B

AFFILIATE INFORMATION

FAX TO: (770) 449-8113 or Email to: info@eapworklife.com

(Required for payment disbursement)

Clinician Name: Last name _____, First name _____

Phone: Work _____Cell _____ Fax_____

Email _____ Tax Id or SSN: _____

License type _____ License # _____ TIN# _____

Group Name (if applicable) _____

Office #1 Street Address :_____

City_____ State_____ Zip_____

Office #2 Street Address:_____

City_____ State_____ Zip_____

Billing Address (if different than office address): _____

City_____ State_____ Zip_____

Do you offer evening and/or Saturday hours? Evenings: yes / no, Weekends: yes / no.
Are you willing to routinely serve new EAP clients within three business days? Yes or no.

Do you accept insurance? Yes or no. If yes, list insurance panels: ❑Aetna, ❑Anthem, ❑ BC/BS, ❑Cigna, ❑Humana, ❑ Magellan, ❑ Tricare, ❑ UBH, ❑ Other_____

---

1. EAP Works requests all our EAP counselors assess and refer clients needing specialized care. Please list certified and/or specialized training, please check: ❑Depression, ❑Anxiety, ❑Anger Mgmt., ❑CISD, ❑Trauma,❑Substance Abuse, ❑Relationship, ❑ Phone Counseling, ❑ Video Counseling, ❑ DOT Qualified Substance Abuse Prof.,❑ Grief ❑Child/Adolescent. What is the youngest age served? ❑ Other specialties _____
2. What types of clients do you not serve? _____
3. Additional professional certifications, areas of expertise, and/or Training Programs: ❑ EAP Orientation Trainer, ❑ Phone Counseling, ❑ Video Counseling,_____

Required: Please fax proof of professional license, liability insurance & W-9 Form to: 770-449-8113.
Ph. 1-844-361-4348

EAP Works a division of Health Works Solutions, LLC