



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) Appointment availability:

___ Children: 1 – 9

___ Children: 10 – 12

___ Adolescents' ages: 13 – 18

___ Adults': 18+

[] 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)

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

Signature: _____

Date: _____



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Return completed forms to:
eapmailbox@wheelerclinic.org

Or

FAX # 800-793-3554

WEAP 4/6/26