

CAQH Data Summary Date 9/9/2025

Lee, Soo Kyoung Applied Behavioral Analyst
CAQH Provider ID : 16068574

Last Reattestation Date: 9/9/2025 5:10:12 PM

PREPARE

NUCC Grouping:	Behavioral Health & Social Service Providers		
Provider Type:	Applied Behavioral Analyst	Practice Setting:	Inpatient/Outpatient or Outpatient Only
Primary Practice State:	CA		
Other Practice State(s):			

PERSONAL INFORMATION**Name**

First Name : **Soo Kyoung** Middle Name :
 Last Name : **Lee** Suffix :

Have you used other names?

No**Home Address**

Street 1 : **78 Bronze Leaf** Street 2 :
 City : **Irvine** State : **CA**
 Country : Province :
 County : Zip Code : **92620**

Mailing Address

Is Mailing address and Home Address Same? No
 Street 1 :
 City :
 Country :
 County :
 Street 2 :
 State :
 Province :
 Zip Code :

Primary Method of Contact

Primary E-mail Address : **soolee@acesaba.com** Personal E-Mail Address :
 PMOC CC Email1 :
 PMOC CC Email2 :

Phone Numbers

Home Phone : Personal Cell Phone :
 Personal Fax :

Personal Identification Numbers

Social Security Number : **620-55-3264** FNIN Country of Issue :
 Foreign National Identification Number :

Do you have a Unique Physicians Identification Number (UPIN)? **No**
 Do you have an Individual (Type 1) National Provider Identifier (NPI)? **Yes** Individual NPI: **1316417975**

Demographics

Gender Identity: **Female**
 Race/Ethnicity : **Asian**
 Birth Date : **9/26/1997** Birth City :
 Birth State : Birth Country :

Languages

Non-English languages spoken by provider : **Korean**

PROFESSIONAL IDENTIFICATION NUMBERS**Professional License**

License State : **CA** Do you currently practice in this state? **Yes**
 License Number : **1-23-68564** License Type : **ABA**
 License Status : **Active**
 Issue Date : **09/29/2023** Expiration Date : **09/29/2027**

DEA Registration

Do you have a DEA Registration Certificate? **No**
 I do not Prescribe : **Yes**
 Reason For Not Having DEA : **I am not required to prescribe per my specialty**
 Alternate Prescriber Name :
 More Information :
 Controlled Dangerous Substance (CDS) Registration

Do you have a CDS Registration Certificate?

No**Medicare**

Are you a participating Medicare provider?

No**Medicaid**

Are you a participating Medicaid provider?

No**ECFMG**

Do you have a Educational Commission for Foreign Medical Graduates (ECFMG) Number?

No**USMLE**

USMLE No. :

Exam Date :

Workers Compensation Number

Workers Compensation Number :

EDUCATION

Graduate Type : **US/Canada Graduate**

Professional School Information

Country : **United States** State : **MN**

County :

Professional School : **Capella University** Street 1 : **225 South 6th St**
Street 2 : **Minneapolis**

Province :

Zip Code : **55402**

Phone Number : Fax Number :

Degree : **Master of Science (MS)**

Professional School Start Date : **04/2021** Professional School End Date : **12/2022**

Area of Training / Course of Study / Major : **Applied Behavior Analysis**

Did you complete your professional education at this school? **Yes** Graduation Date : **12/31/2022**

TRAINING INFORMATION**Cultural Competency Training :**

Have you completed cultural competency training?

Please select which program(s) you have completed:

SPECIALTY INFORMATION**Primary Specialty**

Primary Specialty : **Behavior Analyst (103K00000X)**

Board Certified? **Yes**

Name of Certifying Board : **Behavior Analyst Certification Board**

Country : **United States** State : **CA**

County : **Orange County**

Street 1 : Street 2 :

City : Province :

Zip Code :

Certification Number : **1-23-68564**

Initial Certification Date : **9/29/2023** Does your board certification have an expiration date? **Yes**

Expiration Date : **9/29/2025** Last Recertification Date : **9/29/2023**

Do you wish to be listed in the directory under this primary specialty? By HMO

Do you wish to be listed in the directory under this primary specialty? By PPO

Do you wish to be listed in the directory under this primary specialty? By POS

Secondary Specialty

Do you have a Secondary Specialty? **No**

Special Experience, Skills, and Training

Please select one or more special experience, skills, and training that apply from the list below:

