Wheeler | EMPLOYEE ASSISTANCE PROGRAM (EAP)

Affiliate Provider Information Form

Please complete all sections.

Last name: _____ First name:_____DOB: MM: _____DD:_____ YYYY: _____

Name of practice (if applicable): _____

Email address: _____ Practice phone number: _____

Cell number: _____ Fax number: _____ TIN or SSN: _____

Degree type(s): _____ License number(s): _____

What languages do you speak? _____

Mailing address for payment remittance: _____

Street: _____ City: _____ State: _____ Zip: _____

Primary Service and Location Information

Practice location(s):

Street: _____ City: _____ State: _____ Zip: _____

Street: _____ City: _____ State: _____ Zip: _____

Street: _____ City: _____ State: _____ Zip: _____

Is your practice wheelchair accessible? Yes ☐ No ☐ Virtual Visits? Yes ☐ No ☐ In Person Visits? Yes ☐ No ☐

Age preferences (Start with 1-prioritize age groups you prefer to work with)

____Children: 1 – 9
____Children: 10 – 12
____Adolescents' ages: 13 – 18
____Adults': 18+

Appointment availability:

☐ Mornings
☐ Afternoons
☐ Evenings
☐ Weekends

Do you have a psychiatrist in your practice? Yes ☐ No ☐
Name: _____

If not, do you work closely with a psychiatrist? Yes ☐ No ☐
Name: _____

Do you facilitate management trainings and/or wellness seminars? Yes ☐ No ☐
If so, please specify: _____

Insurance

Please indicate insurance companies covering your service:

☐ Aetna
☐ Anthem Blue Cross
☐ Cigna
☐ ConnectiCare
☐ Husky
☐ Magellan
☐ Medicaid
☐ Medicare
☐ TRICARE
☐ United Health Group
☐ Other _____
☐ Other _____
☐ Other _____
☐ Other _____
☐ Other _____

Do you participate in other EAP programs? Yes ☐ No ☐
Name(s): _____

Provider Practice Focus

Areas of Concentration/Specialty: (Check all that apply)

☐ ACOA/Co-dependency	☐ Eating Disorder	☐ Physical abuse	
☐ ADHD – adults	☐ Eldercare issues	☐ Police/fire population	
☐ ADHD – children	☐ EMDR	☐ PTSD	
☐ Adoption issues	☐ Family therapy	☐ Rape/Sexual assault	
☐ Anger management	☐ Forensic	☐ Sexual dysfunction	
☐ Anxiety disorders	☐ Geriatrics	☐ Sleep disorders	
☐ Autism/Asperger	☐ Grief/loss	☐ Spirituality	
☐ Bipolar	☐ Hearing-impaired population	☐ Substance abuse	
☐ Career counseling	☐ Learning disabilities	☐ Suicide	
☐ Child abuse	☐ LGBTQ +	☐ Transgender	
☐ Childhood conduct disorders	☐ Mediation	☐ Trauma	
☐ Christian counselor	☐ Medical/chronic illness	☐ Women's issues	
☐ Cognitive behavior	☐ Men's issues	☐ Work life balance	
☐ Compulsive gambling	☐ Mood disorders	☐ CISD	Fee: ☐
☐ Couples/Relationship issues	☐ Neuropsychic testing	☐ Conflict Management	Fee: ☐
☐ Critical incident response	☐ OCD	☐ SAP	Fee: ☐
☐ DBT	☐ Outplacement	☐ Other _____	
☐ Disability management	☐ Parenting issues	☐ Other _____	
☐ Diversity/Cross cultural issues	☐ Personality disorders	☐ Other _____	
☐ Domestic Violence	☐ Phobias	☐ Other _____	

Signature: _____ **Date:** _____

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Return completed forms to:
Henrietta Sabel (hsabel@wheelerclinic.org)
Or
FAX # 800-793-3554