CCACO
Chinese Community Accountable Care Organization
94 Bowery, 4th Floor, New York, NY 10013
Phone: (212) 965-0222 Fax: (347) 332-1762

CCACO MEMBER INFORMATION SUMMARY

I. PHYSICIAN DEMOGRAPHICS

Name:	First Name:	Middle Initial:	Last Name:
Chinese Name:		**Degree:**	**Gender:**
Primary Specialty:		Board Certified? ☐ Yes ☐ No	Certified Date:
Secondary Specialty:		Board Certified? ☐ Yes ☐ No	Certified Date:
Tertiary Specialty:		Board Certified? ☐ Yes ☐ No	Certified Date:
Physician Designation: (Please check one)	☐ PCP (IM/FP/GP/Ger/Ped)	☐ SPECIALIST (GYN included)	☐ DUAL (applies to IM with specialty)
Contact Information:	Mobile:	Email:	
Preferred Method of Communication:	☐ Office Telephone ☐ Mobile ☐ Email ☐ Fax		
Medicare Billing Number and Provider Transaction Access Number (PTAN)	Please check one: ☐ TIN ☐ SSN	Medicare Billing Number:	Provider Transaction Access Number (PTAN):
Legal Business Name Used in Medicare Billing:			
Medicaid Provider ID #:			
NPI #:	Individual NPI #:	Group NPI #:	
License #:	License #:	State where licensed:	
Electronic Medical Record Platform:			
Practice Management Software Platform:			
Answering Service:	☐ Self ☐ Vendor (please specify):_____		
Hospital Affiliations:	☐ NYDH ☐ BIMC ☐ MSSM ☐ LMC ☐ MMC ☐ NYHQ ☐ Flushing ☐ NS/LIJ ☐ Other _____		
Titles:			
Elected Offices Held:			
Professional Affiliations:	☐ ECAP ☐ CAIPA ☐ Neither ECAP/CAIPA		
CCACO Member Reference:			

Please send completed form via FAX: (347) 332-1762 or EMAIL: rzhu@ccaco.org

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II. PRIMARY PRACTICE INFORMATION

(For additional practice locations, please make copies of this page & complete.)

Primary Office Address:			
Primary Office Location:	City:	State:	Zip Code:
Primary Office Contact Information:	Telephone:	Fax:	
Contact Person / Administrator:			
Primary Office Hours:	**M:**	**T:**	**W:**
	Th:	**F:**	**Sa:**
	Su:		
Primary Covering Physician/Practice:	**Primary Covering Physician/Practice:**	**Primary Covering Physician/Practice Telephone:**	
Secondary Covering Physician/Practice:	**Secondary Covering Physician/Practice:**	**Secondary Covering Physician/Practice Telephone:**	

III. SECOND PRACTICE INFORMATION

Second Office Address:			
Second Office Location:	City:	State:	Zip Code:
Secondary Office Contact Information:	Telephone:	Fax:	
Contact Person / Administrator:			
Second Office Hours:	**M:**	**T:**	**W:**
	Th:	**F:**	**Sa:**
	Su:		
Primary Covering Physician/Practice:	**Primary Covering Physician/Practice:**	**Primary Covering Physician/Practice Telephone:**	
Secondary Covering Physician/Practice:	**Secondary Covering Physician/Practice:**	**Secondary Covering Physician/Practice Telephone:**	

AFFIRMATION OF INFORMATION: I warrant the information and documents I have provided and the responses I have given in this enrollment form are correct and complete to the best of my knowledge and belief. I understand that willful falsification and willful omission will be grounds for rejection and termination. By signing this application, I authorize CCACO and its agents to investigate and evaluate my enrollment application.

I authorize CCACO to release and use my name and "practice information" for membership directory and public relation purposes.

Name (please print) _____ Signature _____ Date _____

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