Employee Assistance Program
Contract Provider Credentialing

Date:

Group Name: Tax ID:

If you are in a group practice, all therapists providing services to any UTEAP Client must complete a separate form for contracting.

Therapist Last Name: First Name:

State Licensed as: ☐ Ph.D./PsyD ☐ LCSW ☐ LPC ☐ LMFT ☐ LCDC ☐ Other:

PRIMARY OFFICE ADDRESS

Street: Suite:

City: State: Zip: County:

SECONDARY OFFICE ADDRESS

Street: Suite:

City: State: Zip: County:

BILLING ADDRESS (SAME AS LISTED ON W9)

Street: Suite:

City: State: Zip: County:

Office ph: Office Fax: Message/cell:

Email: Website:

Do you practice from within a home-based facility? ☐ Yes ☐ No

If Yes, we will send you a "Home Based / Non Traditional Practice Site Attestation" document for completion prior to making referrals to your practice.

HOURS OF AVAILABILITY

Mon:	Tue:	Wed:	Thu:
Fri:	Sat:	Sun:	

If you state that your hours are from 9:00 a.m. to 5:00 p.m., we will assume that your last appt begins at 4:00.

DEMOGRAPHIC INFORMATION

Gender: ☐ Male ☐ Female

Ethnicity: (Optional. Some clients request provider ethnicity)

EDUCATION & TRAINING (DEGREE CHECK APPROPRIATE BOXES)

☐ MSW ☐ PhD ☐ PsyD ☐ EdD Psychology
☐ MS Clinical or Counseling Psychology ☐ MA Clinical or Counseling Psychology

Other Masters Degree (Specify Degree/Discipline):

Other Doctorate Degree (Specify Degree/Discipline):

GRADUATE INSTITUTION

Graduate Degree Institution: Date Received:

Licensure Type: State License Number: Expiration Date:

CERTIFICATION(S)

Certification Type: Certificate Number: Expiration Date:

CEAP Certification: ☐ Y ☐ N Certificate Number: Expiration Date:

How many years have you been in private clinical practice?

LICENSE/CERTIFICATION INFORMATION

Is your license to practice in your state of residence under any limitations? ☐ Yes ☐ No

Has your license ever been suspended or revoked? ☐ Yes ☐ No

Have there been any disciplinary actions taken against you by a state licensing body or other certifying or professional organization? ☐ Yes ☐ No

Has any other authority taken disciplinary action, or has any organization declared any actions by you to be unethical or a violation of state law? ☐ Yes ☐ No

LIABILITY INSURANCE

I have Liability Insurance through: ☐ An Individual Plan ☐ Group Plan ☐ Both

Have you ever had your insurance cancelled?	☐ Yes	☐ No
Have you ever been party to litigation related to your clinical practice?	☐ Yes	☐ No
Are you or your practice presently involved in any litigation related to your clinical practice or do you have notice that litigation will commence?	☐ Yes	☐ No
Were any judgments made against you, or settlements made by you in a malpractice action?	☐ Yes	☐ No

Please attach a detailed explanation for any Yes answers noted above to your application.

LANGUAGES: (Other than English. Check all that apply)

☐ Spanish ☐ Sign Language ☐ Other:

POPULATIONS: (Check all that apply)

☐ Children(0-12)	☐ Adolescents (13 – 17)	☐ Adults (18 – 64)	☐ Geriatrics (Age 65+)
☐ ACA	☐ Bi/Multicultural	☐ Gay/Lesbian	☐ Hearing Impaired
☐ Male	☐ Female	☐ Military	☐ Vision Impaired

TREATMENT MODALITIES: (Check all that apply)

☐ Cognitive Behavior Therapy	☐ Family Therapy	☐ Solution Focused Therapy
☐ Dialectical Behavior Therapy	☐ Play Therapy	☐ Telephone Counseling
☐ EMDR	☐ Postpartum Therapy	☐ Other:
☐ Faith Based Counseling	☐ Rational Emotive Therapy	☐ Other:

SPECIALTIES: (Check all that apply)