CERTIFICATION INFORMATION

*** THERE IS NO DATA ON RECORD FOR THIS SECTION ***

PRACTICE LOCATIONS

Active Locations**General Information :**Confirmed Date : **9/9/2025**Office Type : **Primary Practice** Providers's Start Date : **9/8/2025**Do you practice at this location?: **Yes, I practice at this location**Please Explain: **I see patients by appointment at least one day per week on a regular basis**

Provider Directory Classification :

Specialty : **Behavior Analyst** Subspecialty :Will you continue to practice at this location
Yes

Type of Service provided :

Provide a narrative description of your clinical practice including special interests :

Practice Name : **Positive Behavior Supports****Corporation - LA Metro****675 N Euclid St Ste 623**

Street 1 :

Country :

United States

Street 2 :

State :

CACity : **Anaheim**

Province :

County :

Email Address :

92801-4639**RrPinero@teampbs.com**Zip Code :
Can general correspondence be sent to this location?

Practice Location Website

www.teampbs.com

Appointment Scheduling Website

Mailing Address :Street1 : **Positive Behavior Supports**

Street2 :

City :

State :

County :

Province :

Country :

Zip Code :

Type of Practice : **Single Specialty Group**Do you have an organization (Type 2) NPI? : **Yes** Organization (Type 2) NPI:**1528405008**

Group Medicaid Number :

Group Medicare Number :

Phone Numbers :Appointment Phone Number : **855-832-6727**

Phone Extention :

Fax Number : **772-675-9100**

Back Office Phone Number :

Phone Coverage :

Does this location provide 24hour/7day a week phone coverage?:

Phone Coverage Type :

Tax Information :Practice Name as it appears on the W-9 : **Positive Behavior Supports****Corporation****462843213**

Type of Tax ID :

GroupTax ID : **462843213**Is this the primary Tax ID for this practice location?
YesGroup Name : **Positive Behavior Supports Corp****Network Denial :**Have you closed your practice to any plans or programs ? **No****Office Hours :**

Monday

Start Time : **9:00 AM** End Time : **5:00 PM**

Tuesday

Start Time : **9:00 AM** End Time : **5:00 PM**

Wednesday

Start Time : **9:00 AM** End Time : **5:00 PM**

Thursday

Start Time : **9:00 AM** End Time : **5:00 PM**

Friday

Start Time : **9:00 AM** End Time : **5:00 PM**

Saturday

Start Time : **9:00 AM** End Time : **5:00 PM**

Sunday

Start Time : **None** End Time : **None**

Start Time : **None** **End Time :** **None**

Patients :

Do you accept new patients at this practice location? **Yes**
 Do you accept existing patients with change of payor at this location? **Yes**
 Do you accept all new patients at this location? **Yes**
 Do you accept new Medicare patients at this location? **No**
 Do you accept new Medicaid patients at this location? **Yes**
 Do you accept new CHIP patients at this location? **No**
 Do you accept new patients from physician referrals (i.e., referring letter) at this location? **Yes**

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan ? **No**

Colleagues :

Do you have any Partners/Associate at this location ?

Covering Colleagues :**Mid-Level Practitioners :**

Do you have any mid-level practitioners at this location?

Office Manager or Business Staff Contact :

First Name :	Rafael	Last Name :	Pinero
Middle Name :		Suffix :	
Phone Number :	855-832-6727	Fax Number :	772-675-9100
E-mail Address :	RrPinero@teampbs.com		

Is Office Manager Credentialing

Contact :

Billing Contact :

Office Manager & Billing Contact are same ?

Payment and Remittance :

Billing department name :	PBS Corp Billing Department	Check Payable to :	Positive Behavior Supports corp
Electronic billing capabilities ?	Yes		

Office Manager & Payee Contact are same ?

Practice Limitations and Patient Populations :

Are there any Practice Limitations ? **No**

Gender Limitations :

Are there any Age Limitations ?

