Kepro Network Employee Assistance Program (EAP) Credentialing Application

Dear Prospective or Returning Network Provider,

Kepro is a global provider of Employee Assistance Program (EAP) services serving over 200 customer accounts throughout the United States. We are looking to expand our availability of independently licensed mental health providers to administer employee assistance services to the employees, dependents, and household members of our customer accounts. If this is of interest to you, please submit this application. We have outlined below (Credentialing Application Checklist) all the information you will need to complete Kepro's application.

Credentialing Checklist - below is a checklist of all items you will need to email to Kepro's EAP Credentialing Team at Keprocredentialing@kepro.com.

- A copy of your CAQH Application (Council for Affordable Quality Healthcare, Inc.) or your CAQH number or your current resume
- Copy of your malpractice insurance
- If you provide Telemental Health sessions (virtual EAP sessions) and are not using Zoom, a copy of your signed Business Associate Agreement with your technology provider

Thank you for completing this application! We look forward to partnering with you.

(Use your computer's TAB key to move to next field)	
Date	
Name of EAP Provider (First, Last)	
Email Address	
Application Status	--
Have you discussed the expectations, session authorizations, and reimbursement rates with the Keprocredentialing@kepro.com team?	
CAQH Number	
CAQH Helpful Hints: • Download your CAQH application and email to: Keprocredentialing@kepro.com • If you do not participate with CAQH, please **register**. Copy and paste this link into your browser: https://proview.caqh.org/PR/Registration • You may download the CAQH Application to complete it if you prefer:	
Optional: If not included in the CAQH application, list additional language information (e.g., for ASL, Spanish, Portuguese), specialties or experience with critical incident debriefings.	
Practice Setting	--
Group/Practice Name	
Name of Group Administrator or Credentialing Liaison	
Email Address of Group Administrator or Credentialing Liaison	
Owner Name or Authorized Signer of Group Practice	
Email Address of Owner or Authorized Signer of Group Practice	

Kepro

Provider Survey

Data Access Protection	
Do you have administrative safeguards in place to satisfy all HIPAA PHI, security, and privacy requirements (i.e., your organization provides security services and software systems for your work)?	--
Describe the physical safeguards in your home office (i.e., locked rooms, locked file cabinets, alarms, etc.) used to prevent inappropriate use or disclosure of personal and medical information across all applicable media, how you back up electronic and/or paper files and all professionally relevant information and data, to satisfy all HIPAA, PHI, security, and privacy requirements.	
Disclosure Survey - Please answer the following questions relative to your professional history within the last five (5) years.	
1. Do you currently have any charges or sanctions filed against you in a criminal, civil, or administrative proceeding, or do you have reason to believe that such charges or sanctions will be filed?	--
2. Have you ever been convicted of a misdemeanor related to your professional functions?	--
3. Do you have pending charges of a felony in any state?	--
4. Have you ever been investigated by any professional or licensure board, professional association, private payor, state or federal regulatory agency, or other authority?	--
5. Has your clinical license, certification, DEA, CDS, or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way by a licensing agency or other regulatory bodies?	--
6. Have you ever voluntarily relinquished your professional license, certification, or other authority to practice for any reason, including as an alternative to disciplinary action?	--
7. Are you aware of any formal disciplinary or criminal charges pending against you?	--
8. Are there any current complaints against you filed with any licensing, certification, or other regulatory body?	--
9. Has it ever been determined that you have operated outside the recognized boundaries of your professional competencies?	--

10. Has your employment, hospital privileges, managed care organization or EAP participation, or other privileges or participation status ever been denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way?	--
11. 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?	--
12. 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?	--
13. Are you aware of any disciplinary actions that have been initiated against you by a professional employer, hospital staff, managed care organization, EAP, or any other organization that granted you privileges or participation status?	--
14. Are you aware of any complaints against you filed with a professional employer, hospital staff, managed care organization, EAP, or any other organization that granted you privileges or participation status?	--
15. Has a professional liability carrier ever denied, limited, not renewed, or canceled your coverage?	--
16. Are you now or have you ever been sanctioned or excluded from federal, state, or local government programs?	--
17. Have any malpractice suits, professional liability suits, arbitration, or other proceedings ever been instituted against you?	--
18. Have you ever entered a plea of guilty or nolo contendere where the offense involved the use or delivery of a controlled substance? If your conviction has been expunged, please answer No.	--
Ability to Perform Essential Function Survey	
19. Is there anything prohibiting you from having the ability to perform the essential functions of a provider in your area of practice?	--
20. Do you require accommodations in order to perform the essential functions of a provider in your area of practice?	--
21. Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients?	--

Please use the space below to explain YES answers to any questions in above survey sections:
If you answered YES to any above questions, you are **required** to send any and all supporting documentation for your credentialing application to be properly reviewed to Keprocredentialing@kepro.com. • Detailed explanation of your involvement. • Date the action was initiated. • Current status, including any final outcome. • Amount of judgment or settlement or adverse decision. • Copy of any court order, consent order and findings, and settlement agreement or other documentation regarding the current status or final resolution matter. If a matter is pending, include a letter from your attorney providing detailed information regarding current status of the matter and any related documentation, such as an indictment, statement of charges, summons, complaints, and answers.

