beat it!
Employee Assistance Programs

For official use only:

☐ APPLICATION ACCEPTED
☐ APPLICATION DECLINED

/ /

DATE OF ACCEPTANCE

PROVIDER ID

INDIVIDUAL PROVIDER APPLICATION

INTRODUCTION AND INSTRUCTIONS

This application is used fo the provider network of Beat It! Employee Assistance Programs, its subsidiaries and affiliates. Individual providers include: therapists, counselors, psychologists and other clinically licensed treatment professionals.

PLEASE COMPLETE THIS APPLICATION IN ITS ENTIRETY,
INCOMPLETE OR ILLEGIBLE APPLICATIONS WILL NOT BE PROCESSED

Current copies of the following documents are required with this application

- All current state and federal licenses and certificates
- All accreditations
- Verification of professional liability insurance
- Verifications of general liability insurance
- Completed IRS W-9 Form
- Staff Roster
- Covid-19 policy and safety guidelines

PART A - GENERAL INFORMATION

PROVIDER INFORMATION

Provider Name:			
Other past/current name(s) used (if different from above):			
City:	County:	State:	Zip:
Primary contact person:		Title:	
Telephone: ( )	Fax: ( )	URL:	
Email Address:			
Highest Degree:	Tax ID No:	Date of Birth:	

MAILING ADDRESS (if different from above)

Mailing name:		TIN:	
Address:		Department:	
City:	County:	State:	Zip:
Primary Contact Person:		Title:	
Telephone: ( )	Fax: ( )	URL:	
Email Address:			

PART B - SERVICE DELIVERY LOCATION

SERVICE DELIVERY LOCATION INFORMATION

Location Name:

Street Address (no PO Box): | Department:

City: | County: | State: | Zip:

Primary Contact Person: | Title:

Telephone: ( ) | Fax: ( ) | URL:

Email Address:

Is this location accessible for patients and visitors with disabilities? □ YES □ NO

Is this location accessible via public transportation? □ YES □ NO | Office Hours:

Days of the week at this location (circle all that apply) **MON TUE WED THU FRI SAT SUN**

PART C - LICENSURE/ EDUCATION

LICENSES (if more licenses are held, use additional sheet of paper)

Licensing State: _____ Licensing Body: _____

License No.:_____ License Type: _____ Expiration Date: ____/____/____

Licensing State: _____ Licensing Body: _____

License No.:_____ License Type: _____ Expiration Date: ____/____/____

Licensing State: _____ Licensing Body: _____

License No.:_____ License Type: _____ Expiration Date: ____/____/____

Licensing State: _____ Licensing Body: _____

License No.:_____ License Type: _____ Expiration Date: ____/____/____

Licensing State: _____ Licensing Body: _____

License No.:_____ License Type: _____ Expiration Date: ____/____/____

EDUCATION (if more degrees are held, use additional sheet of paper)

Institution: _____ Location (City/State) :_____

Degree Awarded:_____ Date Awarded (mm/yyyy):_____

Institution: _____ Location (City/State) :_____

Degree Awarded:_____ Date Awarded (mm/yyyy):_____

Institution: _____ Location (City/State) :_____

Degree Awarded:_____ Date Awarded (mm/yyyy):_____

EDUCATION (if more degrees are held, use additional sheet of paper)

Practice/ Employer/Facility	Position	Address	From (mm/yyyy)	To (mm/yyyy)

PART D - INSURANCE / MALPRACTICE INFORMATION

PROFESSIONAL LIABILITY INSURANCE INFORMATION

Policy Type: ☐ INDIVIDUAL POLICY ☐ GROUP POLICY

Carrier name:	Policy No.:
Current Policy Issue Date:	Current Policy Exp Date:
Dollar limit per occurrence:	Dollar limit per aggregate:

MALPRACTICE HISTORY INFORMATION

1. Have you maintained malpractice insurance for the past five consecutive years? (if "no", please attach explanation.)	☐ YES ☐ NO
2. Have you ever been named in any malpractice action? (if "yes", please provide complete documentation including current status, settlement/dismissal dates and which party accepted liability.)	☐ YES ☐ NO
3. Have you ever been denied, cancelled or refused renewal of malpractice insurance?	☐ YES ☐ NO
4. Have there ever been any investigations, actions, or judgments taken against your license, certifications, etc.? (if "yes", please attach explanation.)	☐ YES ☐ NO
5. Have you ever been convicted of a felony, including but not limited to, those involving fraud, narcotics or minors?	☐ YES ☐ NO
6. Have you ever been charged with ethical violations by a professional association?	☐ YES ☐ NO

