

**Life Management Associates  
Participating Practitioner Application**

1848 Charter Lane  
Lancaster, PA 17601-5896  
717-394-6688 / 800-327-7770

*Please complete all questions. Your application will be returned if it's incomplete.*

---

**Provider Profile**

---

Last Name	First Name:	Middle:
Degree:	License Type:	Soc. Sec. #:
My SS # is different from my Tax ID#: <input type="checkbox"/>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:
School:	Location:	Date of Graduation:

**Office Address**

**Second Office Address**

Street:      Suite:	Street:      Suite:
City:      County:      State:      Zip:	City:      County:      State:      Zip:
Office Phone #:      Fax #:	Office Phone #:      Fax #:
E-mail:      Website:	E-mail:      Website:

\*Billing Tax ID Number (if different from Social Security #):

**Billing Address** (if different from above)

---

Street:      Suite:  
City:      County:      State:      Zip:  
Type of practice:  Solo  Group  Other  
Corporation / Group Name (if applicable):  
Checks should be made out to:  Individual Name       Group Name

**Office Hours** (give specific hours):

---

	<b>Sun.</b>	<b>Mon.</b>	<b>Tues.</b>	<b>Wed.</b>	<b>Thurs.</b>	<b>Fri.</b>	<b>Sat.</b>
Days				5-6			

Evenings

Do you have coverage for after hours?  No  Yes

If yes, please describe:

Do you have a live person answering the phone at all times?  No  Yes

Do you have a clinician on call at all times?  No  Yes

Please list any other employment in addition to private practice:

**Licensing**

List below all states in which you are licensed to practice:

State	Actively in practice now?	Original date of license	Expiration date
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

DEA#:

Expiration Date:

Medicare #:

Medicaid #:

**Board Certification (MD only)**

Name of Board	Eligible	Certified	Certification date	Planning to sit for Board?	Date
Adult	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Geriatric	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Forensic	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Administrative	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Addiction Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Other licensure or certification (i.e. Diplomate or Fellowship Status with a national professional organization – note membership):

**Hospital Affiliations**

Hospitals at which you have admitting privileges:

Hospital	Location	Psychiatric	Chemical Dependency
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

If none of the hospitals listed is in our network, are you willing to seek privileges at a network hospital?  Yes  No

---

**Clinical Profile**

---

Please indicate areas of EXPERTISE and areas of EMPHASIS in daily clinical practice. **Check no more than twelve total areas.**

<b>Populations</b>	<b>Problems</b>	<b>Disorders</b>
<input type="checkbox"/> Adults	<input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Adolescents	<input type="checkbox"/> Infertility	<input type="checkbox"/> Obsessive Compulsive
<input type="checkbox"/> Children (Latency)	<input type="checkbox"/> Rape	<input type="checkbox"/> Organic Mental Disorders
<input type="checkbox"/> Children (Preschool)	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Schizophrenic Disorders
<input type="checkbox"/> Family	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Couples	<input type="checkbox"/> Trauma	<input type="checkbox"/> Somatoform Disorders
<input type="checkbox"/> Geriatric	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> AIDS	<input type="checkbox"/> Phobias
<input type="checkbox"/> Police	<input type="checkbox"/> Medical Stress	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Physically Impaired	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Attn. Deficit Disorders
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Financial Stress	<input type="checkbox"/> Mood Disorders
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Grief	<input type="checkbox"/> Anxiety Disorders
<input type="checkbox"/> Airline Personnel	<input type="checkbox"/> Post-Traumatic Stress	<input type="checkbox"/> Personality Disorders
<input type="checkbox"/> Emergency Serv. Personnel	<input type="checkbox"/> Other:	<input type="checkbox"/> Compulsive Gambling
<input type="checkbox"/> Sex Offenders	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

