Credentialing Information for E4 Health Inc.

Attached below are the application documents for E4 Health. Please provide as much specific information as possible. Filling out the Voluntary Section at the top of the disclosure page will allow us to further identify you for specific member requests. Call Provider Relations at 972-810-3036 ext. 2 if you have any questions or concerns.

Here are some tips and instructions:

- Fill out the application to the best of your abilities.
- We have included a blank W-9 for your convenience in case you don't have the form on hand. Please provide the name and Tax ID number to which E4 should cut checks. This will either be a social security number or an employer identification number. The address on the W-9 should be your billing address - where we will send your checks.
- Sign the fee schedule. If you do trainings or CIR work, make sure you have checked them under specialties.
- Please include all of the following:
  - ✓ Completed W-9
  - ✓ Signed fee schedule
  - ✓ Application
  - ✓ Add a Provider Information form for each group member (if applicable)
  - ✓ Copy of your current license(s) (unless information was provided on the application)
  - ✓ Copy of current liability cover page

Return Options for Provider Application		
Fax: 972-717-7929	Email: Provider.Relations@e4healthcare.com	Mail 105 Decker Court, Suite 475 Irving, TX 75062

Other Contact Information for E4 Health, Inc.

Clinical Contact (for any clinical concerns): 800-227-2195

Member Service Line: 800-227-2195

Return Invoices (Case Summary Document) to our Payment Services Department		
Fax: 401-274-6472	Email: Payment.services@e4healthcare.com	Mail: P.O. Box 1575 Providence, RI 02901-1575

Questions regarding billing: 972-810-3036 ext. 1

Email to: provider.relations@e4healthcare.com

Website: http://www.e4healthinc.com

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E4 Health Inc: Group Application Information

Instructions: Use this sheet for a group where multiple providers bill under the same Tax ID. If your group has more than 2 locations, please attach additional location information separately. Please fill out the mail payment address for check payment.

Questions: 972-810-3036 x2 or e-mail to: provider.relations@e4healthcare.com

Main Contact for EAP

First Name:	Middle Initial:	Last Name:
Phone:	Fax:	e-mail:

Practice Information (attach any additional locations)

Practice Name:

NPI:		EIN or SSN ID:

Address 1: **City:** **State:** **Zip:**

Hours

Address 2: **City:** **State:** **Zip:**

Hours

Payment Information

Mail Payment: **City:** **State:** **Zip:**

Please indicate the area(s) of expertise Group has experience with:

☐ Addictions- Alcohol/Drugs	☐ Domestic Violence	☐ OCD
☐ Addictions- Gambling/Others	☐ Eating Disorders	☐ Training (onsite or web based)
☐ ADHD	☐ Fitness for Duty Evaluation	☐ Play Therapy
☐ Anger Management	☐ Faith Based Counseling	☐ Psychological Testing
☐ Autism/Asperger's	☐ Family Therapy	☐ PTSD/Trauma
☐ Biofeedback	☐ GLBT Issues	☐ Sexual Abuse/Offenders
☐ Career Counseling	☐ Hypnosis	☐ Sexual Abuse/Survivors
☐ CBT ☐ DBT	☐ Major Mental Illness	☐ SAP ☐ CEAP
☐ Couples/Relationship Issues	☐ CISD / CIR	☐ Social Skills Training
☐ EMDR	☐ Mood (depression/bipolar)	☐ Mandatory Referral

Population Served

☐ Preschool (1-5) ☐ Child (6-11) ☐ Adolescent (12-18) ☐ Adult (19-64) ☐ Geriatric (65+)

Additional Languages Spoken

☐ Spanish ☐ French ☐ Japanese ☐ Mandarin Chinese ☐ American Sign Other _____

Insurance Plan Information

☐ Aetna	☐ HMA, HMAA, HMSA	☐ MHNet	☐ TRI CARE
☐ BCBS	☐ Health Net	☐ Medicaid	☐ Tufts
☐ Cigna	☐ Harvard Pilgrim	☐ Medicare	☐ United Behavioral Healthcare
☐ Fallon	☐ Humana	☐ Oxford	☐ Value Options
☐ First Health	☐ Magellan	☐ PacifiCare	☐ NONE

Account Services Information

CISD/CIR	☐ yes	☐ no	**Contact Number**	
Trainings	☐ yes	☐ no	**Contact Number**	
Mgmt Referrals	☐ yes	☐ no	**SAP / DOT**	

Malpractice Insurance Information (Minimum acceptable is 1,000,000/3,000,000)

Name of Liability Carrier:	Policy Number:	Expiration Date:
$ Limit per occurrence:	$ Limit aggregate	

E4 Health Inc: Add A Provider Information

Instructions: Use one sheet for each provider being added. If the provider works at more than 2 locations or has additional certifications / licenses for us to note, please attach separately. Keep this form to add providers as your company grows.

