Practice Analysis Form

Provider Business Name: _____

Contact Name: _____

Email: _____

State: _____ Phone: _____

How many providers are part of your group (include BCBAs and therapists)?

_____

How many clients do you currently serve? _____

Are you in-network with any insurance carriers? _____ If yes, which ones?

_____

Is your current billing done in-house or outsourced? _____

Which of the following therapies does your company provide? Please check:

_____ABA

_____Speech

_____OT

_____PT

_____Music Other (Please specify):_____

Please fax completed form to 866-496-3007; we will email you within 24 hours.