impactsolutions®
Guiding You Through Life

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

_____ 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 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 _____

Additional Language Spoken _____

Appointment availability (days & times) _____

Evening Hours ☐ yes ☐ no **Weekend Hours** ☐ yes ☐ no ( ) **Preferred Provider** (office use only)

Is your practice religious or spiritually guided? ☐ yes ☐ no **if yes, what Faith?** _____

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

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

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:

( ) ABT Medical Plans
( ) Access Health
( ) Aetna
( ) Alliance PPO
( ) Anteres (Cleve Clinic)
( ) Anthem
( ) Ault Care PPO

( ) Beacon Health Options
( ) Blue Cross/Blue Shield
( ) Bureau of Workers Comp

( ) Care Source
( ) Century Health Solutions
( ) Ceridian
( ) Cigna
( ) Com Psych
( ) Concern Services
( ) Corp Health
( ) Coventry /First Health

( ) Dean Care
( ) Direct Care America

( ) Emerald Health Network
( ) Front Path
( ) Guardian

( ) Health Care Value Mgmt.
( ) Health Ohio HMO
( ) Healthspan
( ) Highmark
( ) Hometown Health Plan
( ) Horizon Health
( ) Humana

( ) Kaiser
( ) Lifesync

( ) Magellan Behavioral Health
( ) Medicaid
( ) Medcost
( ) Medicare
( ) Medical Mutual of Ohio
( ) Midlands Choice

( ) Molina
( ) Multiplan

( ) Ohio Health Choice
( ) Ohio State University Health Plan
( ) Ohio PPO Connect
( ) Paramount Health Care
( ) Priority Health
( ) Providence
( ) Psych Care
( ) PHCS Network
( ) Quality Care Partners
( ) QualChoice

( ) SummaCare Tier 1
( ) Summa Care Tier 2
( ) TriCare

( ) United Behavioral Health
( ) United Healthcare Tier 1
( ) United Healthcare Tier 2
( ) Univera Healthcare
( ) Wellborn

***Other** _____
_____
_____
_____

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.