---

**Specialty Areas**

---

<input type="checkbox"/> Critical Incident Debriefing	<input type="checkbox"/> Second Opinion	<input type="checkbox"/> Medication Evaluation
<input type="checkbox"/> Forensic	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Med. Eval for Group Colleague
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> IME – Onsite	<input type="checkbox"/> Medication Management
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> IME – Office Only	<input type="checkbox"/> Med. Mgt. – Grp. Pract. Colleague
<input type="checkbox"/> Neuropsychological Testing	<input type="checkbox"/> Workers Comp – Eval.	<input type="checkbox"/> ECT – Inpatient
<input type="checkbox"/> Biofeedback**	<input type="checkbox"/> Workers Comp – TX	<input type="checkbox"/> ECT – Outpatient
<input type="checkbox"/> Hypnosis**	<input type="checkbox"/> Disability Evaluation	<input type="checkbox"/> Mandatory Referrals
<input type="checkbox"/> EAP**	<input type="checkbox"/> Disability – TX	<input type="checkbox"/> QME

---

**Do you self-identify as:**

---

Certified Pastoral Counselor**	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ordained Clergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Christian Counselor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gay / Lesbian	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bicultural	<input type="checkbox"/> Yes	<input type="checkbox"/> No (specify):
Hearing Impaired	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**\*\* You must include proof of certification**

Languages (other than English) in which you conduct treatment:

Your ethnicity (optional – for members who request clinicians of the same ethnic group):

---

**Managed Care Experience**

---

A. Do you currently participate or have you participated in any Managed Care Program?  Yes  No

Please list organizations:

B. Have you had experience in any of the following Managed Care activities?

Pre-authorization  Yes  No

Concurrent Review  Yes  No

Quality Assurance  Yes  No

Other

C. Describe the experience you have:

---

**Clinical Experience**

---

1. Please summarize the major characteristics of your practice population (age, sex, diagnosis, etc.):

2. How many patients are in your current clinical caseload?

**# of patients**

Inpatient only

Outpatient psychotherapy only

Outpatient medication monitoring only

Outpatient psychotherapy and medication management combined

Other (specify)

Total

3. Please list training, education or supervision sessions (for yourself) which you regularly attend.

---

**Liability Information**

---

Professional liability / malpractice insurance:

Carrier:

Expiration Date:

Coverage limit per incident:

Coverage limit per aggregate:

Please respond to each of the following questions. If you answer yes to any of these questions, please explain clinical details on a separate sheet.

1. Has your clinical license ever been revoked, suspended or limited?  Yes  No

Is there an action pending?  Yes  No

2. Within the past five years, have you ever been subject to disciplinary review by any of the following?

State Licensing Board  Yes  No

State:            Date

County, State or Professional Society  Yes  No

State            Date

Hospital Medical or Clinical Staff  Yes  No

Hospital:            Date

Address:

3. Within the past five years, have you ever been denied hospital privileges?  Yes  No

4. Has your narcotics license ever been revoked, suspended or limited?  Yes  No

5. Within the past five years, have you ever been denied professional liability insurance, has your insurance ever been cancelled, has renewal been refused, or have premiums been surcharged because of claims?  Yes  No

During the past five years, have you been a party to malpractice suits which went to the final disposition and resulted in payment to the Plaintiff?  Yes  No

If the answer is yes, please complete the following:

<b>Year</b>	<b># of Suits</b>	<b>Total Payment(s)</b>	<b>Nature of Suit</b>
-------------	-------------------	-------------------------	-----------------------

6. Presently, do you have any malpractice suits pending against you?  Yes  No

If answer is yes, you MUST attach an explanation of the (1) nature of the suit; (2) the clinical events leading up to the suit.

7. Within the past five years, have you ever resigned from the staff of any hospital or professional organization because of problems regarding privileges or credentials?  Yes  No

8. Within the past five years, have you ever been convicted of or pled guilty to a felony?  Yes  No

9. Do you suffer from any physical or mental condition which impairs your ability to practice?  Yes  No

10. Within the last five years, have you had any chemical dependency, alcohol or other substance condition?

Yes  No

**If you've answered "yes" to any of the previous questions, please submit material of explanation. Your application will be returned incomplete if materials are excluded.**

