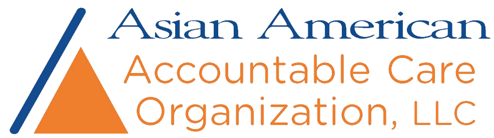

AAACO PROVIDERSHIP APPLICATION*

*** IF YOU ARE A CURRENT CAIPA MEMBER, PLEASE SKIP BELOW QUESTIONNAIRE, AND GO TO SIGNATURE AREA.**

Applicant's Name ____________________ Area of Specialty ____________________

Practice Name ____________________ E-mail Address ____________________

Primary Office Address ____________________ Office Phone Number ____________________

City, State & Zip ____________________ Office Fax Number ____________________

Home Address ____________________ Home Phone Number ____________________

City, State & Zip ____________________ Home Fax Number ____________________

Billing Address (if not the same as home or office address) ____________________ Billing Address Same As: ☐ Office ☐ Home

City State & Zip ____________________ Billing Phone Same As: ☐ Office ☐ Home

Board Certification(s): ____________________

Professional Education ____________________ Degree/Certification ____________________ Year of Completion ____________________

NYS License No. ____________ Medicare No. ____________ NPI No. ____________ CAQH No. ____________

TIN No. ____________ Medicare Enrollment Date: ____________________

Current Affiliations & Admitting Privileges, if applicable ____________________ Status ____________

Electronic Medical Record System: ____________________

☐ I am a member of the Chinese American IPA (CAIPA), and I hereby authorize AAACO to obtain my information from CAIPA for enrollment in AAACO as a participating provider.

☐ I am interested in becoming an investor. Please send or email me an investor information package.

Date: ____________ Please Print Name: ____________________

Signature: ____________________