

# ACU-CARE

## Application

Acupuncture in Managed Care

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: \_\_\_\_\_ Degree(s) (B.A., B.S., MSOM etc): \_\_\_\_\_

specialties: \_\_\_\_\_

foreign languages: \_\_\_\_\_

personal email address (required): \_\_\_\_\_

business email address: \_\_\_\_\_

Other email address (e.g. Billers, Assistants, Owner): \_\_\_\_\_

Other 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: \_\_\_\_\_

Please answer all of the questions to the right. Sign below to indicate 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.*