WHOLENESS HEALING EAP

"Solutions That Work For People At Work"

AFFILIATE PROVIDER APPLICATION

Company Name _____ Tax Identification Number* _____

Primary Address _____ City/State/Zip _____

Mailing Address _____ City/State/Zip _____

(____) ____ - (____) ____ - (____) ____ -

Primary Phone Number Secondary Number Fax Number

E-mail address(s) _____

Satellite Location (s) _____ City/State/Zip _____

_____ City/State/Zip _____

Primary Contact *(about this application)* Title Phone Number Email

Licenses*: ***Also attach copies of your current license(s)***

State	Type	License Number	Issue Date	Expiration Date

NPI# _____ Date Issued: _____

Has there ever been disciplinary action against this provider license by a licensing board in any state? ☐ Yes

Has the provider ever been sanctioned or terminated by Medicare, Medicaid, or any state health program? ☐ Yes

Has employment eligibility been verified for this provider OR for individual providers, do you attest that you are in the United States legally and eligible to work per Pub.L. no. 104-193 (1997)? ☐ Yes

Liability Insurance Carrier*: _____ Policy Number: _____

Availability for Client Services:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Earliest Time							
Latest Time							

***Submit application with copies of your current license(s), W-9 and proof of liability insurance.**

Submit application via: Wholeness Healing Center, P.C.
2608 Old Fair Road, Grand Island, NE 68803

Fax: 308-382-5315
Email: billing@wholenesshealing.com

Questions? Call 308-382-5297 ext 111

Click Here To Submit This Form