Ancillary Provider Pre-Screening Form

Please print & complete this form in its entirety and fax to (650) 497-6898.

Organization

Legal Name:			
DBA:			
Primary Service Location Address:			
City, State, Zip:			
Phone Number:		Fax Number:	
Does the business have a website? ☐Yes ☐No		Website:	

Provider Identification Numbers

NPI Number:	
Tax ID Number:	
Medicare Provider ID Billing Number **(attach copy)**:	
State License Number **(attach copy):**	
Business License Number **(attach copy)**:	

Administrative Information

Office Manager:			
Address:			
City, State, Zip:			
Phone Number:		Fax:	
Email address:			
Credentialing Contact:			
Address:			
City, State Zip:			
Phone Number:		Fax:	
Email Address:			

Billing Information (attach copy of W-9)

Contact Name:			
Billing Address:			
City, State Zip:			
Phone Number:		Fax Number:	
Email Address:			

Accreditation Information

Is the organization accredited? ☐ Yes ☐ No		Accredited by:	
Expiration of the current accreditation (**attach copy**):			

Insurance Information

Malpractice: (**attach copy of your current Policy Certificate or Declarations Page)**	Carrier_____

Membership Denial

Have you ever been denied membership in Affinity or another IPA?	☐ Yes ☐ No

Additional Office Information

Hours of Operation:	Mon		Tues		Wed		Thurs	
	Fri		Sat		Sun			
Do you use Electronic Health Records: ☐ Yes ☐ No					If Yes, what EHR?			
Electronic Claim Submission: ☐ Yes ☐ No					Does business have internet access? ☐ Yes ☐ No			

Please check the type of service(s) you provide:

☐ Acute Hospital	☐ Home Health	☐ Orthotics/Prosthetics
☐ Ambulance	☐ Hospice	☐ Physical Therapy
☐ Ambulatory Surgery Center	☐ Infusion	☐ Psychiatric Hospital
☐ Behavioral Health	☐ Mammography	☐ Speech Therapy
☐ Dialysis	☐ MRI/CT	☐ Skilled Nursing Facility
☐ DME	☐ Occupational Health	☐ Other (specify) _____ _____

Additional Locations Supplemental Form

If also completing the questionnaire for additional locations please complete this form and include one copy of shared documents (i.e., W9, Malpractice, Business License, State License, Accreditation, etc.)

Additional Location #1

Organization Name:			
Address:			
City, State Zip:			
Phone Number:		Fax Number:	
Email:		Website Address:	
NPI:			

Additional Location #2

Organization Name:			
Address:			
City, State Zip:			
Phone Number:		Fax Number:	
Email:		Website Address:	
NPI:			

Additional Location #3

Organization Name:			
Address:			
City, State Zip:			
Phone Number:		Fax Number:	
Email:		Website Address:	
NPI:			

INTERNAL USE ONLY	
Received By:	Received Date:
<u>Products:</u> ☐ Legacy ☐ Stanford Advantage	<u>Rates:</u> ☐ FS95/100 ☐ FS100/100 ☐ Other _____ _____