PART E - PRACTICE INFORMATION

AVALIABILITY INFORMATION

Are you accepting new clients? ☐YES ☐NO	New clients/month accepted:_____	Accept same day "urgent" appointments? ☐YES ☐NO
Are you available to see clients at least 3-5 days per week? ☐YES ☐NO	Average waiting time for a scheduled appointment: _____	

CLIENT POPULATION INFORMATION

Please check the age group(s) for which you offer services (mark all that apply)

☐ SENIORS (65 & OLDER) ☐ ADULTS (18 TO 65) ☐ADOLESCENTS (13 TO 17) ☐CHILDREN (6 TO 12) ☐SMALL CHILDREN (0 TO 5)

TREATMENT MODALITIES

Please check the treatment modalities that you employ in your practice (mark all that apply)

☐ INDIVIDUAL PSYCHOTHERAPY ☐ FAMILY PSYCHOTHERAPY ☐ BIOFEEDBACK

☐COUPLE PSYCHOTHERAPY ☐ GROUP PSYCHOTHERAPY ☐ HYPNOSIS ☐ OTHER

_____

_____

USUAL AND CUSTOMARY INFORMATION (please include all rates for services you offer. If more space is needed, please attach additional sheet.)

Individual:	Rate:	Normal Session Length:
Couple:	Rate:	Normal Session Length:
Group:	Rate:	Normal Session Length:
Other:	Rate:	Normal Session Length:

PART E - PRACTICE INFORMATION (Cont'd)

SPECIALTY

Please check your area(s) of specialty (mark all that apply)

☐ADDICTIONS ☐ DOMESTIC VIOLENCE ☐ PERSONALITY DISORDERS ☐ WOMENS ISSUES

☐ANXIETY DISORDERS ☐ EATING DISORDERS ☐ POST-TRAUMATIC STRESS ☐ OTHER (Specify below)

☐CRITICAL INCIDENT DEBRIEFING ☐ MARRIAGE/FAMILY ISSUES ☐ PSYCHOTIC DISORDERS

☐ DIVORCE ☐ MOOD DISORDERS ☐ SEXUAL DISORDERS/ISSUES

_____

_____

_____

SPECIAL NEEDS CLIENTS

Languages (Mark all that apply):

- ☐ HISPANIC/LATINO
- ☐ SIGN
- ☐ OTHER (specify:_____

Disabilities/Impairments (Mark all that apply)

- ☐ VISUALLY IMPAIRED
- ☐ HEARING IMPAIRED
- ☐ PHYSICALLY IMPAIRED
- ☐ MENTALLY IMPAIRED
- ☐ DEVELOPMENTAL DISABILITY
- ☐ NEUROLOGICALLY IMPAIRED

Please check your application for completeness and accuracy. Be sure to include all necessary documentation. Applications that are incomplete, illegible or have missing documentation cannot be processed.

Declarations and Consent:
The application hereby warrants and represents that all information supplied with this application, including, but not limited to licensure, and insurance documentation is true, accurate and complete. The applicant further understands that any information contained in this document by the Applicant which is subsequently found to be false could result in removal from the provider network and/or termination of any agreement that may exist between Beat It! Employee Assistance Programs and the Applicant. In addition, the Applicant agrees to maintain professional and general liability insurance.

The Applicant grants permission and consent to Beat It! Employee Assistance Programs, and/or its designee, to obtain and verify the accuracy of the information contained in this document and consents to release to Beat It! any information that may be reasonably relevant to an evaluation including, but not limited to, the Applicant's moral and ethical qualifications and ability to render clinical services.

The applicant further understands that submission of this application is not a guarantee of acceptance and that Beat It! Employee Assistance Programs reserves the right to deny any application for participation in its network regardless of qualifications

APPLICANT SIGNATURE

	X	
NAME OF AUTHORIZATION REPRESENTATIVE (PLEASE PRINT)	SIGNATURE	DATE

COMPLETE AND RETURN THIS APPLICATION TO:

BY MAIL:
Beat It!
Employee Assistance Programs
20079 Stone Oak Parkway,
Suite 1105-158
San Antonio, TX 78258
Tel: 800.828.3939

BY FAX:
210.481.9228
BY EMAIL:
chris@beatiteap.com