

# Questionnaire for AHBA Accreditation

Company Name: \_\_\_\_\_

Owner President: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #:(     ) \_\_\_\_\_ Fax # (     ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

**For primary information, please answer the following questions:**

1. \_\_\_\_\_ Does your organization, owners or management team have a minimum of five (5) years of service to the healthcare industry? Yes \_\_\_\_\_ No \_\_\_\_\_
2. \_\_\_\_\_ Does 60% of your current business assignments derive from the healthcare industry – Physicians – Hospitals, Billing Companies or Ancillary services? Yes \_\_\_\_\_ No \_\_\_\_\_
3. \_\_\_\_\_ If less than 60% of your current assignments are from healthcare providers, or their ancillary services, to qualify for accreditation you can organize a special division to service healthcare referrals. Are you willing to comply? Yes \_\_\_\_\_ No \_\_\_\_\_
4. \_\_\_\_\_ Does your organization have a certified staff that services healthcare referrals? i.e. bad debt, outsourcing assignments etc. Yes \_\_\_\_\_ No \_\_\_\_\_
5. \_\_\_\_\_ Will your organization agree to grant independent compliance representatives access to documents records necessary to ascertain compliance with the accreditation standards? Yes \_\_\_\_\_ No \_\_\_\_\_

Sign: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Upon receipt of this primary information you will be contacted by an AHBA representative to further clarify you requirements for accreditation