E4, LLC: Add Provider Information

Instructions: Once you've completed this form. Please save and email it to provider.relations@e4healthcare.com. If you wish to fax: 972-717-7929. Be sure to include copies of Licensure and Malpractice facesheet.

Individual Provider Information

First Name:	**Middle Name:**	**Last Name:**	
NPI:	**Lic Type:**	**DOB:**	**Gender:** ____M ____F
Phone:	**Fax:**	**e-mail:**	

Practice/Payment Information

Practice Name:								**EIN or SSN ID:**
Address 1:			**City:**			**State:**	**Zip:**	
Phone:		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
(if differs from above)	**Hours**							
Address 2:			**City:**			**State:**	**Zip:**	
Phone:		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
(if differs from above)	**Hours**							
Mail To:			**City:**			**State:**	**Zip:**	

Please indicate the area(s) where the provider has experience:

___Addictions- Alcohol/Drugs	___Eating Disorders	___OCD
___Addictions- Gambling/Others	___EMDR	___ Training (on site or web)
___ADHD	___Financial Concerns	___Play Therapy
___Anger Management	___Fitness for Duty Evaluation	___Psychological Testing
___Autism/Asperger's	___Faith Based Counseling	___PTSD/Trauma
___Biofeedback	___Family Therapy	___Sexual Abuse/Offenders
___Career Counseling	___GLBT Issues	___Sexual Abuse/Survivors
___CBT ___DBT	___Hypnosis	___SAP ___ CEAP
___CISD / CIR	___Legal Concerns	___Social Skills Training
___Communication Skills	___Major Mental Illness	___Stress Management
___Couples/Relationship Issues	___Mood (depression/bipolar)	___Worklife Balance
___Domestic Violence	___Mandatory Referral	___Work Related Issues

Population Served

____Preschool (1-5) ____Child (6-11) ____Tween (11-13) ____Adolescent (14-19) ____Adult (19-64) ____Geriatric (65+)

Additional Languages Spoken

____Spanish ____French ____Japanese ____Mandarin Chinese ____American Sign____Other ______________________

Insurance Plan Information

___Aetna	___First Health	___MHNet	___TRI CARE	___Tufts
___AvMed	___Health Net	___Medicaid	___UBH ___VO	___Sliding Scale
___BCBS	___Harvard Pilgrim	___Medicare	Other______________________________________	
___Cigna	___Humana	___Oxford	____	
___Fallon	___Magellan	___PacifiCare	____	

License Information (Independent Masters level licensed and above only).

Lic Type 1	_________	Number	__________________	Expires	__________________	State	________
Lic Type 2	_________	Number	__________________	Expires	__________________	State	________
CEAP	_________	attach any cert		SAP	__________________	attach cert	

Liability Insurance Information (Minimum acceptable is 1,000,000/3,000,000)

Name of Liability Carrier:	Policy Number:	Expiration Date:
$ Limit per occurrence:	$ Limit aggregate	

Additional Information

Business Status (Put X on all that apply)

____ Minority Owned Business ____ Woman Owned Business ____Veteran Owned Business ____Home Office

Optional, Voluntary, and Not Required

Clients sometimes request a counselor who meets specific criteria within the following categories. Responses will be used to identify you as someone who meets that criteria. The following information regarding sexual orientation, military experience, religious affiliation, and ethnic group is not used for purposes of denying or accepting an application or for participation as a network provider.

Sexual Oriention: ____Gay ____Lesbian ____Transgender ____Bisexual _____Straight

Military Experience: Veteran ___Yes ___ No
Disabled Veteran? ___Yes ___ No ____Decline

Religious Background: ____Catholic ____Christian ____Jewish ____Islam ____ Buddism ____ Hindu

Ethnicity and/or Nationality: ____ African American ____Hispanic ____Native American ____ Chinese ____ Vietnamese ____Japanese ____Caucasian ____ Pacific Islander_____________________________Other____Decline

Disclosure Required

If you answer YES to any of the following questions, provide the date the action was initiated, date resolved or current status. We reserve the right to request additional information.

Question	Answer
1. Have you ever been convicted of a misdemeanor related to your professional function?	___Y ___N
2. Have you ever been convicted of a felony in any state?	___Y ___N
3. Have you ever been investigated by any professional or licensure board, professional association, private payer, state or federal regulatory agency, or other authority?	___Y ___N
4. Has your clinical license, certification, or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked no renewed, placed on probation, or otherwise limited in any way by a licensing agency or other regulatory bodies?	___Y ___N
5. Have you ever voluntarily relinquished your professional license, certification or other authority to practice for any reason,	___Y ___N
6. Are you aware of any formal disciplinary or criminal charges pending against you?	___Y ___N
7. Are you aware of any complaints against you filed with any licensing, certification, or other regulatory body?	___Y ___N
8. Have you ever been involuntarily terminated from professional employment or a hospital staff, or terminated by a managed care organization, EAP or any other organization that granted you privileges or participation status?	___Y ___N
9. Have you ever resigned with knowledge of an investigation about you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	___Y ___N
10. Are you aware of any complaints filed against you or disciplinary actions which have been initiated or adjudicated against you by a professional employer, hospital, managed care organization , EAP or any organization that granted you privileges, compensation for professional services or other participation status?	___Y ___N
11. Are you now or have you ever been sanctioned or excluded from federal, state, or local government programs?	___Y ___N
12. Have any malpractice suits, professional liability suits, arbitration or other proceedings ever been instituted against you due to your own negligence?	___Y ___N
13. Has a professional liability carrier ever denied, limited, not renewed or canceled your coverage?	___Y ___N

Sign and Date

I, the undersigned, attest that the information I have provided in this application is true as of the date of signature. Additionally, I consent to allow E4 to obtain information about my practice history from state and local governments, public and private certification agencies and my malpractice insurer specifically for the purpose of validating the information in this application and any documents provided to support this application. Additonly, by signing bellow I have reviewed the Provider Agreement and understand my responsibilities.

Signature: ____ **Date:**_________________

I have included copies of my current Licensure and malpractice insurance	**___Y ___N**

Additional information:
Allow 2 weeks for us to process your application and get you in network with us.
Allow up to 30 days for your co-signed agreement to be returned.
We will notify you if additional information is needed.
We will notify you if for any reason we decline your network participation.