Kepro EAP Provider Telemental Health Services Acknowledgment (Virtual Sessions) Survey	
1. Do you provide or participate in Telemental Health EAP services/sessions?	--
If you answered "yes," please review each of the following Kepro policies. Policy list: • Kepro Policy EAPTELE.001– Telemental Health: Standard Operating Procedures • Kepro Policy EAPTELE.002– Telemental Health: Licensure, Credentialing and Scope of Practice • Kepro Policy EAPTELE.003 – Telemental Health: Telemental Health: Confidentiality and Informed Consent • Kepro Policy EAPTELE.004 – Standard Operating Procedures– Standard Operating Procedures Kepro Telemental Health Office Setting and Service Delivery Guidelines	
2. I acknowledge my review of all Kepro policies listed and acknowledge continued compliance to these policies.	--

3. I understand that any use of a Telemental Health platform may be subject to periodic audits by Kepro for compliance with contractual and regulatory requirements.	--
4. I further understand that Zoom is the preferred Telemental Health platform for Kepro. I acknowledge that I will use the Zoom platform for all Telemental Health EAP sessions.	--
5. I do not use Zoom. The platform/system that will be used for the Telemental Health sessions is:	
6. Since I elect to use a platform other than Zoom for Telemental Health EAP sessions, I acknowledge this platform is fully compliant with all HIPAA and Privacy requirements. I will provide Kepro a copy of the **Signed** Business Associate Agreement (BAA) I have with my technology provider email.	--

Active License Information: Please provide details to each **active** License you currently hold in **each** state.

Title of Primary License	
State	
License Expiration Date	
Title of License #2	
State	
License Expiration Date	
Title of License #3	
State	
License Expiration Date	
Title of License #4	
State	
License Expiration Date	

Review of Kepro's EAP Provider Acknowledgement

I hereby give permission to Keystone Peer Review Organization, Inc. (Kepro) and its employees, contracted entities, agents, and representatives or its authorized designee thereof (collectively, Representatives) to obtain information about my professional education, training, licensing, competence, ethics, character, and other qualifications. I consent to the release of such information, whether in the form of transcripts, records, tapes, letters, photocopies/duplications of any of the forgoing, or verbal statements by hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians, clinics, or other individuals or organizations who or which possess information about me. Such information may be released to Kepro and its affiliates or Representatives.

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, and the Federation of State Medical Boards to release to Kepro and/or its Representatives, information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in or with Kepro.

I authorize my current and past professional liability carrier(s) to release the past five (5) years of my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Acknowledgement.

I hereby release from liability and agree to hold harmless any person or entity who or which provides the above-described information as authorized herein.

I hereby release from liability and agree to hold harmless Kepro and its affiliates and Representatives for their acts performed and statements made in connection with obtaining, reviewing, and evaluating my credentials and qualifications. I further acknowledge my cooperation by consenting to the production of such information about me as a provider of services to their insurers and enrollees. The determination of whether I am qualified to serve as a provider of services is the reason such information is needed for the review and evaluation by Kepro and its Representatives.

This application shall not be considered complete until Kepro completes a sanction query and primary source verification.

In the event I am accepted for participation by Kepro, I hereby consent to the inspection of my patient records by Kepro relating to covered members as necessary for its peer review, utilization review, quality management, and quality improvement processes and agree to be bound by the Kepro Employee Assistance Program (EAP) Service Provider Agreement.

Provider Acknowledgement	
I acknowledge that all information provided in this application and disclosure is true, correct, and complete to the best of my knowledge and belief. I will notify Kepro within three (3) business days of any material changes to the application. I understand and agree that any material misstatement or omission in this application may constitute grounds for denial or revocation of participation. I acknowledge that I have read the foregoing EAP agreement. I further agree that a photocopy of this document will serve as a duplicate original. Facsimile signatures or signatures imprinted in an electronic medium, such as .pdf format, shall be deemed to be original signatures.	
I have reviewed and agree to the Provider Acknowledgement as outlined above.	--
By typing my name, I acknowledge that I have read and understood this application/document in its entirety and agree to the content of this document.	
Date Signed	

Be sure to save a copy of this application before submitting.

Include EACH of the following items in an email to Keprocredentialing@kepro.com:

1. Completed application
2. CAQH application or resume
3. Malpractice insurance (limits of $1 million per occurrence/$3 million annual aggregate, policy number, legible expiration)
4. **Signed** Business Associate Agreement if you use a platform/system other than Zoom for Telemental Health (virtual) sessions.
5. Any supporting documents to the any survey questions that required additional information.

Next Step:

Once all your supporting documents and complete application has been received by Keprocredentialing@kepro.com, your application will be sent for further review by the Kepro Credentialing Committee. If approved as a Kepro EAP Provider, the following documents will be sent **via DocuSign**. Documents must be completed to finalize the credentialing process:

- Kepro Employee Assistance Program (EAP) Service Provider Agreement
- W9

Please be sure to check your email's spam folder if you have not received either of these documents.

This credentialing process may take several weeks. We thank you in advance for your interest and for your partnership!