The Natural Choice in Healthcare. ™

Credentialing Application

Be sure to attach copies of all items that are requested below in order to avoid delays:

- ❑ **Signed participating provider agreement**
- ❑ **Copy of driver's license**
- ❑ **Practice/Specialty License**
- ❑ **DEA Certificate (if applicable)**
- ❑ **Malpractice insurance declaration page**
- ❑ **Office liability declaration page**
- ❑ **Fee Schedule**
- ❑ **X-ray equipment certifications for State Regulatory Agency**
- ❑ **X-ray certifications/licensure for individual(s) taking radiographs**
- ❑ **A minimum of one photograph per each room in facility and one photograph of the front exterior**
- ❑ **Certifications**
- ❑ **Acceptance letter(s) for hospital affiliations**

Our purpose is to select and organize a panel of providers who have the desire and the skills to provide high quality care in a cost-effective manner. Credentialing means we will examine the information provided by you on your application, as well as additional criteria we may select. We will then screen your application to see if you qualify. All information requested is a requirement for your application to be considered. You can request in writing to review the information submitted in support of your credentialing application including information submitted by outside primary sources.

.General Information

Last Name_____ First Name_____ M.I._____

Degree_____ Date of Birth _____

Foreign Languages you speak:_____

License Number_____ Year Issued _____ State Issued_____

List all other states in which you hold or have held licenses: _____

.Principal Office Information

Clinic Name_____ Phone_____ Fax_____

Address_____ City_____ State_____ Zip_____ County_____

E.Mail Address _____ Web Site _____

Office Contact Name_____Title_____

Number of years at principal location_____ Practice is a: corporation sole proprietorship partnership other

Office Size (# of square feet)_____ # of treatment tables_____ # of examination rooms_____

Does your office provide for handicap access? Y N Type of facility:_____

Office hours: Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____ Sun_____

Specify the providers performing services at each clinic: _____

Emergency service? Y N By whom?_____ Phone _____

Secondary Office Information

Address_____ Phone_____ Fax_____

City_____ State_____ Zip_____ County_____

Office hours: Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____ Sun_____

Hospital Affiliations

Primary Hospital affiliation _____ City_____

Tax and Billing Information

You must submit a sample of an actual submitted HCFA 1500 claim form of a current patient who has been treated within the last month and must contain an itemization of no less than four services.
You must submit a full fee schedule listing all applicable CPT codes with your fee for each service.

Individual Tax ID#_____ Do you use this as a Tax ID Number to bill for any services? Y N

Social Security # _____ Do you use this as a Tax ID Number to bill for any services? Y N

Group Tax ID # _____ Do you use this as a Tax ID Number to bill for any services? Y N

Indicate name and Tax ID Number as would appear on a W-9 for tax filing purposes:

Entity full name _____ Tax ID Number_____

Do you use a billing company or have a central billing office? If different from clinic address, indicate below:

Name _____Phone _____ Fax _____

Address _____City _____ State_____ Zip_____

Do you have the capability to bill electronically? Y N

Professional Liability

Please furnish us with proof of liability insurance, along with named insured, including associate doctors and all staff. (Minimum requirements of $1m/$3m)

Carrier _____ Policy Number _____

Policy Expiration Date _____ Coverage limits _____

Malpractice Action

Number of pending claims (if none, please write "none.") _____ Number of prior judgements or settlements _____

For each malpractice action, attach an explanation to this application.

Business Liability

You must furnish us with proof of business liability insurance for each clinic location.

