Group Practice _____ Existing IMPACT Provider

*New **GROUP** applicants please complete page one of the PROVIDER APPLICATION and have **each therapist in your group** complete all four pages to be added to your group's panel of providers.

Name of Practice (must match name used on W-9) _____ Date _____

*Does your office offer Med Mgmt? _____ Y _____ N

Clinician name _____ Date of Birth _____

Gender: ___ M ___ F **Ethnicity** ___ Caucasian ___ African American ___ Hispanic ___ Asian ___ Other

Tax ID# _____

The number used on W-9 – (please include necessary dashes) use group number if group

Location Address: _____

City _____ State _____ County _____ Zip _____

Phone _____ Fax _____ e-mail _____

Website _____

() Billing () Mailing () Office () HIPPA compliant () Handicap Accessible

Additional Location: Address _____ County _____

City _____ State _____ Zip _____

Phone _____ Fax _____ e-mail _____

() Billing () Mailing () Office () HIPPA compliant () Handicap Accessible

Liability Insurance: Please include copy of liability declaration page.

Minimum \$1,000,000 per occurrence/\$3,000,000 aggregate liability insurance? yes no

Effective date: _____ Expiration date: _____

License/Certification (Please include all licensures/certifications and send copies of all licenses & certifications)

License type _____ Certifications _____

License # _____ State _____

Expiration Date _____

After Hours Contact Information: This number is for IMPACT Staff use only and will NOT be given to clients

Name & phone number: _____

Therapist's Name _____

Appointment availability (days & times) _____ Evening Hours yes no Weekend Hours yes no

Do you offer religious or spiritually guided therapy? yes no if yes, what Faith? _____

Does your practice offer telephonic counseling? yes no Are you in compliance with your state regulations for this? yes no

Can you conduct therapy in any language other than English including ASL yes no if yes please specify _____

Please check all Clinical & Optional Services that apply

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> *DOT Training | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Addiction Interventions | <input type="checkbox"/> *DFWP Drug Free Workplace Training | <input type="checkbox"/> Pre School 4-under |
| <input type="checkbox"/> Adolescent 13-17 | <input type="checkbox"/> DUI Driving Under Influence Asses. | <input type="checkbox"/> PTSD Post Traumatic Stress Disorder |
| <input type="checkbox"/> Adult 18+ | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Schizophrenia/Psychotic Disorder |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> EMDR Eye Movement DR Therapy | <input type="checkbox"/> Sexual Abuse/Perpetrators |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Educational Workshops | <input type="checkbox"/> Sexual Abuse/Victims |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Sexual Disorder/Therapy |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Fertility Issues | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Brief Solution Focused Therapy | <input type="checkbox"/> Fitness for Duty Eval/Assessment | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Career Counseling | <input type="checkbox"/> FMR Formal Mgmt Referrals | <input type="checkbox"/> Substance Use Disorder |
| <input type="checkbox"/> CBT Cognitive Behavior Therapy | <input type="checkbox"/> Geriatric | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Children 5-12 | <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Telephonic Counseling |
| <input type="checkbox"/> Coaching Services | <input type="checkbox"/> Hearing Impaired/Deaf | <input type="checkbox"/> Terminal Illness |
| <input type="checkbox"/> Couples/Marital/Relationship | <input type="checkbox"/> Hypnotherapy/Hypnosis | <input type="checkbox"/> Tobacco Cessation |
| <input type="checkbox"/> Crisis & Emergency Mgmt | <input type="checkbox"/> Impulse Control Disorder | <input type="checkbox"/> Victims of Abuse, Assault, Trauma |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Infidelity | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> CIR Critical Incident Response | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Other Addictions _____ |
| <input type="checkbox"/> Cult Issues | <input type="checkbox"/> LGBT Lesb/Gay/BiSex/Transgend | _____ |
| <input type="checkbox"/> DBT Dialectical Behavior Therapy | <input type="checkbox"/> Mediation | _____ |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Occupational Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression (include Post Partum) | <input type="checkbox"/> OCD Obsessive Compulsive Disorder | <input type="checkbox"/> Wellness Seminars, include topics _____ |
| <input type="checkbox"/> Dysphoria/ Transgender Clients | <input type="checkbox"/> On Site Counseling | |
| <input type="checkbox"/> Disruptive Behavior Disorder | <input type="checkbox"/> On Site Training & Development | |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Panic Disorders | |
| <input type="checkbox"/> *DOT Assessment | <input type="checkbox"/> Personality Disorders | |

For Critical Incident Debriefing Services: please provide proof of formal training and include copies of certifications

***For DOT Training/Assessments you must be a current SAP SAP Expiration Date _____**

***For Drug Free Workplace Training you must have one of the following credentials:** include copy of certification

- SAP CEAP LICDC OCPS-I OCPS-II

Therapist's Name _____

Employee Assistance Program (EAP) Associations yes no Years Associated: _____

Program Name(s): _____

Health Insurance Panel Membership: Do you accept insurance? yes no

Please check all accepted insurances:

