

SOLUTIONS

In order to complete the provider application process, we request that you submit the following documents:

- W-9 Form
- Copy of the individual/agency certificate of insurance
- Copy of the resume or vita of each practitioner requesting recognition within the network
- Copy of the current licensure/certification of each practitioner seeking recognition within the network

Failure to provide the necessary documentation will only slow down the approval process. Therefore, we ask that you submit the application and the necessary documentation in its entirety.

All documents are to be sent to:

**Solutions
Attn: Melissa Forster
601 Washington Street, Suite 102
Columbus, IN 47201**

**If you wish to fax the application,
please send to Melissa Forster: 1-812-377-7194.**

We thank you for your cooperation in this matter.

SOLUTIONS

Provider Application

Part 1

PRACTICE PROFILE

Administrative Office _____

Name: _____

Tax ID #: _____

License(s): _____

Mailing Address: _____

Accreditation: _____

City: _____

State: _____ Zip: _____

Telephone #: (____) _____

Certification(s): _____

Fax #: (____) _____

Toll free #: (____) _____

E-mail: _____

PROGRAMS/SERVICES

Check all that apply:

- Employee Assistance Services
- Emergency Services
- Critical Incident Stress Management
- Availability to provide trainings to employers

Outpatient Services

- Adult Individual
- Adult Group
- Adolescent Individual
- Adolescent Group
- Child Individual
- Child Group
- Psychological Testing

Services are provided by:

- Masters level providers
- Ph.D. level providers

IOP/Partial Hospitalization

- Adult CD
- Adult Psych
- Adolescent CD
- Adolescent Psych
- Children

Services are provided by:

- Masters level providers
- Ph.D. level providers

CLINICAL OFFICE LOCATION(S) AND HOURS:

a. Number of locations for all programs/services available: _____

If there are multiple locations, please identify each address:

1) _____

2) _____

3) _____

b. Office hours (*note specific hours*):

| | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. |
|-----|-------|-------|-------|--------|-------|-------|
| EAP | _____ | _____ | _____ | _____ | _____ | _____ |
| O/P | _____ | _____ | _____ | _____ | _____ | _____ |
| IOP | _____ | _____ | _____ | _____ | _____ | _____ |

MANAGED CARE EXPERIENCE:

a. Briefly describe any experience in providing EAP services.

b. Briefly describe any experience participating in behavioral health managed care programs.

LIABILITY INFORMATION:

Please attach current certificate of liability coverage.

SIGNATURE

Please print name of person completing this form: _____

Title: _____ Date: ____ / ____ / ____

Signature: _____

Please return to: Solutions
601 Washington Street, Suite 102
Columbus, IN 47201
FAX: 812-377-7194
Attn: Melissa Forster

SOLUTIONS

Provider Application

PART 2*

* To be completed by each practitioner seeking recognition by the network.

INDIVIDUAL PROVIDER INFORMATION

Name: _____ Degree: _____ Credential(s): _____

Soc. Sec. #: _____ Practice Name: _____

Address: _____ Phone: (____) _____

_____ Fax: (____) _____

City: _____ State: _____ Zip: _____ E-mail: _____

CERTIFICATION OR LICENSURE INFORMATION

Please respond to each of the following questions. If you answer yes to any of these questions, please provide explanation on a separate sheet.

1. Has your clinical license ever been revoked or limited? _____ Yes _____ No
Is there action pending? _____ Yes _____ No
2. Within the past five years, have you ever been subject to disciplinary review action ? _____ Yes _____ No
3. Within the past five years, have you ever been denied hospital privileges? _____ Yes _____ No _____ N/A
4. Has your narcotics license ever been revoked, suspended or limited? _____ Yes _____ No _____ N/A

ATTESTATION

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate, complete and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested.

Any information entered into this application which subsequently is found to be false could result in our refusal to enter into a contract with you or termination of any contract with you.

Please attach a copy of your current license and resume.

Your signature is required to complete this application.

Signature: _____ Date: _____

Please Print Name: _____

Please return all information to: Solutions
Attn: Melissa Forster
601 Washington Street, Suite 102, Columbus, IN 47201
FAX: 812-377-7194

SOLUTIONS

A Service of Centerstone

WHO WE ARE

Centerstone (www.centerstone.org) is a not-for-profit organization. It is the nation's largest provider of community-based behavioral health services. With a history that spans over fifty years, Centerstone provides a full range of behavioral health and related educational services to more than 69,000 individuals of all ages and their families annually. Children, adolescents, adults, seniors, and families all receive help from a multitude of different programs in more than 120 facilities and 150 partnership locations in Tennessee and Indiana. Centerstone is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

The office of SOLUTIONS, located at 601 Washington Street, Suite 102, in Columbus, Indiana has operated as the EAP service of Centerstone since 1987.

The mission of SOLUTIONS is to assist employers in managing risk. This risk management takes place by providing benefits consultation, Employee Assistance Services, utilization management, corporate training, establishing quality provider networks, and overseeing the delivery of EAP and/or PPO services.

SOLUTIONS provides and/or oversees the provision of EAP services to over 75,000 individuals. Network providers are located in more than 10 states and in over 70 Indiana cities.