Interface Behavioral Health

PO Box 421879, Houston, TX 77242-1879
Phone (713) 781-3364 (800) 324-4327
(713) 784-3241 (Fax)
www.ieap.com

Provider Network
INDIVIDUAL PROVIDER APPLICATION

Provider name: _____
FIRST MIDDLE LAST DEGREE

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

Enclosed	Previously Submitted	
☐	☐	**1) Submit one copy if all providers are covered under the same policy** 1. Professional Liability Coverage: *$1million/$1million* for Master's and Doctoral level clinicians and *$1million/$3million* for all Physicians or Enrolled in the Patient Compensation or Stabilization Fund
☐	☐	**2) STATE** licenses or **STATE** certifications in Counseling Disciplines **MD's:** DEA, State Substance Control, & Board Certifications
☐	☐	**3)** Current Resume or Vita (Clinicians must have 3 years post licensure experience)
☐	☐	**4)** List of hospital staff privilege status (*if appropriate*)
☐	☐	**5)** Form W-9 – Taxpayer Identification Number (see attached) Do others use this Federal EIN? ☐ Yes ☐ No
☐	☐	**6)** NPI # (National Provider Identification Number)

I am with a group who currently has a contract with Interface Behavioral Health

Group Name: _____ Federal EIN: _____

☐ **Yes** ☐ **No**

I am currently seeing an Interface Participant OUT OF NETWORK

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

Interface Behavioral Health

Individual Provider Application – Demographic Information

Provider Name:
FIRST MIDDLE LAST DEGREE

Date of Birth: | | | **Sex:** ☐ **Male** ☐ **Female** **Ethnicity:** (*Optional*)

Bilingual: ☐ **Yes** ☐ **No** **Languages:**

National Provider Identification # (NPI#): ☐ Individual ☐ Group

Practice Name:

Service Address:

City: **State:** **Zip:** **County:**

Mailing Address:

City: **State:** **Zip:**

Primary Phone: **AnsSvc/Pager:** **Fax:**

Billing Contact: **Phone :**

E-mail address (*optional)*: **Web Site**:

Hours: **M** **T** **W** **TH** **F** **Sat** **Sun**

Handicapped Accessible: ☐ **Yes** ☐ **No** **Is this a personal residence?** ☐ **Yes** ☐ **No**

Please indicate areas that you are qualified to assess & counsel potential referrals.

Specialized Populations		**Specialized Knowledge**	**Specialty Areas**		
Geriatrics		Christian Counselor	ADHD	Learning Dis	
Adults		CISD	Adoption Issues	MPD	
Adolescent 14-17		Clergy Peer Hotline	Alcohol	Parenting Issue	
Pre-Teen 10-13		Developmental Dis	Anger Mgmt	Perpetrators	
Children 7-9		ECT	Anxiety Dis	Personality	
Children 4-6		Employer Mandated	Autism Spec Dis	Phobias	
Infant/Todd 0-3		Fit For Duty	Bari/Gastric Eval	Psychosis	
Specialized Modalities		Gay/Lesbian Issues	Bipolar	PTSD	
App Beh Analysis		Mediation	Career Counsel	Rape Issues	
Biofeedback		Men's Issues	Chemical Dep	Rx Drugs	
Conj/Family		Pharmacy Intervention	Chronic Pain	Separation/Divorce	
EMDR		SAP (DOT)	Couple/Marriage	Sexual Dis	
Forensic		Veterans	Death/Dying	Sleep Disorder	
Group		Wellness Seminar	Depression	Smoking Cess	
Hypnosis		Women's Issues	Domestic Violence	Somatic	
Home Visitations		Workplace Violence	Eating Disorder	Stress Mgmt	
Neuro-Psych Test			Family Counseling	Victim Issues	
Online Counseling			Gambling		
Play Therapy			Gang/Cult		
Psych Testing			Grief/Loss		
Tele-Health			Impulse Control		
Web Debriefing					
Web Training					

Interface Behavioral Health

Individual Provider Application – Waiver

Provider name: _____
FIRST MIDDLE LAST DEGREE

YES	NO	Please respond to the following questions:
☐	☐	Has your professional license/certification ever been revoked, suspended, or limited?
☐	☐	Have you ever voluntarily surrendered your license or certification?
☐	☐	Have you ever been denied privileges, were they ever limited, suspended, or renewal denied?
☐	☐	Have you ever resigned from the staff of any hospital or professional organization because of problems regarding privileges or credentials?
☐	☐	Have you 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 involving a hospital, a professional association or an organization?
☐	☐	Have you ever been convicted of or plead guilty to a felony crime?
☐	☐	Have you or your professional association ever sought bankruptcy protection?
☐	☐	Have you ever incurred a malpractice claim?
☐	☐	Has your DEA number ever been revoked or otherwise limited?
☐	☐	Have you ever been suspended from receiving payment from Medicare or Medicaid?

