Allina Integrated Medical Network (AIMN)
Membership Application

Date of Application:	
Application Contact Person:	
Address:	
Phone:	Fax:
Email:	

ORGANIZATION/PRACTICE INFORMATION

Organization Legal Name:	
DBA (if different than Legal Name):	

Type of Organization:

- ☐ Medical group practice
- ☐ Network of individual practices
- ☐ Hospital system(s)
- ☐ Integrated delivery system
- ☐ Partnership of hospital system(s) and medical practices
- ☐ Other, please describe

Organization Specialty:	
Practice Federal Tax ID #:	Practice NPI #:
CMS Certification Number:	
Practice website:	
Administrative Mailing Address:	Billing Address:

Number of Locations:	Hospital(s):	Clinic(s):	Other:
Number of Providers:	Physicians:	Other Providers:	
Patient Population Served:	Patient Volume:		Panel Size:

Currently accepting new patients? ☐ Yes ☐ No

KEY ORGANIZATION/PRACTICE CONTACTS

Administrative/Operations Lead Name:	
Title:	
Phone:	Fax:
Email:	
Physician Lead Name:	
Title:	
Phone:	Fax:
Email:	
Information Technology (IT) Lead Name:	
Title:	
Phone:	Fax:
Email:	
Quality Lead Name:	
Title:	
Phone:	Fax:
Email:	

INFORMATION TECHNOLOGY SYSTEM INFORMATION

	Function	In-House/Outsourced?	Vendor Name	Version (if known)
Hospital	EHR			
	Billing/Claims			
	Lab			
	Pharmacy			
Clinic	**Function**	**In-House/Outsourced?**	**Vendor Name**	**Version (if known)**
	EHR			
	Billing/Claims			
	Lab			
	Pharmacy			
Other	**Function**	**In-House/Outsourced?**	**Vendor Name**	**Version (if known)**

Do you have any planned system upgrades or implementations? ☐ Yes ☐ No

What and when are the upgrade schedule for?

Do you utilize a claims clearinghouse? ☐ Yes ☐ No

If yes, what is the name of the clearinghouse?

PATIENT SATISFACTION

Do you currently send out patient satisfaction surveys? ☐ Yes ☐ No

How often do you send out surveys? ☐ Monthly ☐ Quarterly ☐ Other

Vendor Name?

Do you capture and store email addresses? ☐ Yes ☐ No

If yes, are they stored in a discrete field? ☐ Yes ☐ No

CLINICAL MEASURES

Are you currently reporting to MN Community Measures? ☐ Yes ☐ No

What measurement data set(s) are you submitting?

Are you a mandatory reporter? ☐ Yes If Yes, How many sites? ☐ No

Are you currently reporting to other registries? ☐ Yes ☐ No

If yes, please describe:

CURRENT HEALTH PLAN CONTRACTS

Are you currently contracted with any health plan(s)? (check all that apply)

- ☐ Blue Cross Blue Shield of MN
- ☐ HealthPartners
- ☐ Medica
- ☐ Preferred One
- ☐ Ucare
- ☐ Other, please describe

CURRENT ALIGNMENT WITH AIMN PROVIDERS

Is the organization or any provider associated with your organization actively engaged with an AIMN provider group?

- ☐ Allina Health Clinical Service Line(s)/Care Council(s)
  - If so, which one(s)?
- ☐ Practice within Allina Health or other AIMN member facilities (hospitals, surgery centers, clinics)
  - If so, which one(s)?
- ☐ Allina Medical Clinic (AMC) in the community
  - If so, which one(s)?
- ☐ Other
  - Please describe:

Is your practice/organization a current Allina Health Excellian Affiliate member? ☐ Yes ☐ No

Does your organization have an integrated primary care physician model with a hopsital? ☐ Yes ☐ No ☐ N/A

STATEMENT OF INTEREST

ADDITIONAL COMMENTS