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: _____-_____

Individual 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:_____

personal email address (mandatory): _____

business email address: _____ **website:** _____

mailing address: _____

City _____ State_____ Zip_____

clinic information

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

Clinic Name_____

Street Address_____ Suite_____

City _____ State_____ Zip_____ County_____

Phone: (_____)_____ Fax: (_____)_____

---

location 2 Tax ID#_____ *If different from above* Grp. NPI # _____ *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:_____

I hereby attest that the information I have provided in this application is true and correct.