BEST CARE EAP AFFILIATE PROVIDER APPLICATION

Business Name _____

Individual practice ☐ **Group practice** ☐

If group practice, how many total providers are at all locations under the same Tax ID? _____

Affiliate Administrator Contact Name _____

Phone _____ **Fax** _____**Email** _____

Billing Address _____

City _____ **State** _____ **Zip** _____

States of Licensure _____

Languages Spoken (other than English) _____

Services you are able to provide:

In person Counseling	☐
Telephonic Counseling	☐
Video Counseling	☐
Evening Hours	☐
Weekend Hours	☐
Substance Use Assessments	☐
Critical Incident Response	☐
Education/Training	☐

Please indicate areas of specialty:

African American	☐	Asian	☐	Couples	☐	Child/Adolescent	☐
Domestic Abuse	☐	EMDR	☐	Faith Based	☐	Geriatric	☐
Grief/Loss	☐	Hispanic	☐	Job/Career	☐	LGBT	☐
Parenting	☐	Sexual Abuse	☐	Substance Abuse	☐	Trauma	☐

Please, include the following with your application:

- Professional liability insurance (at least $1,000,000 – $3,000,000minimums)
- Copy of current licenses
- W9 or W8BEN (Canada)
- Additional Office Locations
- Requested Rate _____

*Once our office has reviewed the provider application and required documents, you will receive a contract to sign via DocuSign. Please note after contract submission is complete you will then receive access to our online provider portal, to receive client authorizations and to submit necessary billing. The invitation will be sent to the email listed above.

If you have any questions,

Please do not hesitate to reach out to our business office 800.801.4182