Individual Provider Information

First Name:	**Middle Name:**	**Last Name:**	
NPI:	**Lic Type:**	**DOB:**	**Gender: M** ☐ **F** ☐
Phone:	**Fax:**	**e-mail:**	

Practice/Payment Information

Practice Name: Check Payable to:	**EIN or SSN ID:**

Address 1:				**City:**			**State:**	**Zip:**
Phone:		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
(if differs from above)	**Hours**							
Address 2:				**City:**			**State:**	**Zip:**
Phone:		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
(if differs from above)	**Hours**							
Mail To:				**City:**			**State:**	**Zip:**

Please indicate the area(s) of expertise provider has experience:

☐ Addictions- Alcohol/Drugs	☐ Domestic Violence	☐ OCD
☐ Addictions- Gambling/Others	☐ Eating Disorders	☐ On site Training
☐ ADHD	☐ Fitness for Duty Evaluation	☐ Play Therapy
☐ Anger Management	☐ Faith Based Counseling	☐ Psychological Testing
☐ Autism/Asperger's	☐ Family Therapy	☐ PTSD/Trauma
☐ Biofeedback	☐ GLBT Issues	☐ Sexual Abuse/Offenders
☐ Career Counseling	☐ Hypnosis	☐ Sexual Abuse/Survivors
☐ CBT ☐ DBT	☐ Major Mental Illness	☐ SAP ☐ CEAP
☐ Couples/Relationship Issues	☐ CISD / CIR	☐ Social Skills Training
☐ EMDR	☐ Mood (depression/bipolar)	☐ Mandatory Referral

Population Served

Preschool (1-5) ☐ Child (6-11) ☐ Adolescent (12-18) ☐ Adult (19-64) ☐ Geriatric (65+) ☐

Additional Languages Spoken

Spanish ☐ French ☐ Japanese ☐ Mandarin Chinese ☐ American Sign ☐ Other _____

Insurance Plan Information

☐ Aetna	☐ HMA, HMAA, HMSA	☐ MHNet	☐ TRI CARE
☐ BCBS	☐ Health Net	☐ Medicaid	☐ Tufts
☐ Cigna	☐ Harvard Pilgrim	☐ Medicare	☐ United Behavioral Healthcare
☐ Fallon	☐ Humana	☐ Oxford	☐ Value Options
☐ First Health	☐ Magellan	☐ PacifiCare	☐ NONE

License Information (We credential Independent Masters level licensed and above only).

Type 1	_____	Number _____	Expires _____	State	_____
Type 2	_____	Number _____	Expires _____	State	_____
CEAP	_____		SAP _____		

Liability Insurance Information (Minimum acceptable is 1,000,000/3,000,000)

Name of Liability Carrier:	Policy Number:	Exp Date:
$ Limit per occurrence:	$ Limit aggregate	

Optional, Voluntary, and Not Required

Clients sometimes request a counselor who meets specific criteria within the following categories. Responses will be used to identify you as someone who meets that criteria. The following information regarding sexual orientation, military experience, religious affiliation, and ethnic group is not used for purposes of denying or accepting an application or for participation as a network provider.

Sexual Orientation: ☐ Gay ☐ Lesbian ☐ Transgender ☐ Bisexual ☐ Straight ☐ Decline

Military Experience: Veteran ☐ Yes ☐ No
Disabled Veteran? ☐ Yes ☐ No ☐ Decline

Religious Background: ☐ Catholic ☐ Christian ☐ Jewish ☐ Islam ☐ Buddism ☐ Hindu _____ Other

Ethnicity and/or Nationality: ☐ African American ☐ Hispanic ☐ Native American ☐ Chinese ☐ Vietnamese ☐ Japanese ☐ Caucasian ☐ Pacific Islander_____ Other ☐ Decline

Disclosure Required

If you answer YES to any of the following questions, provide the date the action was initiated, date resolved or current status. We reserve the right to request additional information.