- | | | |
|---|---|--|
| <input type="checkbox"/> ABT Medical Plans | <input type="checkbox"/> Emerald Health Network | <input type="checkbox"/> Ohio Health Choice |
| <input type="checkbox"/> Access Health | <input type="checkbox"/> Front Path | <input type="checkbox"/> Ohio State University Health Plan |
| <input type="checkbox"/> Aetna | <input type="checkbox"/> Guardian | <input type="checkbox"/> Ohio PPO Connect |
| <input type="checkbox"/> Alliance PPO | | <input type="checkbox"/> Paramount Health Care |
| <input type="checkbox"/> Anteres (Cleve Clinic) | <input type="checkbox"/> Health Care Value Mgmt. | <input type="checkbox"/> Priority Health |
| <input type="checkbox"/> Anthem | <input type="checkbox"/> Health Ohio HMO | <input type="checkbox"/> Providence |
| <input type="checkbox"/> Ault Care PPO | <input type="checkbox"/> Healthspan | <input type="checkbox"/> Psych Care |
| | <input type="checkbox"/> Highmark | <input type="checkbox"/> PHCS Network |
| <input type="checkbox"/> Beacon Health Options | <input type="checkbox"/> Hometown Health Plan | <input type="checkbox"/> Quality Care Partners |
| <input type="checkbox"/> Blue Cross/Blue Shield | <input type="checkbox"/> Horizon Health | <input type="checkbox"/> QualChoice |
| <input type="checkbox"/> Bureau of Workers Comp | <input type="checkbox"/> Humana | |
| | | <input type="checkbox"/> SummaCare Tier 1 |
| <input type="checkbox"/> Care Source | <input type="checkbox"/> Kaiser | <input type="checkbox"/> Summa Care Tier 2 |
| <input type="checkbox"/> Century Health Solutions | <input type="checkbox"/> Lifesync | <input type="checkbox"/> TriCare |
| <input type="checkbox"/> Ceridian | | |
| <input type="checkbox"/> Cigna | <input type="checkbox"/> Magellan Behavioral Health | <input type="checkbox"/> United Behavioral Health |
| <input type="checkbox"/> Com Psych | <input type="checkbox"/> Medicaid | <input type="checkbox"/> United Healthcare Tier 1 |
| <input type="checkbox"/> Concern Services | <input type="checkbox"/> Medcost | <input type="checkbox"/> United Healthcare Tier 2 |
| <input type="checkbox"/> Corp Health | <input type="checkbox"/> Medicare | <input type="checkbox"/> Univera Healthcare |
| <input type="checkbox"/> Coventry /First Health | <input type="checkbox"/> Medical Mutual of Ohio | <input type="checkbox"/> Wellborn |
| | <input type="checkbox"/> Midlands Choice | |
| | | *Other _____ |
| <input type="checkbox"/> Dean Care | <input type="checkbox"/> Molina | _____ |
| <input type="checkbox"/> Direct Care America | <input type="checkbox"/> Multiplan | _____ |
| | | _____ |

Therapist's Name _____

IMPACT Provider General Information

- Yes ___ No ___ Has your license ever been revoked?
- Yes ___ No ___ Are there any licensure actions pending against your license currently?
- Yes ___ No ___ Has your application to be a Medicare Participating Provider ever been rejected?
- Yes ___ No ___ Have you ever been the subject of a Medicare or other medical reimbursement plan suspension or probation proceedings?
- Yes ___ No ___ Have your hospital affiliations ever been suspended, denied, diminished, revoked, or not renewed?
- Yes ___ No ___ Do you have, or have you ever had any malpractice actions or claims filed against you, or have you had an out-of-court settlement for a malpractice claim within the past five years?
- Yes ___ No ___ Has your professional liability insurance been denied, cancelled, not renewed, or surcharged, relative to malpractice claims?
- Yes ___ No ___ Have you ever been convicted of a felony?
- Yes ___ No ___ Do you have any physical or mental limitations (including alcohol or drug dependence) that would prevent you from practicing your specialty?
- Yes ___ No ___ Have you ever been disciplined by any licensing body or professional society?
- Yes ___ No ___ Has your membership in any health care plan ever been revoked or suspended?
- Yes ___ No ___ Are you a paid employee or consultant of any other health care plan?

If you answered yes to any of the above questions, please include an explanation and any pertinent documentation with this application/update.

***This completed form will be processed within 7 business days of receipt unless we contact you otherwise.**

Therapist's Name _____

**IMPACT Solutions
Form EXHIBIT A
Acknowledgment of IMPACT Solutions Provider Participation Agreement**

I, (your name) _____, a professional involved in the rendering of Employee Assistance and/or Mental Health and/or Substance abuse assessment and/or treatment services or other EAP services, in association with the practice, (practice name) _____, personally agrees to be bound by the terms of the Provider Participation Agreement between (practice name) _____ and Behavior Management Associates, Inc., DBA IMPACT Solutions, and acknowledges that you have reviewed the Provider Participation Agreement, indicated above, on file with your office.

Signature of Individual Provider

Date

Witness

Date

*By signing this form you are agreeing to the terms and conditions of the Provider Participation Agreement as well as the fee schedule selected by this practice.