



Advantage Chiropractic Network Membership Application Form

(Print or Type)

1. Physician Name: _____

Last

First

Middle Initial

Degree

Date of Birth _____ / _____ / _____
Mo Day Yr

Social Security Number _____ - _____ - _____

Shirt Size: Med _____ Large _____ X-Large _____ XX-Large _____

2. Other Name(s): Please list any other legal names under which you have practiced.

Last First Middle Initial

3. Primary Office Location:

Office / Clinic Name _____

Street Address _____

Mailing Address _____

City, State, Zip _____

Office Manager or contact _____

Phone (____) _____ Fax (____) _____ E-mail _____

4. Other Office Location:

Clinic Name _____

Street Address _____

Mailing Address _____

City, State, Zip _____

Phone (____) _____ Fax (____) _____ E-mail _____

5. Practice Arrangements:

Solo Group Partner /Associate Other _____

Employee (list name of employer) _____

6. Tax ID number other than your Social Security Number:

Federal _____ State _____

Under which do you file claims? Social Security Federal ID State ID

7. Do you have hospital privileges? No Yes

If so, where? (list facility & city) _____

Is your status considered "Allied Provider"? No Yes

8. Your name as it appears on your IOWA license: _____

List all current and previous license numbers and states:

IOWA # _____ Effective date _____ Expiration date _____

State _____ # _____ Effective date _____ Expiration date _____

State _____ # _____ Effective date _____ Expiration date _____

9. Your Individual NPI#: _____ **Group NPI#:** _____

10. Please describe your 24-hour emergency contact protocol (optional): _____

11. Education:

Name of Undergraduate Institution _____

City, State, Zip _____

Dates Attended _____ Year Graduated _____ Degree _____

Name of Chiropractic College _____

City, State, Zip _____

Dates Attended _____ Year Graduated _____ Degree _____

12. Professional Liability Insurance:

Current Carrier _____

Agency Name, City, State _____

Amounts of Coverage \$ _____ Dates From _____ To _____

13. Declarations:

- a. Do you presently have a physical or mental health condition that affects, or is reasonably likely to affect your ability to perform professional duties appropriately?..... No Yes
- b. Have you ever been subject to disciplinary action by a professional organization?... No Yes
- c. Has your professional liability insurance coverage ever been denied, cancelled, non-renewed or initially refused upon application?..... No Yes
- d. Has any malpractice action against you been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against you in a malpractice action?... No Yes
- e. To your knowledge, is any malpractice action against you currently pending?.... No Yes
- f. Are formal charges pending against your professional license at this time?..... No Yes
- g. Has your license ever been voluntarily surrendered or revoked, suspended, restricted or refused by the state licensing board in Iowa or any other state?..... No Yes
- h. Have you ever been sanctioned by the Medicare Program or Medicaid Program?... No Yes
- i. Has your participation in Medicare or Medicaid Programs ever been restricted, suspended or terminated?..... No Yes
- j. Have you ever been convicted of, or pled no contest to a felony or grand jury indictment? No Yes
- k. Do you have any felony charges pending?.....No Yes
- l. Do you presently have an illegal or legal drug or alcohol dependency?.....No Yes

Note: If “YES” is circled, please explain fully on a separate sheet and sign. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (including any settlements/adjudications, original complaint and final disposition). For pending cases, your signed statement fully explaining the alleged incident will suffice.

14. Additional Declarations:

- a. Are you a member in good standing with the Iowa Chiropractic Society?No Yes
(If “No” please explain circumstances on a separate sheet of paper.)
- b. Do you fluently speak a foreign language or sign language?No Yes
Please specify: _____
- c. Have you earned any certifications? (i.e.: DACBR, DABCO, CCSP, etc.)
Please specify:_____
- d. Do you carry any other licenses? (i.e.: MD, DO, RN, PT, LMT, etc.) Please specify:_____
- e. List other licensed professionals practicing in your clinic? (i.e. DC, MD, DO, RN, PT, LMT, etc.) Please specify Name/Degree:_____
- f. Please list any other specialty designations that you hold._____

If there is any additional information about you or your practice that you feel will have a bearing on consideration of this application, please provide details. Use a separate sheet for additional explanation.

ATTESTATION

I certify and warrant that all information submitted by me in the application materials to Advantage Chiropractic Network is true, accurate and complete. I understand that if any matter included in my application or on the Participation Statement is false Advantage Chiropractic Network may deny or immediately terminate my provider agreement. Furthermore, I understand that I have an affirmative duty to inform Advantage Chiropractic Network of any changes in the information that I have provided in the application and the Participation Statement. I certify that I have or shall inform Advantage Chiropractic Network of any changes in any of the information that I have submitted in my application or in the Participation Statement and that such changes shall be true, accurate and complete. I understand that any failure to report any changes in the information submitted on my application or in the Participation Statement or if any of that information becomes false Advantage Chiropractic Network may immediately terminate my provider agreement.

I authorize Advantage Chiropractic Network and/or its Credentials Verification Organization (CVO) to consult with and obtain information from the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process and to verify information concerning my membership, professional competence, character and moral and ethical qualifications. I specifically hold Advantage Chiropractic Network, its employees and representatives and/or its CVO harmless for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to and specifically authorize the release of all information that may be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including my information relating to any disciplinary action or suspension and/or curtailment of privileges. I further authorize the release of any information relevant to verify the information contained within my application packet. This authorization for release or information extends to any individual or entity that may have any information relevant to the above stated purposes. I hereby agree to hold harmless any individual or entity who releases information regarding me in good faith.

I understand that many of the entities with which I have contracts through Advantage Chiropractic Network require complete access to my credential file. I specifically consent and authorize the release of all information in my credential file to any entity with which I have a contract through Advantage Chiropractic Network. I further agree to hold Advantage Chiropractic Network, its employees and its agents harmless for the release of anything in my credential file to such entities.

Signature

Date

What/Who lead you to become a Member of Advantage? _____

Copies of the following documents must accompany this application:

- ◆ Chiropractic diploma ◆ Current state license ◆ Original state license
- ◆ Face sheet of liability policy with documents specifying coverage limits
- ◆ Copy of your curriculum vitae including a work history of at least 5 years **with an explanation of gaps greater than 6 months.**

**PAYMENT OF THE ONE-TIME CREDENTIALING FEE
AND ANNUAL MEMBERSHIP FEE MUST ACCOMPANY THE APPLICATION.**

Credentialing Fee \$100 + Membership Fee \$140	Total \$240
RUSH Credentialing Fee (Optional) \$150 + Membership Fee \$140	Total \$290

Paid By: **CHECK** **CREDIT CARD**
If Credit Card **VISA** **MASTER CARD**

Name on Card _____ **Card Number** _____ **CID #** _____

Billing Address: _____

Expiration Date _____ **Signature** _____

Mail completed application to:
Advantage Chiropractic Network, Inc., 100 E. Grand Ave, Suite 240,
Des Moines, IA 50309 or fax to 515/867-2801