



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accredited by:		
Expiration of the current accreditation (attach copy):			

Insurance Information

Malpractice: (attach copy of your current Policy Certificate or Declarations Page)	Carrier _____
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Membership Denial

Have you ever been denied membership in Affinity or another IPA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Additional Office Information

Hours of Operation:	Mon		Tues		Wed		Thurs	
	Fri		Sat		Sun			
Do you use Electronic Health Records: <input type="checkbox"/> Yes <input type="checkbox"/> No					If Yes, what EHR?			
Electronic Claim Submission: <input type="checkbox"/> Yes <input type="checkbox"/> No					Does business have internet access? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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

<input type="checkbox"/> Bariatric Testing <input type="checkbox"/> Diagnostic Testing (Outpatient) <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Laboratory <input type="checkbox"/> Mammography <input type="checkbox"/> MRI/CT/Radiology <input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Pathology <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Sleep Study <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other *(specify) _____ _____	<p>*Please note that some ancillary services are the financial responsibility of our contracted health plans. Therefore Affinity Medical Group will not pursue contracting with these ancillary providers.</p>
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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> <input type="checkbox"/> Legacy <input type="checkbox"/> Stanford Advantage	<u>Rates:</u> <input type="checkbox"/> FS95/100 <input type="checkbox"/> FS100/100 <input type="checkbox"/> Other _____ _____