

EIA SUPERVISOR APPLICATION

The information requested in this application is required under a Federal Program and supercedes any and all information that may be found in a centralized state database. If any data field is not applicable to you, please mark as "N/A" rather than leaving blank.

A. GENERAL INFORMATION			
Please Print or Type Information			
Last Name	Generation (i.e., Sr., Jr., III)	Date of Birth	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
First Name	Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female	If No, list alien Registration Number _____
Social Security Number / /	Languages spoken: Primary: Secondary:	Place of Birth (City, State)	
Email Address:			
AKA Name: Please list any/all other names you may be/have been known as. List any name, other than the name listed above, that your degree(s), professional license(s) has ever been issued under (e.g. maiden name, alias, nickname) etc.			
Last Name	Generation (i.e., Sr., Jr., III)	Provider Type <input type="checkbox"/> Board Certified Behavior Analyst <input type="checkbox"/> Board Certified Associate Behavior Analyst <input type="checkbox"/> MD (specializing in Child and Adolescent Psychiatry) <input type="checkbox"/> DO (specializing in Child and Adolescent Psychiatry) <input type="checkbox"/> PhD (Clinical Psychologist specializing in Pediatrics)	
First Name	Middle Initial		
B. GENERAL INFORMATION ABOUT YOUR PRACTICE - Primary Office Practice <i>If you have additional office practices, please include them on a separate paper and attach to/submit with this application.</i>			
Legal Practice Name		Tax ID Number	
Practice Address			Suite Number
City	State	Zip Code +4	County
Office Phone Number ()	General Office Fax Number ()	Referral Fax Number ()	Office Practice Type <input type="checkbox"/> Solo/Individual <input type="checkbox"/> Multi Provider group
Date (mm/yy) you started with this practice:	E-mail Address	Are you currently accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you able to submit claims or referrals electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Phone Number ()	* If yes, how many TRICARE patients will you accept? _____	
Are there age limitations on your patients? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify age range. From ()years To ()years	Practice Manager Name _____ E-Mail Address _____ Phone Number (_____) _____ Fax (_____) _____		



C. CORRESPONDENCE ADDRESS (If different from Primary Office)				BILLING ADDRESS (If different from Primary Office)			
Name				Name			
Street Address			Suite #	Street Address			Suite #
City				City			
State		Zip Code +4	County	State		Zip Code +4	County
Office Phone Number ()		Office Fax Number ()		Office Phone Number ()		Office Fax Number ()	
D. CREDENTIALS INFORMATION							
Medicare UPIN Number				Medicare Number(s)			
National Provider Identifier (NPI)			NPI is a unique 10-digit numeric identifier assigned to all HIPPA covered healthcare providers. For more information see the CMS website: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart .				
E. QUALIFICATION AS EIA SUPERVISOR							
<i>A TRICARE authorized EIA Supervisor must meet one of the following requirements. Please indicate which applies to you:</i>							
<input type="checkbox"/> I am a Board Certified Behavior Analyst (BCBA), as certified by the Behavior Analyst Certification Board (BACB) (see http://www.bacb.com/ for details of certification); or <input type="checkbox"/> I am a Board Certified Associate Behavior Analyst (BCABA), as certified by the Behavior Analyst Certification Board (BACB) (see http://www.bacb.com/ for details of certification); or <input type="checkbox"/> I am a licensed MD or DO (select one) ___ Board Certified or ___ Board Eligible in Child and Adolescent Psychiatry; or <input type="checkbox"/> I am a Clinical Psychologist (PhD) working primarily with children							
F. PROFESSIONAL LIABILITY INSURANCE							
<i>Attach a copy of your current Professional Liability Insurance Certificate or declaration page (usually the first page of your policy) showing the name of the insured, the dates of coverage, and the amounts of coverage (you must maintain \$1 million per claim and \$3 million per aggregate, unless there are state requirements that are in different amounts). Your name must appear on the page as a covered provider.</i>							
CURRENT INSURANCE CARRIER				STATE INSURANCE FUND			
1.	Name of Carrier			2.	Name of Carrier		
	State		Zip Code		State		Zip Code
	Years with Carrier		Amounts of Coverage		Years with Carrier		Amounts of Coverage
	Effective Date		Expiration Date		Effective Date		Expiration Date
G. CONFLICT OF INTEREST STATEMENT							
Do you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgery center, or other business dealing with the provision of ancillary health services, equipment or supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information:							
Name of Organization				Percent of Investment/Ownership			
Address							
City			State			Zip Code	
Phone Number ()			Tax ID Number			Nature of business interest (i.e., Partner, owner, investor)	
Type of Organization						Size of Organization	

H. CONSENT and RELEASE / ATTESTATION FORM – Any alteration or failure to sign & date this form will delay processing your application.

