

Provider Registration Form

Date: _____

Name: _____ Credentials: _____

Agency: _____

Office Address: _____

Office Phone: _____ Fax: _____ Cell: _____

E-Mail: _____ Website: _____ SS# _____

CEAP Certified _____ License #: _____ Referred by: _____

Prior EAP experience? _____

Clinical Primary Specialties:

<input type="checkbox"/> Individual	<input type="checkbox"/> Anger	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> CISD
<input type="checkbox"/> Couple	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> OCD	
<input type="checkbox"/> Children	<input type="checkbox"/> Bereavement	<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Woman's Issues	
<input type="checkbox"/> Adolescent	<input type="checkbox"/> Survivor Child Abuse	<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Workplace Presentations	
<input type="checkbox"/> Family	<input type="checkbox"/> Divorce/Separation	<input type="checkbox"/> PTSD	<input type="checkbox"/> Victim/Offender Sexual Abuse	
<input type="checkbox"/> Geriatric	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Phobias	<input type="checkbox"/> Foreign Language Specify: _____	

What EAP referrals are of particular interest to you : _____

Private Practice Fee: _____ Sliding Scale: Yes _____ No _____ Days/Hours Available: _____

Your Preferred Private Practice Modalities:

Cognitive Behavioral Solution Focused/Narrative EMDR Family Systems Dialectical Behavioral (DBT)
 Hypnotherapy Psychodynamic Group Psychoanalytic Body/Mind TFT Play Therapy

If you are a participating practitioner in any of the insurance plans below, please check:

<input type="checkbox"/> Aetna Us Healthcare	<input type="checkbox"/> Health Net	<input type="checkbox"/> Medicare	<input type="checkbox"/> Tricare
<input type="checkbox"/> American Medical & Life	<input type="checkbox"/> HIP	<input type="checkbox"/> Merit Behavioral Health	<input type="checkbox"/> United Behavioral Health
<input type="checkbox"/> Anthem	<input type="checkbox"/> Horizon	<input type="checkbox"/> Met Life	<input type="checkbox"/> United Health Care
<input type="checkbox"/> Beech Street	<input type="checkbox"/> Humana	<input type="checkbox"/> MHN	<input type="checkbox"/> Value Options
<input type="checkbox"/> Blue Cross/Blue Shield	<input type="checkbox"/> Kaiser	<input type="checkbox"/> Multi Plan	<input type="checkbox"/> Vytra
<input type="checkbox"/> Cigna	<input type="checkbox"/> Magellan	<input type="checkbox"/> Oxford	Others: _____
<input type="checkbox"/> Core Source	<input type="checkbox"/> Magna Care	<input type="checkbox"/> PacifiCare	_____
<input type="checkbox"/> Empire BC/BS	<input type="checkbox"/> MDNY	<input type="checkbox"/> Prudential	_____
<input type="checkbox"/> GHI	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Select Pro	_____

Please tell us about your overall experience providing specialized EAP services and list EAPs you have worked with:

EAP Service Specialties: (Please specify your experience and availability to service the following EAP needs)

___ EAP Sessions to Address Personal or Work Issues

___ EAP Sessions for Administrative/Employer Mandated Referrals To Address Work Performance Issues

___ EAP Substance Abuse Assessment & Referral

___ On-Site Critical Incident Debriefing (CISD)

___ Workplace Training (organizational/policy/leadership/wellness)

___ On-Site Management/HR Consultation

___ Conflict Management Services (counseling, coaching, mediation)

___ Other