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

WAIVER STATEMENT

I hereby release from liability all representatives of Interface Behavioral Health, for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby consent to the release and exchange of information to Interface Behavioral Health, 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 I, as an applicant, have 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 Behavioral Health 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 Behavioral Health.

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

Provider Signature Date: _____

Interface Behavioral Health

Individual Provider Application – Managed Care Services

Provider Name: _____
FIRST MIDDLE LAST DEGREE

Your PPO network service agreement will be sent at the indicated IEAP rate. You must include your usual (*published*) rate.

PSYCHIATRISTS				PSYCHOLOGISTS			
CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE	CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE
*99201	New patient (10 Minutes)		27	*90791	New Pt w/o Medical Services		125
*99202	New patient (20 Minutes)		51	*90792	New Pt w/Med Services **(Med Psych Only)**		145
*99203	New patient (30 Minutes)		79	*90832	Psychotherapy 30 Min		45
*99204	New Patient – Moderate		161	*90834	Psychotherapy 45-50 Min		90
*99205	New Patient – Severe		200	*90837	Psychotherapy 60 Min		118
*99211	Est. Patient – 5 Min		20	*90846-7	Family w/ & w/o Patient		90
*99212	Est. Patient – 10 Min		43	*90853	Group Therapy		35
*99213	Est. Patient – 15 Min		60	*90863	Med Mgmt **(Med Psych Only)**		60
*99214	Est. Patient – 25 Min		104	*90901	Biofeedback		90
*99215	Est. Patient – 40 Min		140	*90839	Psychotherapy-Crisis 30-74 Min		135
Add-on Codes for E/M Services Only				*90840	Psychotherapy Crisis Add-On for each addl 30 Min		45
*90833	Psychotherapy 30 Min		35	*90785	Interactive Complexity		4
*90836	Psychotherapy 45 Min		56	*96101	Psych Testing		90
*90838	Psychotherapy 60 Min		90	*90102	Psych Testing by Technician		25
*90792	Psychiatric Evaluation w/ (medical services)		145	*96103	Psych Testing by Computer		45
*99221-3	Initial Hospital		140	*96118	Neuro Psych Testing		90
*99251-5	Initial Inpatient Consultation		140	*96119	Neuro Psych Testing by Tech		25
*99231-3	Subsequent Hosp		100				
*90870	ECT		100				
*99271-5	Confirmatory Consultation		100				
*99238-9	Discharge Day		100				
*90846-7	Family w/ & w/o Patient		100				
*90853	Group Therapy		40				
*90875	Interactive Complexity		4				

APRN				MASTERS			
CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE	CPT Code	DESCRIPTION	USUAL FEE	IEAP RATE
*99201	New patient (10 Minutes)		27	*90791	New Patient w/o Medical Services		115
*99202	New patient (20 Minutes)		51	*90832	Psychotherapy 30 Min		40
*99203	New patient (30 Minutes)		79	*90834	Psychotherapy 45-50 Min		80
*99204	New Patient – Moderate		121	*90837	Psychotherapy 60 Min		108
*99205	New Patient – Severe		150	*90846-7	Psychotherapy w/ & w/o Patient		80
*99212	Est. Patient – 10 Min		32	*90853	Group Therapy		30
*99213	Est. Patient – 15 Min		53	*90839	Psychotherapy for Crisis 30-74 Min		120
*99214	Est. Patient – 25 Min		78	*90840	Psychotherapy for Crisis Add-on		40
*99215	Est. Patient - 40		105	*90785	Interactive Complexity		4
Add-on Codes for E/M Services Only							
*90833	Psychotherapy 30 Min		35				
*90836	Psychotherapy 45 Min		56				
*90838	Psychotherapy 60 Min		90				
*90792	Psychiatric Evaluation w/ (Medical Service)		145				
*90846-7	Family w/ & w/o Patient		80				
*90853	Group Therapy		30				
*90875	Interactive Complexity		4				

Interface Behavioral Health

Individual Provider Application – EAP and On-Site Services

Provider name: _____
FIRST MIDDLE LAST DEGREE

Applies **ONLY** to **Psychologists** and **Masters Level Clinicians**.

$50.00 EAP:

- Interface Behavioral Health will include this EAP rate on all network agreements
- EAP sessions are for Assessment and Brief Resolution Therapy.
- There are a limited number of EAP sessions available to each participant.
- EAP sessions are not filed under insurance.
- EAP sessions are FREE to participant and paid at 100% by Behavioral Health when authorized by Behavioral Health

Applies ONLY to Psychologists and Masters Level Clinicians that conduct these services.

CISD	**Grief Debriefing**
$100 per Hr + $50 Flat Fee for travel	$100 per Hr + $50 Flat Fee for travel
☐	☐

EAP rate is acceptable as Wellness Seminar rate? Yes No

If no, requested Wellness Seminar rate $_____

Does Wellness Seminar rate include Travel rate? Yes No

If no, requested Travel rate $_____