FxN FUNCTIONAL NEUROLOGY RELIEF FOUNDATION

PROVIDER APPLICATION

A. PERSONAL INFORMATION

Name (Last)	(First)	(Middle)	Degree

Other Names (Used/Married)	Date of Birth (REQUIRED)	Social Security Number

GENDER? ☐ Male ☐ Female	U.S. Citizenship? ☐ Yes ☐ No	Preferred Method of Contact: ☐ EMAIL ☐ FAX ☐ MAIL ☐ PHONE Credentialing Contact Person:

B. PRIMARY PRACTICE LOCATION:

Business Name:	Contact Person/Title	Contact's Phone/Ext

Mailing Address	Street Location Address	County

City	State	Zip Code	City	State	Zip Code

Phone Number	Fax Number	Email Address

Office Hours	Weekend Hours	Handicap Accessible? ☐ Yes ☐ No

C. SATELLITE PRACTICE LOCATION

Business Name	Contact Person/Title	Contact's Phone/Ext

Mailing Address	Street Location Address	County

City	State	Zip Code	City	State	Zip Code

Phone Number	Email Address	Fax Number

Office Hours	Weekend Hours	Handicap Accessible? ☐ Yes ☐ No

List any additional locations on a separate attachement.

Attach Additional Documents: (Company Letterhead is preferred)

- Treatment Philosophy Statement
- Equipment List
- Accepted Insurance List
- Copy of Standard Billing Reciept
- Reference Contact Information - 2 References