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ASBP EXCLUSIVE PREFERRED PROVIDER - BARIATRIC PROGRAM

APPLICANT NAME _____

CLINIC NAME _____

ADDRESS _____

PHONE _____ E-MAIL _____

FAX _____ WEBSITE _____

1. CLINIC:

NUMBER OF LOCATIONS _____ EST GROSS REVENUE (ANNUAL) _____

EST NUMBER OF PATIENT VISITS PER WEEK NEW _____ FOLLOW-UP _____

2. NUMBER OF HEALTH CARE PROFESSIONALS:

FULL-TIME PHYSICIANS (> 21 HRS) _____ PHYSICIAN ASSISTANTS _____

PART-TIME PHYSICIANS (< 21 HRS) _____ NURSE PRACTITIONERS _____

OTHERS _____ RN / LPN'S/LVN's _____

3. PRACTICE:

BARIATRIC _____ % FAMILY _____ % PSYCHIATRIC _____ %
 AESTHETIC _____ % HOLISTIC _____ % URGENT CARE _____ %
 ANTI-AGING _____ % INTERNAL _____ % OTHER _____ %

DRUGS USED FOR WEIGHT REDUCTION? YES NO

HCG USED? YES NO

SURGERY DONE? YES NO DESCRIBE _____

NUMBER OF PROCEDURES:

BOTOX _____ DERMAL FILLERS _____ MESOTHERAPY _____
 CHEMICAL PEELS _____ LASER TREATMENTS _____ MICRODERMABRASION _____
 CELLULITE _____ LIPODISSOLVE _____ SCLEROTHERAPY _____

4. DISCIPLINARY ACTION/CLAIM HISTORY: NONE, OR DESCRIBE:

5. CURRENT INSURER INFORMATION:

EFFECTIVE DATE _____ LIMITS: _____

RETROACTIVE DATE _____ PREMIUM: _____

COMPANY _____

ASBP MEMBER C.V. ATTACHED POLICY DEC PAGE ATTACHED