



**Bristol Place 4819 Emperor Blvd.,  
Durham, NC 27703**

Prospective Providers,

Thank you for your interest in joining the **eni** EAP provider network. **eni** EAP also offers, phone, and video counseling to our clients so let us know if you are interested in providing these services as well.

Please feel free to contact us with any questions that you may have. Send in the completed application along with a copy of your professional license, liability insurance, and a completed W9. Please note that if you are applying as a facility, and billing as such, you only need to complete one application. This will cover all providers working under your facility. We will just need you to provide a roster of their names so that we can add them to our system under your facility.

We look forward to working with you in the future.

Sincerely,  
The **eni** Provider Network Team

**Carla Harrelson**  
Provider Relations Coordinator  
[charrelson@eniweb.com](mailto:charrelson@eniweb.com)



## PROVIDER APPLICATION

GENERAL INFORMATION	
Name of Organization or person to which payment should be made	
Please provide your Tax ID #	

CONTACT INFORMATION			
Name of person to contact when making referrals			
Phone number for referrals		Professional phone number to be given to clients	
Fax number		Email for referrals (internal use only)	
Website (if applicable):			
Mailing Address			Apartment/Unit #
City	State	ZIP	
Office 1 Address			Apartment/Unit #
City	State	ZIP	
If this is a home office, is there a separate entrance?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this office handicap accessible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a waiting room?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this office easily accessible via public transportation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Office 2 Address			Apartment/Unit #
City	State	ZIP	
If this is a home office, is there a separate entrance?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this office handicap accessible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a waiting room?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this office easily accessible via public transportation?	Yes <input type="checkbox"/> No <input type="checkbox"/>

TYPICAL AVAILABILITY			
<input type="checkbox"/> Days	<input type="checkbox"/> Evenings	<input type="checkbox"/> Saturdays	<input type="checkbox"/> Sundays

**Please include hours of operation above.**

## LICENSURE

Please list all professional licensures for all of your members:

***Please be sure to submit a copy of all listed licensures & insurance with this application***

## LANGUAGES

Please list any languages your members speak in addition to English:

## CLINICAL SPECIALTIES:

**Please check all that apply:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD                     | <input type="checkbox"/> Depression                     | <input type="checkbox"/> Trauma                        |
| <input type="checkbox"/> Addictions: Non-chemical     | <input type="checkbox"/> Domestic Violence: Perpetrator | <input type="checkbox"/> Trauma: Sexual/Physical Abuse |
| <input type="checkbox"/> Adolescents: 13-15 years old | <input type="checkbox"/> Domestic Violence: Victim      | <input type="checkbox"/> Video Counseling              |
| <input type="checkbox"/> Adolescents: 16-18 years old | <input type="checkbox"/> Eating Disorders               | <input type="checkbox"/> Work Issues                   |
| <input type="checkbox"/> Anger Management             | <input type="checkbox"/> Eldercare Issues               |  |
| <input type="checkbox"/> Anxiety Disorders            | <input type="checkbox"/> Families                       |  |
| <input type="checkbox"/> Autism/Aspergers             | <input type="checkbox"/> Formal Referrals/Mandates      |  |
| <input type="checkbox"/> Career Planning/Counseling   | <input type="checkbox"/> Marital                        |  |
| <input type="checkbox"/> CBT                          | <input type="checkbox"/> Grief/Loss                     |  |
| <input type="checkbox"/> Children: 5 years and under  | <input type="checkbox"/> Military                       |  |
| <input type="checkbox"/> Children: 6-8 years old      | <input type="checkbox"/> Psychological Testing          |  |
| <input type="checkbox"/> Children: 9-12 years old     | <input type="checkbox"/> Substance Abuse                |  |
| <input type="checkbox"/> Christian Counseling         | <input type="checkbox"/> EMDR                           |  |
| <input type="checkbox"/> Couples                      | <input type="checkbox"/> LGBTQ                          |  |

**Are you interested in providing telephonic or video counseling?:**  Telephonic  Video

How many years of EAP experience do your members have?

