Interface EAP

PO Box 421879, Houston, TX 77242-1879
Phone (713)-781-3364 (800)-324-4327

Provider Network
FACILITY APPLICATION

Facility name: _____

The following items MUST be attached in order for your application to be considered:

Enclosed	Previously Submitted	
☐	☐	Liability Coverage
☐	☐	License – Joint Commission (JC), State or Other
☐		NPI# & W-9
☐	☐	Current Program Schedules .... Intensive Outpatient .... Day or Partial Treatment
☐	☐	Aftercare Information
☐	☐	List of Psychiatrists with hospital staff privileges

An Interface Participant is currently in treatment at our facility? ☐ **Yes** ☐ **No**

If yes, include clients IEAP case number: _____

I agree to see this referral for Interface EAP (IEAP). I have received, read and understand the policies and forms sent to me by IEAP. I agree to follow said policies and utilize the forms. I understand this agreement will allow me to see up to 2 more managed care referrals prior to signing the full IEAP agreement. I also understand IEAP is available for any questions or help with procedures associated with this referral.

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FACILITY APPLICATION

Corporate Name: _____

Facility name: _____

Languages Spoken (*Other Than English*) _____
by staff/clinicians _____

SERVICE LOCATION

Facility Name: _____
Physical Address _____
City: _____ County _____ State: _____ Zip: _____
Primary Phone: _____ Other: _____ Fax: _____
Contact: _____ Handicapped Accessible: ☐ **Yes** ☐ **No**

Please note: All correspondence regarding patient care will be directed to this physical address.

INFORMATION FOR AGREEMENT

Legal Name _____
(Name to appear on agreement)
Federal EIN _____ Do others use this #? ☐ Yes ☐ No
Address: _____
(Address to send agreement)
City: _____ County: _____ State: _____ Zip: _____

Contact & Title: _____
(Person whose name will appear on the agreement)
Primary Phone: _____ Ext.: _____ Fax: _____

STAFF COMPOSITION

Psychiatrist/Addictionologist _____ Licensed Psychologists _____
Master's Level Counselors _____ Alcohol/Drug Counselors _____

LIST NAME OF:	**PHONE NUMBER & EXT.**
CEO / CFO	
Program Director:	
Utilization Review:	
Medical Director:	
Billing Contact:	

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FACILITY APPLICATION

Corporate Name: _____

Facility name: _____

YES	NO	Please respond to the following questions:
☐	☐	Has your professional accreditation ever been revoked, suspended, or limited?
☐	☐	Have you ever voluntarily surrendered your professional accreditation?
☐	☐	Have you ever been the subject of disciplinary proceedings by any professional association or governmental organization?
☐	☐	Has your facility ever been denied professional liability insurance, or has your insurance ever been canceled or refused renewal?
☐	☐	Have you ever been the plaintiff or defendant in any lawsuit?
☐	☐	Have you ever been suspended from receiving payment from Medicare or Medicaid?
☐	☐	Have you ever sought bankruptcy protection?
☐	☐	Have you ever incurred a malpractice claim?

If you answered "YES" to any of the above questions you must attach a statement with full details.

WAIVER STATEMENT

In my position with _____

I hereby release from liability all representatives of Interface EAP, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualification, and I hereby consent to the release and exchange of information to Interface EAP, relating to any disciplinary action, suspension or curtailment of privileges, or professional malpractice claims whether or not settled or in judgment.

I understand and agree that this facility has the burden of providing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I understand that Interface EAP may verify all or any of the information contained herein.

I certify that the information provided herein, including attachments, represents full and truthful disclosures of the matters to which they pertain. I understand that omission or falsification of data may invalidate any agreements in place with Interface EAP.

A photocopy of this document shall be considered as valid as the original when so presented.

Signature _____ Date**:** _____

Title _____

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FACILITY APPLICATION

Facility Program & Proposed Fee Schedule

(For programs to be considered you must attach Program Descriptions and Schedules)

FACILITY NAME: _____

	FACILITY'S PUBLISHED RATE**	PROPOSED CONTRACT RATE**	FREQUENCY OF MD SERVICES	NUMBER OF IT AND FT SESSIONS PER WEEK	AVERAGE LENGTH OF STAY
ACUTE ADULTS					
ADOLESCENTS					
CHILDREN					
SUBACUTE ADULTS					
ADOLESCENTS					
CHILDREN					
RESIDENTIAL ADULTS					
ADOLESCENTS					
CHILDREN					
PARTIAL ADULTS				Program Hours	
ADOLESCENTS					
CHILDREN					
IOP ADULTS				Program Hours	
ADOLESCENTS					
CHILDREN					
DETOX ADULTS					
ADOLESCENTS					
CHILDREN					
INPATIENT-CD ADULTS					
ADOLESCENTS					
CHILDREN					
RESIDENTIAL-CD ADULTS					
ADOLESCENTS					
CHILDREN					
PARTIAL-CD ADULTS				Program Hours	
ADOLESCENTS					
CHILDREN					
IOP-CD ADULTS				Program Hours	
ADOLESCENTS					
CHILDREN					

****Include:** Room and board, 24 hr. nursing, routine labs, routine medications, education, group social services, IT, FT.
Exclude: H & P, psychological testing, MRI, CT scans, EEG, EKG, X-rays.

Do you include physician charges in your per diem? _____

Do you offer ECT? ☐ Yes ☐ No If yes, what is your charge? _____