ESI EMPLOYEE ASSISTANCE GROUP
TotalCare EAP
Public Safety EAP
Educators' EAP
Higher Ed EAP
HealthCare EAP
Union AP

SERVICE PROVIDER APPLICATION FORM

1 Horace Mann Plaza, Springfield, IL 62715

Name Organization/PC:	Date:
Practice Address:	Office Phone:
	Mobile:
Handicap Accessible ☐No ☐ Yes	Fax No:
Second Location:	Email:
Handicap Accessible ☐No ☐Yes	Preferred Method of Contact:
Mailing Address:	☐Email ☐Text ☐Phone
	Tax ID.
	NPI No.
License/Certifications Held	License No.

Optional, Voluntary and Not Required

The following information regarding sexual orientation, religious beliefs, and race/ethnic group is not used for purposes of denying an application for participation. Often clients will ask for a counselor who meets a specific preference within one of the following categories. If your application is approved, and you provide this information, your response will be entered into our database so that you can be identified for our use only if a client requests a counselor who meets a specific category. Any responses you provide or your decision to not provide this information will not be the basis for denying your application for participation.

☐Female ☐Male ☐undisclosed/other

☐Christian ☐Jewish ☐Islam ☐Non-Secular ☐Other:_____

☐Hispanic ☐Caucasian ☐Asian ☐African American ☐Native American

Are you willing to identify your military experience? ☐Yes ☐No, if so, are you a veteran? ☐Yes ☐No

Any other information that would help us place Members in your practice (e.g. experience with elderly, medical social work etc.…)? _____

☐I do not wish to provide this information

Do you speak a second language? ☐No ☐ Yes, please specify_____

Can you use sign language? ☐No ☐Yes

Office setting: ☐**Group Practice** ☐**Private Practice** ☐**Home Office** ☐**Other** _____

Modality

☐Telehealth ☐ Face to Face

Areas of Specialization

☐Affective Disorders	☐Grief	☐Drug/Alcohol Evaluation	☐CISD/CISM
☐Marriage/Couples	☐Phobias	☐Drug/Alcohol Treatment	☐Trauma/PTSD
☐Family	☐Christian Counseling	☐DOT Assessment/ SAP	☐Public Safety
☐Children Less than 8	☐Anger Management	☐Eating Disorders	☐Military/Veteran
☐Children Ages 8-13	☐LGBTQ+	☐Administrative Referrals	☐EMDR
☐Children Ages 14-18	☐LGBTQ- Transitioning		

Other: _____

Workplace Services

Are you interested in providing on-site services indicated above? (**Attach experience and/or training**) ☐No ☐ Yes

Hours of Availability: ☐Days ☐ Evenings ☐ Weekends

Have you ever had a malpractice claim brought against you? ☐ **No** ☐ **Yes**
Has your professional license ever been limited, revoked or suspended? ☐ **No** ☐ **Yes**
Have you ever been disciplined by any professional association, organization, or professional society? ☐ **No** ☐ **Yes**
(If yes to any of the three previous questions, please attach documentation of final resolution.)

Major Health Insurance Panels (Please check all that apply)

☐**Aetna**	☐**Fidelis**	☐**Independent Health**	☐**MVP**
☐**BCBS see below**	☐**Geisinger**	☐**Kaiser**	☐**NYSHIP**
☐**Beacon/Carelon**	☐**Harvard Pilgrim**	☐**Magellan**	☐**Optum**
☐**BS of CA**	☐**Health First**	☐**Medicaid**	☐**PHCS/Multiplan**
☐**CDPHP**	☐**Health New England**	☐**Medicare**	☐**Tricare**
☐**Cigna**	☐**Health Net**	☐**Medical Mutual- See Below**	☐**Tufts**
☐**Connecticare**	☐**Humana**	☐**Moda**	☐**UHC/UBH/UMR/Optum**

Other Plans: _____

_____

BCBS: ☐**Anthem** ☐ **Excellus** ☐ **Empire** ☐ **Highmark** ☐ **Horizon** ☐ **Carefirst** ☐ **Regence**
☐**Premera** ☐ **Florida Blue** ☐ **Wellmark** ☐ **Independence** ☐ **Capital** ☐ **Other**_____

Medical Mutual: ☐**Cle Care** ☐ **MedFlex** ☐**Super Med**

Do you or your organization provide direct services to employers? ☐No ☐ Yes, please specify_____

Summary of Experience:

Please provide a brief summary of your professional experience, areas of expertise and clinical interests-

_____

_____

_____

☐ I authorize the use of publicly available professional information in lieu of a written summary.

I authorize Employee Services to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to Employee Services for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of my knowledge and belief.

_____ _____

Applicant Signature _____ Date _____

Any questions comments or concerns please reach us at 800-821-5040 Opt 7

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TotalCare Wellness

PROVIDER SUMMARY & CHECKLIST

1 Horace Mann Plaza, Springfield, IL 62715

PROVIDER SUMMARY

Mandatory Provider Requirements:

- State Licensure as a Behavioral Health Professional with at least a Master's Degree.
- Minimum and current Malpractice Liability Insurance Coverage of $1,000,000/$3,000,000
- Empanelment with at least one major/area Behavioral Health Insurance Plan

EAP Need/Rate:

- Three session initial evaluation at Contracted rate.

Referral Stipulations:

- ESI-Employee Assistance Group strives to make an Insurance match between the Member and Provider to allow for self-referral after the EAP sessions and continuum of care. Provider may refuse referral if Insurance coverage is not compatible.
- Service Provider may continue to see Client after initial evaluation at Provider's regular hourly rate.
- Paperwork is limited to a one-paged Member Referral Form.
- ESI-Employee Assistance Group pays its bills each week. Payment will be sent on the date following the receipt of Member Referral Form and Billing Invoice (of Provider's choice) for services.

APPLICATION CHECKLIST

Please Return ALL of the following:

- ☐ Application (Completed & Signed)
- ☐ Professional Malpractice Liability Insurance Face Sheet
- ☐ State Licensure or Registration with Expiration Date
- ☐ Resume or training certificates
- ☐ W9 Tax ID Form