

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 – \$3,000,000 minimums)
- Copy of current licenses
- W9 or W8BEN (Canada)
- Additional Office Locations
- Requested Rate _____

*Once we have reviewed your provider application, received all required documentation, and the contract has been fully executed, you will receive an invitation to register for our billing portal. After completing registration, you will be activated as a provider with Best Care EAP.

If you have any questions, please do not hesitate to contact our business office at 800-801-4182.