



Affinity Medical Group Provider Pre-Screening Form

Primary Care

Specialty Care

Provider Information

Full Name: _____ Degree: _____

Gender: _____ License #: _____ Primary Specialty: _____

Have you previously applied for membership with Affinity Medical Group?

Yes

No

If yes, please provide date: _____

Board Certifications

Board Certification: _____ Expiration Date: _____

If Board eligible, when did you complete your residency or fellowship?

Date: _____

Practice Information

Solo Practice

Group Practice

please provide a participating provider roster

Group: _____ Provider Name: _____

Primary Office Address: _____

Office Phone: _____ Office Fax: _____

Tax ID: _____ Languages: _____

IPA or Medical Group Affiliations: _____

On Call Group / MD (must be an Affinity contracted provider): _____



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Hospital Privileges *(Please list all Hospitals with whom you hold privileges)*

Hospital & City: _____ Privileges Type: _____

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Hospital & City: _____ Privileges Type: _____

Contact Person

Name of Person Facilitating this Request: _____

Title / Position: _____ Email: _____

Phone: _____ Fax: _____

Physician Signature: _____ **Date:** _____