Updated Information Needed
License and/or Liability Insurance

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**

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

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

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: _____

Modality:

☐Telehealth ☐ Face to Face

Preferred Method of Contact:

☐ Email ☐ Text ☐ Phone

Hours of Availability:

☐ Days ☐ Evenings ☐ Weekends

Have you ever been disciplined by any professional association, organization, or professional society? ☐ No ☐ Yes

Has your professional license ever been limited, revoked or suspended? ☐ No ☐ Yes

Have you ever had a malpractice claim brought against you? ☐ No ☐ Yes

(If yes to any of the three previous questions, please attach documentation of final resolution.)

Name: _____ Tax ID #_____ NPI _____
Phone:_____ Fax: _____Email:_____
After Hours Phone:_____(If you provide On-site Services)
Please Update the following: **(If your mailing Address has changed, please provide a new W9)**
Practice Address: _____
_____
Mailing Address: _____
_____

Forms can be returned to: Fax: 585-593-6311, providers@theEAP.com
Mail: ESI EAP, 1 Horace Mann Plaza, Springfield, IL 62715. Any questions please call: 800-821-5040