Carrier _____ Policy Number_____

Policy Expiration Date _____ Coverage _____

Professional Affiliations

Indicate if you participate or have participated in any professional societies:

_____ from_____ to_____

_____ from_____ to_____

_____ from_____ to_____

Other (please specify) _____

Professional Education

Medical School Education:

Institution _____

Address _____ City _____ State _____ Zip_____

Degree _____ Dates: from _____ to _____

Please Attach Educational Commission of Foreign Medical Graduate Certificate – ECFMG (if applicable)

Internship:

Institution _____

Address _____ City _____ State _____ Zip_____

Specialty _____ Dates: from _____ to _____

Residency:

Institution _____

Address _____ City _____ State _____ Zip_____

Specialty _____ Dates: from _____ to _____

Other Residency/Fellowship – (specify):

Institution _____

Address _____ City _____ State _____ Zip_____

Specialty _____ Dates: from _____ to _____

Professional Certifications

If you are board certified by a specialty please indicate name of board and date of certificate.

Primary Specialty Board _____ Date Certified _____ Exp. Date _____

Secondary Specialty Board _____ Date Certified _____ Exp. Date _____

If you have applied to a specialty board for examination, give the name of board and the date of scheduled examination.

_____ Date _____

Previous Practice .

List in chronological order all previous professional experience for the last 5 years, beginning with current practice. If necessary, use a separate sheet.

Current Practice _____ Dates _____

Name and title of practitioner responsible for evaluating your performance _____

Address _____ City _____ State _____ Zip_____

Reason for leaving _____

Prior Practice _____ Dates _____

Name and title of practitioner responsible for evaluating your performance _____

Address _____ City _____ State _____ Zip_____

Reason for leaving _____

Prior Practice _____ Dates _____

Name and title of practitioner responsible for evaluating your performance _____

Address _____ City _____ State _____ Zip_____

Reason for leaving _____

Professional References .

List names, address, and telephone numbers of three professionals in the same discipline who have supervised your clinical practice or have worked with you professionally within the past three years, or have personal knowledge of your current professional competence and conduct.

Name _____ Institution or practice name _____

Address _____ City _____ State_____ Zip _____

Telephone _____ Relationship _____ Dates _____

Name _____ Institution or practice name _____

Address _____ City _____ State_____ Zip _____

Telephone _____ Relationship _____ Dates _____

Name _____ Institution or practice name _____

Address _____ City _____ State_____ Zip _____

Telephone _____ Relationship _____ Dates _____

Practice Profile

This information is a requirement for consideration of this application to become a preferred provider in this network.

Full Major Med _____% Managed Care _____% Workers' Comp _____% PI _____% Cash_____%

Averages per month: New Patients _____ Patient Visits _____ Services $ _____ Collections $ _____

Do you accept Medicare? Y N If yes, Medicare Provider # _____ Are you a participating provider? Y N

Do you accept Medicaid? Y N If yes, Medicaid Provider # _____ Are you a participating provider? Y N

If Applicable:

DEA # _____ Exp. Date _____

SC Controlled Drug Substance Certificate _____ Exp. Date _____

Staff Roster

List all by title: (i.e., CA, CT, DC, DO, LAc, MD, ND, OT, PT, RT, Herbalist, Massage Therapist, Nutritionist)

Full-time (FT), Part-time (PT), Independent Contractor (IC)	Name	Professional Title	State License **(Attach copy of all licenses)**	Board Certified	Professional Fee **(A) included in facility or (B) billed separate**

Practice Review

If you answer any of the following questions "Yes", please give details on a separate sheet of paper. Each case will be judged on its merits with respect to its effect on your professional qualifications and competence.

1. Has your license to practice medicine in any jurisdiction ever been investigated, reviewed, limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied, not renewed; or have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? Y N
2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, voluntarily relinquished during or under threat of termination for any reason? Y N
3. Have you ever been investigated, sanctioned, or suspended by Medicare or Medicaid? Y N
4. To your knowledge, has a report, complaint, or other filing regarding your practice or professional conduct or a malpractice payment made on your behalf ever been made to the National Practitioner Data Bank or any state licensing board? Y N
5. Have you ever been convicted of a felony or misdemeanor, or are you under criminal investigation with respect to such conduct? Y N
6. Have you ever been named in a professional liability, judgement, settlement, case or has a professional liability claim ever been assessed against you or are there any professional liability cases pending against you? Y N
7. Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk? Y N
8. Have you ever practiced without professional liability coverage? Y N
9. Do you currently have any medical, chemical dependency or psychiatric problems that might adversely affect your ability to practice medicine or surgery? Y N
10. Have your clinical privileges, request for privileges or medical/professional staff membership, or renewal thereof, at any hospital or health care facility ever been investigated, limited, restricted, reduced, suspended, revoked, denied or subject to a warning or any disciplinary action or probationary condition, or has such an action been recommended by a medical/professional staff committee, any health facility, or governing body? Y N
11. Do your nurse practitioners, physician assistants, or other non-physician providers provide care to patients in your practice? Y N

Application Agreement

All information submitted by me in this application is true to my best knowledge and belief. I fully understand that any significant misstatement in application may constitute cause for denial or my application or termination of a resulting participation agreement.

I understand that Alternative Healthcare Options, LLC is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct, and judgement in order to make appropriate recommendations to the management of Alternative Healthcare Options, LLC.

I also understand, that I am responsible for producing adequate information for the proper evaluation of this application. I also agree to provide updated information regarding all questions in this application as such information becomes available, and such additional information as may be requested by Alternative Healthcare Options, LLC or its authorized representatives. I understand that failure to produce this information or any additional information requested will prevent my credentialing application form being evaluated and acted upon, and may result in immediate suspension or termination of my services.

I affirm that the information given in this credentialing application is accurate and represents the current level of my training, experience, capability, and competence to perform any professional duties. As a condition of submitting this credentialing application, I understand that any misrepresentations or misstatements in or omissions from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application as an individual provider. If my services are used prior to the discovery of such misrepresentations, misstatements, or omissions, such discovery may result in immediate suspension or termination of our agreement.

Print Name _____

Signature _____ Date _____

Acupuncture

Diagnostic Procedures

Circle the frequency that best describes your use of each of the following procedures.

	Always	Frequently	Occasionally	Never
1. History/Physical Examinations	A	F	O	N
2. Pulse Diagnosis	A	F	O	N
3. Tongue Diagnosis	A	F	O	N
4. Akabani Technique	A	F	O	N
5. Eye Diagnosis	A	F	O	N
6. Aurirular Diagnosis	A	F	O	N
7. Facial/Hand Diagnosis	A	F	O	N
8. Skin Color	A	F	O	N
9. Five Elements	A	F	O	N
10. Other, _____	A	F	O	N

Do you dispense or sell vitamins, nutrients, herbs or other products? Y N If yes, give details: _____

_____

Do you use Disposable Needles exclusively? Y N

Do you use adjunctive modalities in your office? Y N

If yes, check below:

Hot Packs/Cold Packs
Diathermy
Soft Tissue/Massage-type Therapy
TENS
Hydrotherapy/Whirlpool
Other, _____

Techniques Commonly Used in Your Office .

Circle the frequency that best describes your use of each of the following procedures.

	Always	Frequently	Occasionally	Never
1. Acupuncture without electricity	A	F	O	N
2. Acupuncture with electricity	A	F	O	N
3. Cupping	A	F	O	N
4. Plum Blossom	A	F	O	N
5. Tuina	A	F	O	N
6. Moxabustion	A	F	O	N
7. Four needle technique	A	F	O	N
8. Acupressure	A	F	O	N
9. Laser Acupuncture	A	F	O	N
10. Auricular Acupuncture	A	F	O	N
11. Scalp Acupuncture	A	F	O	N
12. Hand Acupuncture	A	F	O	N
13. Aqua-puncture	A	F	O	N
14. Five Elements	A	F	O	N
15. Qi Gong	A	F	O	N
16. Detox (NADA)	A	F	O	N
17. Trigramatic Mgnt./Triangular Equilib.	A	F	O	N
18. Myofascial Release	A	F	O	N
19. Other,_____	A	F	O	N

Notes:

Chiropractor

Diagnostic Procedures

Circle the frequency that best describes your use of each of the following procedures.

	Always	Frequently	Occasionally	Never
1. History/Physical Examination	A	F	O	N
2. X-Rays	A	F	O	N
3. Thermography	A	F	O	N
4. Cineradiography	A	F	O	N
5. EKG	A	F	O	N
6. Vascular Analysis (Doppler, Plethysnography)	A	F	O	N
7. Clinical Laboratory	A	F	O	N
8. Hair/Mineral Analysis	A	F	O	N
9. Cytotoxic White Cell Testing	A	F	O	N
10. Paraspinal EMG	A	F	O	N
11. Neurocalometer (Nervoscopes, Thermoscribes)	A	F	O	N
12. Comparative Muscle Tester	A	F	O	N
13. Isometric Strength Testing Unit	A	F	O	N
14. Isokinetic/Isodynamic Testing Unit	A	F	O	N
15. Other, _____	A	F	O	N

Do you employ X-ray Technicians? Y N

Enclose copies of all technician and facility certifications as applicable.

Equipment: On-site X-ray Y N If yes, Make _____ Model _____

Year _____ KV _____ MA _____ Table Bucky _____ Wall Bucky _____

Explain your protocols for X-rays _____

Do you refer radiology to an outside facility for production or reading of radiographs? Y N

If yes, please list most frequently used referral facilities.

Name of facility _____ Telephone _____

Address _____ City _____ State _____Zip _____

Techniques Commonly Used in Your Office .

Circle the frequency that best describes your use of each of the following procedures.

	Always	Frequently	Occasionally	Never
1. Activator	A	F	O	N
2. Applied/Clinical Kinesiology	A	F	O	N
3. Applied Spinal Biomechanical Engineering	A	F	O	N
4. Chiropractic Biophysics	A	F	O	N
5. Flexion/Distraction (Cox, Leander, etc.)	A	F	O	N
6. Diversified/States	A	F	O	N
7. Gonstead	A	F	O	N
8. Logan Basic	A	F	O	N
9. Motion Palpation	A	F	O	N
10. Palmer Upper Cervical Specific (HO)	A	F	O	N
11. SOT	A	F	O	N
12. Thompson	A	F	O	N
13. Other, _____	A	F	O	N

Do you dispense or sell vitamins, nutrients or other products? Y N If yes, give details: _____

_____

Do you have rehabilitation equipment in your office? Y N If so, please list the type of rehab equipment: _____

_____

Do you use adjunctive modalities in your office? Y N

If yes, check below:

Acupuncture	Hot Packs/Cold Packs
Diathermy	Hydrotherapy/Whirlpool
Soft Tissue/Massage-type Therapy	Ultrasound
Electrical Stimulation	Intermittent Static Traction
Intersegmental Traction	Other, _____

Do you perform your own physical therapy procedures? Y N

If not, indicate with a check mark how needed physical therapy services are accomplished.

On-site Physical Therapist (employees or independent). Include details on “Staff Roster”.

Off-site Physical Therapist (open script or referral). Include details below.

Name of facility _____ Telephone _____

Address _____City _____State _____ Zip _____

Naturopathic

Diagnostic Procedures .

Circle the frequency that best describes your use of each of the following procedures.

	Always	Frequently	Occasionally	Never
1. History/Physical Examination	A	F	O	N
2. X-Rays	A	F	O	N
3. Clinical Laboratory	A	F	O	N
4. Complimentary Laboratory	A	F	O	N
5. EKG	A	F	O	N
6. Vega/Vol	A	F	O	N
7. Iridology	A	F	O	N
8. Pulse/Tongue Diagnosis	A	F	O	N
9. Clinical Kinesiology	A	F	O	N
10. Gyn Exam	A	F	O	N
11. Other, _____	A	F	O	N

Do you employ X-ray Technicians? Y N

Enclose copies of all technician and facility certifications as applicable.

Equipment: On-site X-ray Y N If yes, Make _____ Model _____
Year _____ KV _____ MA _____ Table Bucky _____ Wall Bucky _____

Explain your protocols for X-rays _____

Do you refer radiology to an outside facility for production or reading of radiographs? Y N

If yes, please list most frequently used referral facilities.

Name of facility _____ Telephone _____

Address _____ City _____ State _____Zip _____

Do you employ Laboratory Technicians? Y N

Enclose copies of all technician and facility certifications as applicable.

Equipment: On-site Laboratory Test Y N If yes, Make _____ Model _____
Year _____ KV _____ MA _____ Table Bucky _____ Wall Bucky _____

Explain your protocols for Laboratory Testing_____

Do you refer Laboratory Testing to an outside facility for production or reading of results? Y N

If yes, please list most frequently used referral facilities.

Name of facility _____ Telephone _____

Address _____ City _____ State _____Zip _____

Techniques Commonly Used in Your Office .

Circle the frequency that best describes your use of each of the following procedures.

	Always	Frequently	Occasionally	Never
1. Naturopathic Manipulation	A	F	O	N
2. Hydrotherapy	A	F	O	N
3. Bilateral Nasal Specifics	A	F	O	N
4. Ultrasound	A	F	O	N
5. Diathermy	A	F	O	N
6. Electrical Muscle Stimulation	A	F	O	N
7. IV Nutrition	A	F	O	N
8. Acupressure	A	F	O	N
9. Laser Acupuncture	A	F	O	N
10. Detoxification	A	F	O	N
11. Myotherapy	A	F	O	N
12. Cranio-sacral	A	F	O	N
13. Other, _____	A	F	O	N

Do you dispense or sell vitamins, nutrients or other products? Y N If yes, give details: _____

_____

Do you have rehabilitation equipment in your office? Y N If so, please list the type of rehab equipment: _____

_____

Do you use adjunctive modalities in your office? Y N

If yes, check below:

Hot Packs/Cold Packs
Hydrotherapy/Whirlpool
Soft Tissue/Massage-type Therapy
Intermittent Static Traction
Intersegmental Traction
Other, _____

Do you perform your own physical therapy procedures? Y N

If not, indicate with a check mark how needed physical therapy services are accomplished.

On-site Physical Therapist (employees or independent). Include details on “Staff Roster”.

Off-site Physical Therapist (open script or referral). Include details below.

Name of facility _____ Telephone _____

Address _____City _____State _____ Zip _____

Checklist .

Thank you for completing your application. This document is the cornerstone of the Credentialing process and is incorporated as a part of your contract. Be sure to attach copies of all items that are requested below in order to avoid delays.

Signed participating provider agreement

Copy of driver's license

Practice/Specialty license

DEA Certificate

Malpractice insurance declaration page

Office liability declaration page

Fee Schedule

X-ray equipment certifications from State Regulatory Agency

X-ray certifications/licensure for individual(s) taking radiographs

A minimum of one photograph per each room in the facility and one photograph of the front exterior

Certifications

Acceptance letter(s) for hospital affiliations

Malpractice Liability Release Form

I, the undersigned, do hereby consent to, and authorize the release of any, and all information regarding, but not limited to, and in connection with my Malpractice Insurance by any and all persons hereunder: including, but not limited to, the procurement and inspection of any and all documents including but not limited to coverage, claims, or pending claims to the representative(s) of Alternative Healthcare Options, LLC deems necessary, for proper documentation. I further agree that anyone releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors or omissions contained in such released information. The address for notification is: Alternative Healthcare Options, LLC, 4701 Hedgemore Drive, Suite 806, Charlotte, NC 28209.

Applicant's Signature _____ Date _____

Print Name _____

OfficeLiability Insurance Coverage Release Form

I, the undersigned, do hereby consent to, and authorize the release of any, and all information, regarding, but not limited to, and in connection with my Office Liability Insurance coverage by any and all persons hereunder: including, but not limited to, the procurement, and inspection of any and all documents the representative(s) of Alternative Healthcare Options, LLC deems necessary for proper documentation. The address for notification is: Alternative Healthcare Options, LLC,
4701 Hedgemore Drive, Suite 806, Charlotte, NC 28209.

