Advantage Billing Solutions – Network Management Form

Please provide all of the following information. During the application process I will contact you for any other information I may need. If you would prefer that I DO NOT sign pre-screening forms or applications on your behalf, please advise me and I will forward completed materials to you for submission.
Checklist – please check off the following items indicating that they are attached to this form.
This form was created for completion in Word, if you do not have Word, please print and complete. You will need to answer several questions on a separate sheet of paper if not completed in Word.

☐ Copy of current license(s). If not on your license, include original license date:

☐ Completed New Client Information Form

☐ Copy of highest level degree

☐ Copy of malpractice coverage face sheet. If the address and ph # of your carrier are not on your face sheet, include that information here:

☐ Copy of your current C.V. containing complete dates of employment and education. Dates must include a beginning and ending month and year. If any gaps of 6 months or more in employment, please include narrative explaining gaps.

☐ IRS Documentation confirming your tax identification number and legal business name. A W-9 is not acceptable. (Provide this information only if applying to Medicare.)

Please Complete the Following:

6 Specialty Areas in order of most experience/expertise (e.g. Sexual abuse, OCD, children, depression).

If you provide specialized services that are not adequately available in your area, please explain.

List the populations and percentage of each that your treat (pre-school, adolescent, adult, etc.)

My office is within one block of public transportation ☐ Yes ☐ No

My office is handicapped accessible ☐ Yes ☐ No

I speak a foreign language ☐ Yes ☐ No If yes, please list

I can use sign language in therapy ☐ Yes ☐ No

If you have been with your current malpractice carrier less than 5 years, provide the name, address, ph # and policy # of your previous carrier here:

Please check all of the following areas in which you are ***CERTIFIED*** to treat:

☐ Workman's Comp ☐ EAP ☐ Substance Abuse Professional ☐ Disability

☐ Court Custody Evaluations

Provide the name, address and phone # of the individual who will cover your patients when you are unavailable

If a patient requires hospitalization, I refer to

List all certifications relevant to your training and the date certified and expiration (e.g. CEAP, Critical Incident, SAP, etc.)

List any professional associations and memberships along with any position(s) held and effective dates

List any teaching appointments including name of school, position and status (full-time, adjunct, etc.) along with dates, address and ph # of school.

Date when you met 2 years or 3,000 hours of post-master's degree experience and supervision
Name, address and ph # of supervising individual

If you have ever been charged with a felony, fired, suspended, investigated, revocation of license or participation in a program or a claim filed against your insurance, provide complete details of this event.

Include any details surrounding training, internship or fellowship including position held, facility, address, ph #, supervising party's name and dates

I am available for emergency/same day appointments ☐ Yes ☐ No

I am available for evening or weekend appointments if necessary ☐ Yes ☐ No

Average waiting time for a new patient routine visit

Emergency phone # Cell phone # Pager #

Indicate all of the following areas in which you can demonstrate sufficient training and clinical Experience. **Please add any specialties not listed.**

☐ Anxiety/Panic Disorders ☐ ADHD/Learning Disorders ☐ EAP Assess & Referral
☐ Chemical Dependency ☐ Child/Adolescent Disorders ☐ Dual Diagnosis
☐ Chronic Pain ☐ Eating DO ☐ Co-Morbidity
☐ Conduct DO ☐ Group Therapy ☐ Marriage/Family
☐ Depression ☐ MPD ☐ Gay & Lesbian Iss.
☐ Gender Identity ☐ Grief ☐ Men's Issues
☐ Women's Issues ☐ OCD ☐ PTSD
OTHER:

Start Date of Current Practice:

Country & State of Birth:

If patient records are not kept at your current office location, please give storage address: