ACI Specialty Benefits Corporation
Tel. 800-932-0034 Fax 858-452-1254
www.acieap.com

PROVIDER SURVEY

Please fax or mail this information immediately to ensure your information is current.
Incomplete information can affect your provider status.

PLEASE PRINT

Name of Provider: ______________________ Date: ___/___/___
First Last

Mailing Address: ______________________
Street City State Zip Code

Phone #: ( ) ______________________ **Fax #:** ( ) ______________________

***Email:** ______________________

Ethnicity:
☐ African American ☐ Caucasian ☐ Asian
☐ Hispanic ☐ Native American

Gender:
☐ Female
☐ Male

DOB: ___/___/___

24-hours answering? ☐ Yes ☐ No

Languages that you provide counseling in other than English?

Office Locations: **Please specify office locations differ from mailing address above.**

1 ______________________
Street City State Zip Code Phone # Emergency Phone #

2 ______________________
Street City State Zip Code Phone # Emergency Phone #

Office Hours: **Mon:** **Tues:** **Wed:** **Thurs:** **Fri:** **Sat:** **Sun:**

CLINICAL SPECIALTIES

- ☐ Learning Disabilities (ADD/ADHD)
- ☐ Elder Care
- ☐ Hypnotherapy
- ☐ Smoking Cessation
- ☐ Substance Abuse
- ☐ Couple Therapy
- ☐ Trauma
- ☐ Gay/Lesbian Issues
- ☐ Christian Counseling
- ☐ Children/Adolescents (please specify ages) __________
- ☐ Other (please list)

TRAINING

- ☐ EAP Orientations & Supervisory Trainings
- ☐ Parenting
- ☐ CISD
- ☐ Coping w/Change
- ☐ Coping w/Difficult People
- ☐ Anger Management
- ☐ Sexual Harassment
- ☐ Diversity
- ☐ Team Building
- ☐ Negotiation Strategies
- ☐ Benefits/Health Fairs
- ☐ Other (please list)

Please note what insurance plans you currently accept:

INCOMPLETE/INCORRECT PAYMENT INFORMATION WILL DELAY PAYMENTS

Make Check Payable to: ______________________

Tax ID: ________ - ________ **or SSN#;** ____ - ____ - ____

License Type: ______________________ **License Expiration:** ______________________

License #: ______________________ **Insurance Expiration:** ______________________

Please refer to Provider Agreement &/or ACI Program Utilization Form for billing terms.
Provider Relations Email: Provider-Relations@acieap.com

(updated 2/8/2010)