



Instructions for Completing the EIA Supervisor Application

Complete the EIA Supervisor Application in its entirety. Incomplete applications will be returned to the applicant and will delay the application process. You will not be considered an approved provider until the application process is complete. Each application may take up to four weeks to process. Humana Military will notify you once your application has been approved.

**** Important Instructions – PLEASE READ ****

Section A – General Information. Ensure all blocks are completed.

Section B – Qualification as EIA Supervisor

- You must include a copy of your Certification(s)

Section C – General Practice Information Ensure all blocks are completed. If any blocks do not apply to you, please mark the block with “N/A”.

Section D – Correspondence Address / Billing Address. Ensure all blocks are completed

Section E – NPI Information

- The National Provider Identifier (NPI) is a unique 10-digit numeric identifier assigned to all HIPAA covered healthcare providers. **All EIA Supervisors must obtain an Individual NPI number if you do not already have one assigned to you.** To apply for an NPI number, please visit the National Plan and Provider Enumeration System (NPPES) website: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Section F – Professional Liability Insurance

Professional Liability Insurance documentation must show the name of the insured, the dates of coverage, and the amounts of coverage. Coverage must be maintained at a minimum of \$1 million per claim and \$3 million per aggregate, unless State requirements specify greater amounts.

- **Please attach a copy of your certificate of insurance.**

Section G – Conflict of Interest Statement Ensure all blocks are completed. If any blocks do not apply to you, please mark the block with “N/A”.

Section H – Consent and Release / Attestation Form EIA Supervisor must print name, sign and date. Stamped signatures are not acceptable.

Section I – EIA Tutor General Information This must be completed for each EIA Tutor that the EIA Supervisor supervises. All blocks must be completed. Please make additional copies of this page as needed.

Section J – EIA Tutor Qualifications

The EIA Tutor must have completed the 40 hours of Classroom Training **and** either **a., b., or c.**, below:

40 Hours of Classroom Training in ABA therapy techniques. You must submit evidence of the 40 hours of training in ABA techniques in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts (<http://www.bacb.com>), and

- a. **12 Semester hours of college coursework** in psychology, education, social work, behavioral sciences, human development or related fields and be currently enrolled in a course of study leading to an associate’s or bachelor’s degree by an accredited college or university; or
- b. **48 Semester hours of college coursework in an accredited college or university.** A copy of the transcript is acceptable.
- c. **High School graduate OR GED equivalent and have completed 500 hours of employment providing ABA services as verified by the provider.**

A copy of a Diploma is acceptable for the High School Grad/ GED. For the 500 hours, a copy of timesheets or pay stubs, or letter from employer on letterhead, signed and dated showing employment start date and average number of hours worked per week is acceptable.

Section K – EIA Tutor Criminal Background Check

Although the industry standard is a 7-year background check, TRICARE Policy requires a 10-year Federal, State, and County Criminal background check and Sex Offender report. **Prior to selecting an organization to conduct this service, it is important you verify with the organization, in which you are requesting Background Check services, their background checks go back at least 10 years and include Federal Criminal, State Criminal, County Criminal and Sex Offender reports.**

Humana Military cannot provide listings of organizations/vendors that provide these services. It is solely the responsibility of the provider.

Section L – EIA Supervisor Attestation EIA Supervisor must print name, sign and date. Stamped signatures are not acceptable.

Please double check your application for accuracy and completeness. Ensure all required documentation is attached before you submit your application. Incomplete applications or applications missing required documentation will be returned.

Please send your EIA Supervisor Application and supporting documentation to the following address:

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

OR

By Fax to: (502) 301-6563



The information requested in this application is required under a Federal Program and supersedes 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	First Name	Middle Initial	Generation (i.e., Sr., Jr., III)
B. 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 verify that I have a current, unrestricted State-issued license to provide ABA services (submit copy); OR <input type="checkbox"/> I verify that I have a current, unrestricted State-issued certificate as a provider of ABA services (submit copy); OR <input type="checkbox"/> I verify that I am certified by the BACB (http://www.bacb.com) as either a BCBA or a BCABA where such state-issued license or certification is available; AND <input type="checkbox"/> I verify that I employ directly or contract with EIA Tutors; AND <input type="checkbox"/> I verify that all applicable business licenses and employment or contractual documentation are maintained in accordance with Federal, State, and local requirements.			
Have you, or are you currently, authorized to provide services under the Autism Demonstration Project as an EIA Supervisor or a Tutor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
C. GENERAL PRACTICE Information- <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
Are you able to submit claims electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		* If yes, how many TRICARE patients will you accept? _____

C. GENERAL PRACTICE Information- Continued					
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 (_____) _____			
Please list the counties/states where your/tutor services are immediately available:					
D. 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 ()
E. National Provider Identifier (NPI) Information					
Organizational NPI		Individual [ABA Therapist] NPI		NPI is a unique 10-digit numeric identifier assigned to all HIPAA covered healthcare providers. For more information see the CMS website: https://nppes.cms.hhs.gov/NPPES/Welcome.do	
F. PROFESSIONAL LIABILITY INSURANCE					
Name of Carrier		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.			
State	Zip Code				
Years with Carrier	Amounts of Coverage				
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 of 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. Tutors hired at a later date must be authorized by Humana Military before rendering services to TRICARE beneficiaries.

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 Name and 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: _____

K. EIA TUTOR CRIMINAL BACKGROUND CHECK

- I attest I have completed Criminal Background Check within the past 180 days* **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.

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	Date
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All Documents may be returned to:

<p>Humana Military Healthcare Services Attn: Network Development 3-515 PO Box 740085 Louisville, KY 40201-9927</p>	OR	<p>FAX: 502-301-6563</p>
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