I hereby give permission to HMHS and/or its designee(s) to request information regarding my professional qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certificate boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers, and any other entity needed to obtain information necessary to complete the verification process.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and or professional competence, character, ethics, or any other matter applicable to the verification procedure. I release and agree to hold harmless HMHS and its designee(s) and their respective authorized representatives, from any and all liability for any damages, costs and expenses which may result from the gathering of and good faith use of the information gathered during the verification process.

I hereby authorize the education facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers to submit information requested by HMHS, directly and/or through its designee(s) including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the verification procedure. I hereby further release and agree to hold harmless any such entity referenced in the previous sentence, their representatives, employees, and agents from any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which information is needed to complete the verification process. The photocopy or facsimile is sought with the same authority as the original, and I specifically waive written notice from any such entity or individual who may provide information based upon this authorized request.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by HMHS and may result in denial of my application or termination of my participation. I further understand that any misrepresentation, misstatement, or omission from this application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of my participation status. I agree to use my best efforts to inform HMHS in writing, within 15 days, if there is any change in the information contained in this application as a result of developments subsequent to my signing this application.

If I am accepted for participation, I consent to the inspection of my patient records as necessary for peer, utilization, and quality review purposes and agree to be bound by the EIA Supervisor Individual Corporate Services Agreement.

I understand that if my application is rejected for reasons related to my professional conduct or competence, HMHS may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I understand that I have the right to review and correct erroneous information obtained by HMHS to evaluate my verification application. This includes information obtained from any outside primary source (e.g., malpractice insurance carriers, state licensing boards, Criminal History Background Checks, etc). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require HMHS to allow a provider to review references, recommendations or other information that is peer-review protected.

I represent that the information provided in or attached to this application is complete, accurate and true to the best of my knowledge and that I have current malpractice protection through a commercial carrier. Prior to final review of this application by the HMHS, HMHS will accept additional information to correct incomplete, inaccurate or conflicting credentialing information.

I agree that the submission of the application does not constitute approval or acceptance as an EIA Supervisor provider for HMHS.

This health care organization does not discriminate on the basis of race, color, national origin, age, or disability.

If at any time during the verification process you have any questions regarding the status of your application, please call 1-800-444-5445 and ask for the Credentialing Department.

This attestation statement must be signed no more than 180 days prior to the acceptance decision. If the review and decision takes place more than 180 days after the signature below, you must re-sign and date this application page attesting that all application information remains current, complete, and correct.

Your signature is required to complete this application. STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Name (Please Print or Type)	Signature	Date

I. EIA TUTOR GENERAL INFORMATION – This page MUST be completed for each EIA Tutor you supervise. You may make additional copies as needed. If you hire a Tutor at a later date, you must submit this form to fax # 502-301-6563 and receive approval prior to Tutor providing Services.

Please Print or Type Information

Last Name	Generation (i.e., Sr., Jr., III)	Date of Birth	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
First Name	Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female	If No, list alien Registration Number _____
Social Security Number / /	Languages spoken: Primary: Secondary:	Place of Birth (City, State)	
Practice Address (include street address, city, state and zip code):			

J. EIA TUTOR QUALIFICATIONS

The EIA Tutor must have completed* a minimum of (Please check all that apply):

- 40 hours of classroom training in ABA therapy techniques (College course work does not qualify for this element) ; **and**
- 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development or related fields and currently be enrolled in course of study leading to an associate's or bachelor's degree by an accredited college or university; **or**
- 48 semester hours of college coursework in an accredited college or university; **or**
- High School graduate or GED equivalent and completed 500 hours of employment providing ABA services.

***Please submit evidence that you have ensured 40 hours of training in ABA therapy techniques and documents to support college education and current enrollment, if applicable, or copy of HS Diploma and evidence of 500 hours of employment.**

Name of Educational Institution*: _____

City and State of Educational Institution: _____

***Must be an accredited college**

K. EIA TUTOR CRIMINAL BACKGROUND CHECK

- I certify I have completed Criminal Background Check* including Federal Criminal, State Criminal, County Criminal and Sex Offender reports for the above named Tutor for **the state and county in which he or she has worked or resided during the past 10 years**. I certify, based on the results of the completed Criminal Background Check, the Tutor has not been convicted of any prohibited offenses including incest, unlawful sexual contact, abandonment of child, endangering the welfare of a child, child abuse or neglect, spousal abuse, crimes against children, (including child pornography), crimes involving violence including rape, sexual assault and homicide committed at any time, and/or physical assault, battery and drug related offenses committed within the past five years.

***Copy of Criminal Background Check must be included with the application.**

L. EIA SUPERVISOR ATTESTATION - I represent the information provided regarding the above named Tutor is complete, accurate and true to the best of my knowledge.

EIA Supervisor Name (Please Print or Type)	EIA Supervisor Signature	EIA Supervisor SSN	Date
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All Documents may be returned in the mail to:

Humana Military Healthcare Services
Attn: Network Development 3-515
PO Box 740085
Louisville, KY 40201-9927