B EAP WORKS

AFFILIATE INFORMATION

Copy of professional license, proof of liability insurance, & W-9 required for payment
Fax to 844-996-1303

Clinician name:_____

License type and number: _____

Group name (if applicable): _____

Office phone: _____ Cell phone: _____

Fax: _____ Email: _____

Office #1 Street Address:_____

City_____ State_____ Zip_____

Office #2 Street Address:_____

City_____ State_____ Zip_____

Billing Address (if different than office address): _____

City_____ State_____ Zip_____

Indicate payment options: ☐ Self pay ☐ Aetna ☐ BC/BS ☐ Cigna ☐ Humana
☐ Magellan ☐ Tricare ☐ United ☐ Sliding scale for low income/uninsured
☐ Other (list) _____

Do you offer appointments during evening hours? ☐ Yes ☐ No Weekends? ☐ Yes ☐ No

Are you willing to serve new EAP clients within three business days? ☐ Yes ☐ No

Please indicate certified and/or specialized training: ☐ Depression ☐ Anxiety ☐ Anger Mgmt.
☐ CISD ☐ Trauma ☐ Substance Abuse ☐ Couples ☐ Families ☐ Grief
☐ Phone Counseling ☐ Video Counseling ☐ DOT Qualified Substance Abuse Prof.
☐ Child/Adolescent ☐ Other (list):_____

What age range do you serve? _____

What types of clients do you not serve? _____

Additional notes on expertise, preferences, etc: _____

_____

_____

EAP Works requests all our EAP counselors assess and refer clients needing specialized care.