1. Have you ever been convicted of a misdemeanor related to your professional function?	☐Y ☐N
2. Have you ever been convicted of a felony in any state?	☐Y ☐N
3. Have you ever been investigated by any professional or licensure board, professional association, private payer, state or federal regulatory agency, or other authority?	☐Y ☐N
4. Has your clinical license, certification, or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked no renewed, placed on probation, or otherwise limited in any way by a licensing agency or other regulatory bodies?	☐Y ☐N
5. Have you ever voluntarily relinquished your professional license, certification or other authority to practice for any reason,	☐Y ☐N
6. Are you aware of any formal disciplinary or criminal charges pending against you?	☐Y ☐N
7. Are you aware of any complaints against you filed with any licensing, certification, or other regulatory body?	☐Y ☐N
8. Have you ever been involuntarily terminated from professional employment or a hospital staff, or terminated by a managed care organization, EAP or any other organization that granted you privileges or participation status?	☐Y ☐N
9. Have you ever resigned with knowledge of an investigation about you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	☐Y ☐N
10. Are you aware of any complaints filed against you or disciplinary actions which have been initiated or adjudicated against you by a professional employer, hospital, managed care organization , EAP or any organization that granted you privileges, compensation for professional services or other participation status?	☐Y ☐N
11. Are you now or have you ever been sanctioned or excluded from federal, state, or local government programs, including but not limited to Medicare and Medicaid?	☐Y ☐N
12. Have any malpractice suits, professional liability suits, arbitration or other proceedings ever been instituted against you due to your own negligence?	☐Y ☐N
13. Has a professional liability carrier ever denied, limited, not renewed or canceled your coverage?	☐Y ☐N

For questions, call Provider Relations 972-810-3060 or e-mail: provider.relations@e4healthcare.com

Sign and Date

I, the undersigned, attest that the information I have provided in this application is true as of the date of this signature. Additionally, I consent to allow E4 Health to obtain information about my practice history from state and local governments, public and private certification agencies and my malpractice insurer specifically for the purpose of validating the accuracy of information in this application and documents provided independently to support this application. Additionally, by signing below I have reviewed the Provider Agreement and understand my responsibilities.

Signature: _____ **Date:**_____

I have included copies of current Licensure and malpractice insurance? ☐Y ☐N

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

or

Employer identification number
___ ___ - ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

EAP PROVIDER AGREEMENT

E4 Health, Inc.

This is an agreement between E4 Health, Inc. ("e4 health") and the Provider or the Group Provider Organization ("Provider") listed on the final page of this document. E4 Health, as a provider of Employee Assistance Programs, facilitates referrals to licensed health care providers. It is our goal to provide the highest quality care to clients in need, and to assure that all ethical, legal, and professional standards are maintained.

By signing your associated Provider Application you have agree to the following below:

I. E4 Health agrees to:

1. Help facilitate referrals to Provider when such a referral is deemed necessary due to work, psychological, personal or interpersonal problems. It is also E4 Health's obligation to respond to client requests for treatment and to help such clients evaluate the best possible course of treatment.

2. E4 Health shall be responsible for payment to Provider for EAP services that are delivered to a referred client when Provider is acting under the auspices of E4 Health.

3. Provide consultation to Provider on counseling/consultation goals, objectives, length of time, type and/or delivery of service.

4. Make payment on invoices for work authorized by E4 Health in a timely fashion (typically within 3-4 weeks of the time it is received.)

II. The Provider agrees to:

1. Provide services deemed clinically appropriate, ethical, and legal according to the standards of his or her professional affiliation, State and Federal laws governing such practice, and any other applicable guidelines. Provider agrees only to provide services that he or she is qualified, authorized, and trained to provide.

2. Refer clients back to E4 Health when additional or different services are required that the Provider cannot or does not customarily offer. E4 Health will assist Provider and Client to locate an appropriate referral resource.

3. Accept, as full payment for services, the designated fees as listed in the attached schedule or cover letter. The Provider agrees not to charge clients, their employers, or their health insurance providers additional fees (i.e., "balancing billing") in excess of the agreed upon fee schedule for specific listed services. No co-pay is to be collected from the client (member). EAP is a benefit program not related to health insurance.

4. The Provider agrees to not charge members for no-shows related to their EAP sessions. If the member rolls into their insurance or goes into self pay, the provider's no-show policy can apply.

5. Submit to E4 Health, when requested, evidence of services provided. Provider will cooperate in E4 Health's quality assurance practices which can include, but will not be limited to, evaluation reports

of Provider's services, client's satisfaction with clinical services, changes in Provider's status or location, feedback on E4 Health services, etc.

6. Provider agrees to offer an initial appointment to E4 Health clients within 5 working days of the time referral is received.

7. If referrals for ongoing treatment are indicated, the Provider will review future treatment plans, fee structure, and limits of benefit coverage with the client. If indicated, Provider will contact E4 Health care manager for assistance in referral. Payment for services that go beyond the limits of the client's current benefit coverage shall be the responsibility of the client, and not E4 Health or the client's employer. A statement of 'Freedom of Choice' shall be reviewed, signed by client, and kept on file by the Provider, should a 'Self-referral' be requested by the member (client).