Are any of your members a **DOT Substance Abuse Professional (SAP)**?  Yes  No

*If YES, please provide a copy of his/her original SAP Certificate and CEUs for the past three (3) years*

Are any of your members a **Certified Employee Assistance Professional (CEAP)**?  Yes  No

*If YES, please provide an updated copy of his/her CEAP Certificate*

Would any of your members be interested in providing **CISD services**?  Yes  No

*If YES, please provide a copy of current CISD certificates or CEUs they have completed*

Would your members be interested in providing **Trainings or Mediations**?  Yes  No

If YES, please list the trainings he/she would be willing to present:

Are any of your members a **Certified Smoking Cessation Professional**?  Yes  No

**INSURANCE/MANAGED MENTAL HEALTH PLANS ACCEPTED**

<input type="checkbox"/> Aetna	<input type="checkbox"/> Kaiser	<input type="checkbox"/> UniCare
<input type="checkbox"/> Anthem BCBS	<input type="checkbox"/> Magellan	<input type="checkbox"/> United Behavioral Health
<input type="checkbox"/> BCBS	<input type="checkbox"/> Mass Health	<input type="checkbox"/> United Health Care
<input type="checkbox"/> Beacon Health Strategies	<input type="checkbox"/> Humana	<input type="checkbox"/> Value Options
<input type="checkbox"/> Cigna	<input type="checkbox"/> Medicare	<input type="checkbox"/> None
<input type="checkbox"/> Empire BCBS	<input type="checkbox"/> Multiplan PPO	<input type="checkbox"/> Other:
<input type="checkbox"/> Fallon	<input type="checkbox"/> MVP	
<input type="checkbox"/> GIC	<input type="checkbox"/> Oxford Health Plan	
<input type="checkbox"/> Great Western	<input type="checkbox"/> PacifiCare	
<input type="checkbox"/> Harvard Pilgrim	<input type="checkbox"/> PHCS	
<input type="checkbox"/> Health New England	<input type="checkbox"/> TriCare	
<input type="checkbox"/> Individual Blue Plans	<input type="checkbox"/> Tufts	

**APPLICANT ATTESTATIONS**

1. Has a licensing/certification board in any U.S. or foreign jurisdiction taken any disciplinary action against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you the subject of pending disciplinary actions by a licensing/certification board in any U.S. or foreign jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in any U.S. or foreign jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you ever applied for and been denied a professional license in any U.S. or foreign jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever admitted to or been convicted of a felony or misdemeanor in any U.S. or foreign jurisdiction, other than a traffic violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Please state the details of any YES answer on a separate sheet, and attach the explanation to this application*

**OPTIONAL INFORMATION**

This information is entirely optional, and may be used to meet clients' requests

Age	Race/Ethnicity	Religion	Gender
<input type="checkbox"/> 20-29 years old	<input type="checkbox"/> African	<input type="checkbox"/> Christian	<input type="checkbox"/> Female
<input type="checkbox"/> 30-39 years old	<input type="checkbox"/> African American	<input type="checkbox"/> Jewish	<input type="checkbox"/> Male
<input type="checkbox"/> 40-49 years old	<input type="checkbox"/> Asian	<input type="checkbox"/> Muslim	
<input type="checkbox"/> 50-59 years old	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Other:	
<input type="checkbox"/> 60 and over	<input type="checkbox"/> Hispanic/Latino		
	<input type="checkbox"/> Other:		

**PRINT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**PARTICIPATION STATEMENT**

I fully understand that if any matter stated in this application is or becomes false, Employee Network will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize Employee Network *and/or its Credentials Verification Organization (CVO)* to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to Employee Network *and/or its CVO*. I release Employee Network and its employees and/or its CVO and all those whom Employee Network and/or its CVO contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to Employee Network and/or its CVO of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

\_\_\_\_\_  
Signature of Applicant

Date (mm/dd/yy): \_\_\_\_\_

\_\_\_\_\_  
Name (Please Print)

**RETURN COMPLETED APPLICATION TO:**

[charrelson@eniweb.com](mailto:charrelson@eniweb.com)

**OR PRINT AND RETURN TO:**

Employee Network, Inc.  
ATTN: Network Development  
Bristol Place 4819 Emperor Blvd.,  
Durham, NC 27703

**REQUIRED DOCUMENTATION TO ACCOMPANY THIS APPLICATION**

- **COPY OF CURRENT STATE LICENSE AND/OR LICENSE REGISTRATION CERTIFICATE**
- **COPY OF CURRENT STATE CONTROLLED DANGEROUS SUBSTANCE (CDS) CERTIFICATE**
- **COPY OF CURRENT FEDERAL DRUG ENFORCEMENT AGENCY (DEA) CERTIFICATE**
- **COPY OF CURRENT MALPRACTICE INSURANCE FACE SHEET**
- **COPY OF SMOKING CESSATION CERTIFICATE**
- **COPY OF ANY OTHER MENTIONED DOCUMENT OR CERTIFICATE**