ACI Enterprises Inc.
5405 Morehouse Drive, Suite 200, San Diego, CA 92121
ACI Provider Relations: provider-relations@acispecialtybenefits.com
Tel: (858) 736-0047 | Fax: (858) 452-7819

PROVIDER SURVEY

PLEASE PRINT OR TYPE

Last Name*:		**First Name*:**	
Mailing Address*:	**City*:**	**State*:**	**ZIP Code*:**
Office Address (If different from mailing address)**:**	**City:**	**State:**	**ZIP Code:**
Phone Number*:	**Fax Number:**	**24-Hour Answering*:** ☐ Yes ☐ No	
Email*:	**Date of Birth*:** / /	**Gender*:** ☐ Female ☐ Male	

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

Languages Other Than English*:

Telephonic Sessions Provided*:
☐ Yes ☐ No

Operating from a Personal Residence*:
☐ Yes ☐ No

Office Hours*:

Monday		Friday	
Tuesday		Saturday	
Wednesday		Sunday	
Thursday			

Currently Accepted Insurance Plans*:

Clinical Specialties:
- ☐ Learning Disabilities (ADD/ADHD)
- ☐ Elder Care
- ☐ Hypnotherapy
- ☐ Smoking Cessation
- ☐ Substance Abuse
- ☐ Couple Therapy
- ☐ Trauma
- ☐ Fitness for Duty Evaluation
- ☐ Gay/Lesbian Issues
- ☐ Christian Counseling
- ☐ Children/Adolescents, specify ages:
- ☐ Other:

Training Experience:
- ☐ EAP Orientation/Supervisory Trainings
- ☐ Parenting
- ☐ CISD
- ☐ Coping with Change
- ☐ Coping with Difficult People
- ☐ Anger Management
- ☐ Sexual Harassment
- ☐ Diversity
- ☐ Team Building
- ☐ Negotiation Strategies
- ☐ Benefits/Health Fairs
- ☐ Other:

Fields marked with an asterisk (*) are required. Please upload the following on ACI's website when submitting this form:
- License
- Insurance
- W-9 (required for payment/reimbursement)

For your convenience, this form and ACI Provider FAQ can be located online at **www.acispecialtybenefits.com**. Please refer to Provider Agreement and/or ACI Program Utilization Form for billing terms.

If unable to upload the required documents electronically, please fax to **858-452-7819 Attn: Provider Relations**

By submitting this form I agree to the ACI Provider Contract Agreement. I agree that once I have submitted the above truthful information I will be eligible to become part of ACI's network of providers.

PRINT FORM