ORGANIZATION PROVIDER APPLICATION

For official use only:

☐ APPLICATION ACCEPTED
☐ APPLICATION DECLINED

/ /

DATE OF ACCEPTANCE

PROVIDER ID

INTRODUCTION AND INSTRUCTIONS

This application is used fo the provider network of Beat It! Employee Assistance Programs, its subsidiaries and affiliates

PLEASE COMPLETE ONE APPLICATION FOR EACH SERVICE LOCATION.

- ONE SERVICE LOCATION: If all levels of care are delivered in one service location, only one copy of this application is necessary.
- MULTIPLE SERVICE LOCATIONS: Please complete one application for each location where services are delivered.
- Incomplete or illegible applications will not be processed.

Current copies of the following documents are required for this application

- All current state and federal licenses and certificates
- All accreditations
- Verification of professional liability insurance (minimum of $1M/$3M required)
- Verifications of general liability insurance
- Completed IRS W-9 Form
- Staff Roster
- Covid-19 policy and safety guidelines

PART A - CORPORATE/ MAIN SITE

MAIN SITE CORPORATE INFORMATION

Tax Identification Number (TIN):

Legal name of organization:

Other name(s) the organization is known by (or DBA):

If organization is a subsidiary of, partner in or otherwise affiliated with a health system or other group, please identify the entity below:

Name of entity:

MAILING ADDRESS

Primary Mailing Address:		Department:	
City:	County:	State:	Zip:
Primary contact person:		Title:	
Telephone: ( )	Fax: ( )	URL:	
Email Address:			

PART B - SERVICE DELIVERY LOCATION

SERVICE DELIVERY LOCATION INFORMATION

Location Name:			
Street Address (no PO Box):			Department:
City:	County:	State:	Zip:
Primary Contact Person:			Title:
Telephone: ( )	Fax: ( )	URL:	
Email Address:			
This location is accessible for patients and visitors with disabilities? ☐ YES ☐ NO			

MAILING ADDRESS (if different from above)

Mailing name:			TIN:
Address:			Department:
City:	County:	State:	Zip:
Primary Contact Person:			Title:
Telephone: ( )	Fax: ( )	URL:	
Email Address:			

PART C - INSURANCE INFORMATION

PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please check all that apply and provide the information below:

- Carrier: ☐ INDEPENDENT CARRIER ☐ SELF-INSURED ☐ COVERED BY STATE TORT LIABILITY CLAIMS ACT

Carrier name:	Policy No.:
Current Policy Issue Date:	Current Policy Exp Date:
Dollar limit per occurrence (min. of $1M):	Dollar limit per aggregate (min. of $3M):
(If self-insured) Current Reinsurance Entity:	Risk Management Contact Name:

GENERAL LIABILITY INSURANCE INFORMATION

Please check all that apply and provide the information below:

- Carrier: ☐ INDEPENDENT CARRIER ☐ SELF-INSURED ☐ COVERED BY STATE TORT LIABILITY CLAIMS ACT

Carrier name:	Policy No.:
Current Policy Issue Date::	Current Policy Exp Date:
Dollar limit per occurrence (min. of $1M):	Dollar limit per aggregate (min. of $3M)::
(If self-insured) Current Reinsurance Entity:	Risk Management Contact Name:

PART D - LICENSING

LICENSES (if more licenses are held, use additional sheet of paper)

Licensing State: ____________ Licensing Body: ____

License No.:____________________ License Type: _____________________________ Expiration Date: ____/____/____

Licensing State: ____________ Licensing Body: ____

License No.:____________________ License Type: _____________________________ Expiration Date: ____/____/____

Licensing State: ____________ Licensing Body: ____

License No.:____________________ License Type: _____________________________ Expiration Date: ____/____/____

Licensing State: ____________ Licensing Body: ____

License No.:____________________ License Type: _____________________________ Expiration Date: ____/____/____

Licensing State: ____________ Licensing Body: ____

License No.:____________________ License Type: _____________________________ Expiration Date: ____/____/____

PART E - ACCREDITATIONS

ACCREDITATION INFORMATION (By completing this section you are attesting to the accreditation status of all levels of care are this service location.)

JCAHO Accreditation: ☐ YES ☐ NO Expiration Date: _____/_____/_____/

The levels of care covered by this accreditation: ☐ INPATIENT ☐ RESIDENTIAL ☐ INTENSIVE OUTPATIENT (IOP) ☐ OUTPATIENT

CARF Accreditation: ☐ YES ☐ NO Expiration Date: _____/_____/_____/

The levels of care covered by this accreditation: ☐ INPATIENT ☐ RESIDENTIAL ☐ INTENSIVE OUTPATIENT (IOP) ☐ OUTPATIENT

Other Accreditation: ☐ YES ☐ NO Expiration Date: _____/_____/_____/

The levels of care covered by this accreditation: ☐ INPATIENT ☐ RESIDENTIAL ☐ INTENSIVE OUTPATIENT (IOP) ☐ OUTPATIENT

Other Accreditation: ☐ YES ☐ NO Expiration Date: _____/_____/_____/

The levels of care covered by this accreditation: ☐ INPATIENT ☐ RESIDENTIAL ☐ INTENSIVE OUTPATIENT (IOP) ☐ OUTPATIENT

Other Accreditation: ☐ YES ☐ NO Expiration Date: _____/_____/_____/

The levels of care covered by this accreditation: ☐ INPATIENT ☐ RESIDENTIAL ☐ INTENSIVE OUTPATIENT (IOP) ☐ OUTPATIENT

PART F - USUAL AND CUSTOMARY CHARGES

UAC INFORMATION

Inpatient:	Per Diem:	Global:	Average LOS:
Residential:	Per Diem:	Global:	Average LOS:
Intensive Outpatient:	Per Diem:	Global:	Average LOS:
Outpatient:	Per Diem:	Global:	Average LOS:

Please check your application for completeness and accuracy. Be sure to include all necessary documentation. Applications that are incomplete, illegible or have missing documentation cannot be

Declarations and Consent:
The application hereby warrants and represents that all information supplied with this application, including, but not limited to licensure, and insurance documentation is true, accurate and complete. The applicant further understands that any information contained in this document by the Applicant which is subsequently found to be false could result in removal from the provider network and/or termination of any agreement that may exist between Beat It! Employee Assistance Programs and the Applicant. In addition, the Applicant agrees to maintain professional and general liability insurance coverage at all levels stated in this document.

The Applicant grants permission and consent to Beat It! Employee Assistance Programs, and/or its designee, to obtain and verify the accuracy of the information contained in this document and consents to release to Beat It! any information that may be reasonably relevant to an evaluation including, but not limited to, the Organization's moral and ethical qualifications and ability to render clinical services.

The applicant further understands that submission of this application is not a guarantee of acceptance and that Beat It! Employee Assistance Programs reserves the right to deny any application for participation in its network regardless of qualifications

APPLICANT SIGNATURE

I certify that I am authorized to make the above warranties, representations and authorizations and releases on behalf of this provider organization and sign this application on behalf of this organization

	X	
NAME OF AUTHORIZATION REPRESENTATIVE (PLEASE PRINT)	SIGNATURE	DATE

COMPLETE AND RETURN THIS APPLICATION TO:

BY MAIL:
Beat it!
Employee Assistance Programs
20079 Stone Oak Parkway
Suite 1105-158
San Antonio, TX 78258
Tel: 800.828.3939

BY FAX:
800.956.6927
BY EMAIL:
vikki@beatiteap.com