



4220 Von Karman  
Suite 120  
Newport Beach, CA 92660  
949.756.1628

**ALLIANCE MEDICAL NETWORK APPLICATION**

Last Name,	First Name	Professional Degree
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Date of Birth / /	Social Security #:	Group Affiliation
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**PROVIDER IDENTIFICATION NUMBERS**

Federal DEA #	State CDS/DEA#	UPN#
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Exp. Date	Exp. Date	Medicare #
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<b>Office #1</b>	Practice Name: _____
Street _____	
City _____ State _____ Zip _____	
Phone ( ) _____ FAX ( ) _____ Email _____	
Type of Office:	<input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing
List all Tax Id#s associated with this office:	

<b>Office #2</b>	Practice Name: _____
Street _____	
City _____ State _____ Zip _____	
Phone ( ) _____ FAX ( ) _____ Email _____	
Type of Office:	<input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing
List all Tax Id#s associated with this office:	

<b>Office #3</b>	Practice Name: _____
Street _____	
City _____ State _____ Zip _____	
Phone ( ) _____ FAX ( ) _____ Email _____	
Type of Office:	<input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing
List all Tax Id#s associated with this office:	

**LICENSURE (Attached copy of medical/registration for State of California)**

State	License Type:	License #:	Yr. Obtained:	Exp. Date: / /
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**HOSPITAL AFFILIATION:**

Please list each hospital/facility with which you are affiliated, using boxes below in the order in which you most frequently admit patients. On separate attached sheet list all additional affiliations. For all nursing degrees, please list admitting privileges for supervising physicians.

**#1**  
Hospital Name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Staus \_\_\_\_\_

**#2**  
Hospital Name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Staus \_\_\_\_\_

**#3**  
Hospital Name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Staus \_\_\_\_\_

**PROFESSIONAL LIABILITY INSURANCE**

Attach a copy of face sheet of current liability insurance policy.

Current Carrier \_\_\_\_\_ Policy #: \_\_\_\_\_ Exp. Date \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Initial Coverage Date \_\_\_\_\_  
Policy Limits: \_\_\_\_\_

**Other accredited (NCQA, JCAHO, URAC) health plans networks of which you are a member.**  
(OPTIONAL)



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1.	Name of Plan/Network _____ Address _____	<input type="checkbox"/> Active/Unrestricted <input type="checkbox"/> Restrictions
2.	Name of Plan/Network _____ Address _____	<input type="checkbox"/> Active/Unrestricted <input type="checkbox"/> Restrictions

**SPECIALTY/SUB-SPECIALTY CERTIFICATIONS & DICTORY**

\*\*If you request a non ABMS/AOA specialty which is listed in the AMA list of Self-Designated Practice Specialties, submit supportive documentation. ALLIANCE may change your requested specialty to a specialty more consistent with the evidence of training submitted. You will be listed under the specialty in which you are trained if you do not indicate a specialty.

Specialty (MD/DO Only)	Board Certified By ABMS/AOA only	***Check the Specialty you want want to be listed under in the Alliance Directory
1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes

If you are not board Certified, have you completed the training requirements for your specialty within the past five (5) years?  Yes  No

If you practice Internal Medicine, Obstetrics and Gynecology, Family Practice or Pediatrics, do you accept patients from primary care services?  Yes  No

Specialty (Non MD/DO Only)	Certified (If Applicable)
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**EDUCATION & TAINING (Medical/Graduate School):**

Name _____	from: ____/____/____	To: ____/____/____
City _____	State _____	Specialty _____

If foreign medical school, are you certified by the Educational Council for Foreign Graduate?  Yes  No



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**INTERNSHIP:**

Program/Hospital Name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Specialty \_\_\_\_\_

**RESIDENCY:**

Program/Hospital Name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Specialty \_\_\_\_\_

**FELLOWSHIP/OTHER TRAINING\*:**

Program/Hospital Name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Specialty \_\_\_\_\_

\*If necessary, list additional training on a separate sheet.

**PROFESSIONAL AND HEALTH STATUS INFORMATION:**

1. Has your DEA/CDS registration or any license to practice your profession in any jurisdiction been restricted, suspended, placed on probation, revoked or surrendered involuntarily?  Yes  No
2. Have you been denied membership, or been subject to disciplinary proceedings, in any medical or professional organization?  Yes  No
3. Has any disciplinary action been taken against you or your licenses by any state licensing Board and/or is any such action pending and/or is any investigation of you by such a Board underway?  Yes  No
4. Have your privileges been restricted, refused, suspended, revoked, or dropped involuntarily from any Hospital, other health care institution or healthplan/network?  Yes  No
5. Do you have any ongoing physical and/or mental impairment or condition, or substance abuse problem, which would make you unable with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice? If you require reasonable accommodation, what reasonable accommodation is necessary?  Yes  No
6. Have you been named in any malpractice action, or paid any judgments of settlements within the last (10) years? Include any cases which are current or may have been dismissed with no cash payment. (If yes, please complete the attached Malpractice History sheet).  Yes  No

- |    |  |  |
|----|--|--|
| 7. | Have you been excluded or suspended from participation in any governmental health program (e.g. Medicare, Medicaid, etc.)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. | Has your professional liability coverage been restricted, suspended, refused, revoked, or denied?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. | Have you been convicted of a felony or any other criminal charges (excluding minor traffic violations)?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

*Note: If you answer YES to any of the above questions, please explain on a separate sheet*

I represent and warrant that the information contained in the foregoing application is true and complete to the best of my knowledge and belief. I agree to inform Alliance within five (5) business days if any material change in such information occurs. I, hereby authorize release to Alliance or its designated agent's information to verify the above. I release Alliance from any liability in connection with any request for information hereunder. **The applicant, and only the applicant, is responsible for the accuracy and completeness of the information provided on, and in support of, this application including any attached sheets or photocopy which is part of this application.**

**THE SUPPLYING OF INACCURATE, MISLEADING, AND/OR IMCOMPLETE INFORMATION ON OR IN SUPPORT OF THIS APPLICATION MAY SUBJECT THE APPLICANT TO CIVIL AND/OR CRIMINAL PENALTIES UNDER STATE AND/OR FEDERAL LAW, AND MAY SUBJECT THE APPLICANT TO LICENSE REVOCATION AS WELL.**

Signature \_\_\_\_\_, Date \_\_\_\_\_

Name \_\_\_\_\_  
(Please Print)



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