8. Maintain malpractice insurance at customary levels, remain licensed or certified according to applicable State laws, and notify E4 Health of any legal actions or occurrences taken against the Provider within 30 days of such action or occurrence. As a group or an individual you are responsible to send copies of updated licensure and malpractice coverage to E4 Health.

9. Respond to E4 Health staff in a timely manner and cooperate with the referral process in the interests of efficient, professional, quality, and clinically appropriate care.

10. The Provider agrees to send yearly updates of the clinician roster, updated areas of expertise, and a list of acceptable insurance plans.

11. The Provider agrees to a timely filing period for invoices of 90 days of the last service date. Invoices received after 90 days of last date of service will be denied for payment. Provider group agrees not to bill our member (client) or their employer for any amount not paid due to administrative error on the part of the group.

III. This agreement shall be in effect on the date noted on the final signature page of the Provider's associated Provider Appilcation and will remain in effect for 1 (one) year. This agreement will be automatically renewed unless either party provides written notice to the other that termination is desired. Unless the provider serves a notice to us 90 days prior to expiration of initial agreement, this will renew under the same terms, conditions, and fees for an additional one-year term.

IV. E4 Health is under no obligation to provide any number of referrals to the Provider Listed in this agreement. This agreement does not guarantee that the Provider will receive referrals from E4 Health.

V. Either party to this agreement has the right to terminate this agreement with or without cause upon written notice by one party to another. The effective date of termination of agreement is 30 days after receipt of written notice of termination. Termination does not require Provider to interrupt or terminate ongoing treatment with referred clients.

VI. Both Parties agree to maintain confidentiality with regard to medical/psychological records on each client's treatment program. Both parties agree to uphold the state and federal laws pertaining to confidentiality, privacy and security of records and clients.

VII. E4 Health and its' employees and agents shall at all times be an independent contractor and not employers or agents of Provider, and shall not hold themselves out as an employer or agent of

Provider. Provider and its' employees and agents shall at all times be independent contractors and not employees of E4 Health, and shall not hold themselves out as employees or agents of E4 Health. Neither party shall withhold on behalf of the employees of the other, any sums for income tax, unemployment insurance, social security or any other withholding or benefit pursuant to any law or requirement of any governmental body. Nothing in this Agreement is intended nor shall be construed to create any employer/employee relationship, a joint venture relationship, or to allow the parties to exercise control over one another or the manner in which their employees or agents perform the services which are the subject of this Agreement.

VIII. The Provider will, without exception, indemnify and hold harmless E4 Health from any suits, claims, losses, expenses, attorney fees, and all other costs that arise from the Provider's services to clients. Upon notice from E4 Health, Provider will resist and defend at its own expense, with legal counsel reasonably satisfactory to E4 Health, any such claim or actions. E4 Health shall, without exception, indemnify and hold harmless the Provider from any suits, claims, losses, expenses, attorney fees, and all other costs that arise from E4 Health's services to clients. Upon notice from Provider, E4 Health will resist and defend at its own expense, with legal counsel reasonably satisfactory to Provider, any such claim or actions.

IX. The Agreement shall not prevent E4 Health or the Provider from entering into any other agreements with other parties.

X. E4 Health does not send out 1099 forms unless the annual amount paid to the group is over $600.

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EAP FEE SCHEDULE

The fee payable for EAP services performed shall be as follows:

Service Description	Fee
EAP SERVICE-Member Services	$70.00
EAP-initial session 45-60 minutes	$70.00
EAP- individual 45-60 minutes	$70.00
EAP- family without client present	$70.00
EAP- family (any combination member/family)	$70.00
EAP SERVICE-Account Services	
CIR, CISD (if applicable)	$150.00/hr.
Training (if applicable)	$150.00/event
Certified SAP services (2 session)	
Travel Mileage (varies with annual IRS rates)	$0.58/mi

Please note the following:

- Face to face sessions of 45 to 60 minutes are covered in the EAP benefit.
- Group sessions and/or telephonic sessions are not a covered benefit.
- We support self-referral where appropriate once the EAP benefit is completed.
- Service dates must be in referral timeframe. Timely filing is 90 days after the last date of service.
- Regrettably, E4 Health does not reimburse for no-shows and late cancellations. Members cannot be charged for no-shows.

By signing below you are agreeing to the agreement terms and the fee schedule rates.

E4 Health, Inc.	Individual/Group Provider
Date: _____	Date: _____
	Indiv./Group Name:_____
BY:_____	(Print):_____
	(Sign):_____
	Title:_____