ACU-CARE
Acupuncture in Managed Care

# Application

This application will become part of your "Provider Agreement." Please complete the form either by typing or clearly printing the information, and return it at your earliest convenience to our offices. Once approved we will mail you a copy of your agreement and other information you might need.

## provider information

First Name: ____________________ Last Name: ____________________ M.I.: ______

Gender: ☐ Female ☐ Male Date of Birth: ____________________ Country of Birth: ____________________

**acupuncture license number:** ____________________
Date of License: ____________________ Valid through: ____________________

**social security number:** ________-______-________
**federal tax i.d. number:** ______-____________________

**Ind. NPI#** ____________________

**malpractice carrier (limits must be 1M/3M):** ____________________
Policy Number: ____________________ Certificate Number: ____________________
Limit of Policy: ____________________ Valid through: ____________________

**general liability carrier (limits must be 1M/2M):** ____________________
Policy Number: ____________ Limit of Policy: ____________ Valid through: ____________

**school attended:** ____________________
Graduation Date: ____________________

**specialties:** ____________________

**foreign languages:** spoken by applicant: ____________________ by staff: ____________________

**email address:** ____________________ **website:** ____________________

**mailing address:** ____________________
City ____________________ State ____________ Zip ____________

## clinic information

**location 1** Tax ID# ____________________ Grp. NPI # ____________________
*If different from above* *if applicable*

Clinic Name ____________________
Street Address ____________________ Suite ____________
City ____________________ State ____________ Zip ____________ County ____________
Phone: (______) ____________________ Fax: (______) ____________________

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**location 2** Tax ID# ____________________ Grp. NPI # ____________________
*If different from above* *if applicable*

Clinic Name ____________________
Street Address ____________________ Suite ____________
City ____________________ State ____________ Zip ____________ County ____________
Phone: (______) ____________________ Fax: (______) ____________________

# additional information

1. Length of time in Practice:_________________________ Do you practice as a: ☐ Sole practitioner ☐ Partnership ☐ Corporation
2. What are your office hours? Monday_______________ Tuesday_______________ Wednesday_______________
   Thursday_______________ Friday_______________ Saturday_______________ Sunday_____________
3. What style(s) of Acupuncture do you practice?_______________________________________
4. Do you use any of the following: ☐ Electro Stimulation ☐ Moxa ☐ Cupping ☐ Massage ☐ Exercises
5. Do you use Herbs? ☐ Yes ☐ No If "yes," in what form?_______________________________
6. How often do you use Disposable Needles?_______________________________________
7. Are you Available for Emergency? ☐ Yes ☐ No
8. Do you have a back-up Acupuncturist when you are not working? ☐ Yes ☐ No
9. Do you treat: ☐ Alcohol Addiction ☐ Drug Addiction ☐ HIV Infection
10. Do you treat Medi-Cal Patients? ☐ Yes ☐ No What percentage?_______________________
11. Do you currently treat Workers' Compensation Patients? ☐ Yes ☐ No Have you treated ☐ 1-5 ☐ 5-10 ☐ Over 10 this year?
12. Do you have any other Licenses? If so what are they:_______________________________
13. Are you licensed to practice Acupuncture in other states? ☐ Yes ☐ No Which States?_______________
14. Are you a member in a professional Acupuncture association? ☐ Yes ☐ No Which one?_______________
15. Do you refer patients to other Professionals? ☐ Yes ☐ No
16. Who referred you to Acu-Care?_______________________________________
17. Number of Employees in your office:________________Who should we contact?_______________________

**Please answer all of the questions to the right. Sign below to indicate that that you have truthfully and accurately answered everything, on this application, to the best of your knowledge and that you have read the "Important Note" below.**

1. Any action or charges against you in the past 5 years? ☐ Yes ☐ No
2. Has your Acupuncture License ever been revoked, suspended or subject to probation? ☐ Yes ☐ No
3. Have you ever been convicted of a felony? ☐ Yes ☐ No
4. Has your Malpractice coverage ever been denied? ☐ Yes ☐ No
5. Do you have any physical or mental limitation (including drug or alcohol dependency) that would interfere with the practice of your speciality? ☐ Yes ☐ No

**IMPORTANT NOTE: Acupuncturists must credential and obtain individual membership through Acu-Care and are not under contract simply by affiliation with another Acu-Care Member. Back-up acupuncturists must also have individual membership with Acu-Care to maintain benefit levels. No benefits will be paid otherwise.**

Return your completed application to our office with the following. ***(See separate checklist for complete list of items needed to satisfy credentialing materials.)***:

1. A copy of the first page of your Malpractice Insurance (must be at least 1M/3M)
2. A copy of the first page of your Office Liability Policy (must be at least 1M/2M)
3. Your Current C.V. (Resume detailing, at minimum, current work history for the last five years, explaining any gaps of six months or more)
4. A completed W9 form
5. A signed contract

Signature:_______________________________________ Date:_______________________