Applicant's Signature _____ Date _____

Print Name _____

School/University Grade Transcript Release Form

I, the undersigned, do hereby consent to, and authorize the release of any, and all information, regarding, but not limited to, and in connection with my School/University Grade Transcript by any and all persons hereunder: including but not limited to the procurement and inspection of any and all documents the representative(s) Alternative Healthcare Options, LLC deems necessary for proper documentation. I further agree that any party releasing the information, its agents, servants, and employees, shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors or omissions contained in such released information. The address for notification is:
Alternative Healthcare Options, LLC, 4701 Hedgemore Drive, Suite 806, Charlotte, NC 28209.

Applicant's Signature _____ Date _____

Print Name _____

Licensure Release Form

I, the undersigned, do hereby consent to, and authorize the release of any, and all information, regarding, but not limited to, and in connection with my Licensure by any and all persons hereunder: including but not limited to the procurement and inspection of any and all public documents relating to disciplinary action to the representative(s) Alternative Healthcare Options, LLC, deems necessary for proper documentation. The address for notification is:
Alternative Healthcare Options, LLC, 4701 Hedgemore Drive, Suite 806, Charlotte, NC 28209.

Applicant's Signature _____ Date _____

Print Name _____

On-Site Inspection Release Form

I, the undersigned, do hereby authorize any or all representatives of Alternative Healthcare Options, LLC to an on-site inspection, during office hours, as deemed necessary.
Applicant's Signature _____ Date _____

Print Name _____

Supplement Form

Provider Name _____ **Provider ID#** _____

1) License Limited, Reprimanded, etc.

List State(s) where action took place _____

Date(s) license revoked, suspended, etc. From _____ to _____

Please explain briefly _____

_____.

_____.

_____.

_____.

2) Employment/Membership Suspended, Limited, etc

List State(s) where action took place _____

Date(s) license revoked, suspended, etc. From _____ to _____

Please explain briefly _____

_____.

_____.

_____.

_____.

3) Medicare/Medicaid Sanction Disciplinary Action(s)

Disciplined Action(s) _____

List State(s) _____ Date(s) of action From _____ To _____

Please explain briefly _____

_____.

_____.

_____

4) National Practitioner Data Bank Report(s)

Please explain the NPDB report (if you have a copy please attach) _____

_____.

_____.

_____.

_____.

5) Felony or Misdemeanor

Did you serve a sentence? Y N If YES, circle how many years 1 2 3 4 5 6 other _____

Please explain charge and verdict _____

_____.

_____.

_____.

_____.

6) Named in Professional Liability Judgement, Settlement, etc.

Please explain briefly, include dates & amounts _____

_____.

_____.

_____.

_____.

7) Canceled, Refused Coverage, etc.

Please list Insurance Carrier(s) _____

Please explain briefly _____

_____.

_____.

_____.

_____.

8) Practiced Without Liability Coverage

Please explain _____

_____.

_____.

_____.

_____.

9) Medical, Chemical Dependency, or Psychiatric Problems

Please explain _____

_____.

_____.

_____.

_____.

10) Hospital or Clinic Privileges Revoked, Restricted, etc.

List Hospital(s) _____

Date privileges revoked, suspended, etc. From _____ To _____

Please explain _____

_____.

_____.

_____.

_____.

11) Other practitioners providing care

Please explain _____

_____.

_____.

_____.

_____.

Drug Enforcement Agency (DEA) Explanation (if applicable)

Please explain _____

_____.

_____.

_____.

_____.

.

P O Box 220395
Charlotte, NC 28222
(704) 523.3440 Bus (704) 844.2977 Fax
(877) 203.3440 Toll Free