Abuse:	☐ Abuse	☐ Emotional Abuse	☐ Sexual Assault
	☐ Child Abuse	☐ Physical Abuse	☐ Victim of Crime
	☐ Domestic Abuse	☐ Sexual Abuse	
Addiction:	☐ ACOA	☐ Sexual Addiction	☐ Gambling
	☐ AOD	☐ Gaming/Internet Addiction	
Anxiety:	☐ Anxiety D/O Acute	☐ GAD	☐ Panic
	☐ Stress/PTSD	☐ OCD	☐ Self-Harming
Bio-psychosocial:	☐ Eating D/O	☐ Psychosis	☐ Somatic Concerns
	☐ Medical Issues	☐ Sexual Issues	☐ Sleep D/O
	☐ Pain Management		
Family:	☐ Family	☐ Divorce	☐ Couples
	☐ Parenting		
General Wellness:	☐ Adjustment D/O	☐ Personal Growth	☐ Stress Mgmt
	☐ Anger Mgmt	☐ Relationship Issues	☐ Test Anxiety
	☐ Bereavement	☐ Smoking Cessation	☐ Wellness Coaching
	☐ Life Coaching	☐ Spiritual Issues	
Issues of Childhood/Adolescence:		☐ ADD/ADHD	☐ Developmental D/O
		☐ Behavioral Problems	☐ Learning Disability
Mood D/O:	☐ Depression/Dysthymia	☐ Bipolar/Cyclothymic	☐ Mood D/O
Multicultural Diversity Issues:	☐ Multicultural Issues		☐ Women's Issues
	☐ Sexual Identity/LGBT Issues		☐ Men's Issues
Work Issues:	☐ Career Issues	☐ Work-Related Issues	

ADDITIONAL SERVICES YOU PROVIDE

Do you have an interest in conducting on site Trauma Debriefings should we have a need for these services in your geographic area? ☐ Yes ☐ No

Please describe your training and philosophy in conducting debriefings:

We normally reimburse $125 per hour for Debriefing Services.
Is this rate agreeable to you? ☐ Yes ☐ No

Do you have an interest in conducting Mediation services should we have a need for these in your community? ☐ Yes ☐ No

Are you a Credentialed/Certified Mediator? ☐ Yes ☐ No

We normally reimburse $125 per hour for Mediation Services.
Is this rate agreeable to you? ☐ Yes ☐ No

Are you a Certified Chemical Dependency Professional (Certified to do CD treatment in your state)? ☐ Yes ☐ No

Are you a DOT qualified Substance Abuse Professional? ☐ Yes ☐ No

Do you have an interest in conducting Training and Education for our clients? ☐ Yes ☐ No

Please list topics and training you have previously completed:

What is your hourly fee for doing education and training? $

What is your daily fee for doing education and training? $

Are you interested and skilled in conducting Mandatory Referrals? ☐ Yes ☐ No

Mandatory Referrals require initial appointments within a day or two and you will need to prepare and return your Treatment Recommendations within one day of your last visit with the client. We will work with you to certify your experience.

Do you have the capability to make appointments on-line for your practice? If so, please describe the procedure or process to schedule the appointment:

UPDATED LIST OF INSURANCE PANELS AND PPO AFFILIATIONS:

UTEAP currently serves clients nationwide who are covered by many different insurance plans and Networks. Whenever possible we will attempt to connect one of our clients to a provider that will be able to continue seeing them after the EAP assessment has been completed. Please take a few moments to complete this section so we can update your records and ensure a process of accurate and timely referrals to your practice.

☐ Aetna	☐ Magellan	☐ United Behavioral Health
☐ BlueCross/Blue Shield	☐ MHN/Managed	☐ Other:
☐ Cigna	☐ Tricare	☐ Other:

CERTIFICATION OF ACCURACY

Written Signature(Fax Only):

Electronic Signature(Email Only): Date:

HAVE YOU INCLUDED A COPY OF THE FOLLOWING:

- ☐ ALL PAGES OF THE APPLICATION
- ☐ COPY OF YOUR CURRENT, VALID AND UNRESTRICTED STATE LICENSE OR NATIONAL CERTIFICATION
- ☐ COPY OF YOUR CURRENT, VALID MALPRACTICE LIABILITY FACE SHEET WITH LIMITS OF ONE MILLION DOLLARS PER OCCURRENCE AND THREE MILLION DOLLARS AGGREGATE
- ☐ A W-9 (Find the latest form here: https://www.irs.gov/uac/about-form-w9)

NOTE: UTEAP will not process incomplete applications. If you have any questions or concerns regarding the content of this form, please contact us at 713-500-3327 or email us at UTEAP.ProviderRelations@uth.tmc.edu.

SUBMIT PRINT