Only Native Americans:

Only Enrolled Students:

Other Limitations :

Accessibility :

Does this office meet ADA accessibility requirements ? **Yes**

Does this office provide handicapped accessibility ? **Yes**

Please specify how this location meets handicapped accessibility requirements:

Exterior Building	No
Interior Building	No
Wheelchair access to exam room	No
Exam table/scale/chair	No
Gurneys & Stretchers	No
Portable Lifts	No
Radiologic Equipment	No
Signage & documents	No
Parking	Yes
Restroom	Yes

Other Handicapped Access :

Does this office have other services for the disabled ?

No**Please specify other services for the disabled:**

Text Telephony (TTL) :

No

American Sign Language :

No

Mental/Physical Impairment Services :

No

Other Disability Services :

Is this office accessible by public transportation ?

No**Please specify how this office is accessible by public transportation:**

Bus Transportation:

No

Subway :

No

Regional Train :

No

Other Transportation :

Does this Location Provide Child Care Services?

No

Does this office meet all state and local fire, safety and sanitation requirements?

No

Do you have TDD(hearing impaired device) available :

No

Do you accept Workers' Compensation Patients?

No

Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy?

No

Modified or alternative duty is actively evaluated for each Workers' Compensation claimant?

No

Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible

No

Staff are available and willing to provide compensation representatives information regarding a claimant's care.

No

Telehealth :

I provide telehealth services at this location:

Yes

Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)?

Yes**Telehealth Service Type:**

Audio :

Yes

Audio/Video :

Yes

Online Adaptive Interviews :

Yes

Secure Text Messaging :

Yes

Remote Monitoring :

Yes

Store-and-Forward :

No

Are you willing and able to support family caregivers?

Yes

Services :

Does this location provide any of the following services:

Laboratory Services? :

No

Accrediting/Certifying Program :

Radiology Services :

No

X-ray?

No

X-Ray Certification Type :

No

EKG Services?

No

Care of Minor Lacerations?

No

Pulmonary Function testing?

No

Allergy Injections :

No

Allergy Skin Testing :

No

Office Gynecology?

No

Drawing Blood?

No

Age Appropriate Immunizations?

No

Asthma Treatment?

No

Tympanometry/Audiometry

No

Flexible Sigmoidoscopy?

No

Screening?

Osteopathic Manipulation?

No

IV Hydration treatment?

No

Cardiac Stress Test?

No

Physical Therapy?

No

Treadmill?

Is anesthesia administered in your office ?

No

What class/category of anesthesia is used ?

Anesthesia Administered by First Name :

Anesthesia Administered by Last Name :

Other Services :

Special Skills By The Practitioner :

Special Skills By The Staff :

Non-English language spoken by office personnel :

Employee Type :

Do you have any interpreters at this location?

No

Confirmed Date :	1/22/2025	Providers's Start Date :	10/18/2023
Office Type :	Other Practice		
Do you practice at this location?:	No, I do not practice here		
Please Explain:	I no longer practice at this location		
End Date :	1/1/2025		
Provider Directory Classification :			
Specialty :	Behavior Analyst	Subspecialty :	
Will you continue to practice at this location	No	If no, last date of employment	9/13/2024
Type of Service provided :			
Provide a narrative description of your clinical practice including special interests :			
Practice Name :	Aces		
Street 1 :	16782 Von Karman Ave Ste 11		
Street 2 :			
City :	Irvine	Country :	United States
County :			
Zip Code :	92606-2417	State :	CA
Can general correspondence be sent to this location?			
Province :			
Email Address :			
Practice Location Website			
Appointment Scheduling Website			
Mailing Address :			
Street1 :			
City :	Street2 :		
County :	State :		
Country :	Province :		
Type of Practice :			
Do you have an organization (Type 2 NPI)? :	Yes	Organization (Type 2) NPI:	1467520452
Group Medicaid Number :			
Phone Numbers :			
Appointment Phone Number :	855-223-7123	Phone Extention :	
Fax Number :			
Back Office Phone Number :			
Phone Coverage :			
Does this location provide 24hour/7day a week phone coverage?:			
Phone Coverage Type :			
Tax Information :			
Practice Name as it appears on the W-9 :	Aces 2020 LLC		
Tax ID :	330883047	Type of Tax ID :	Group
Is this the primary Tax ID for this practice location?	Yes		
Group Name :			
Network Denial :			
Have you closed your practice to any plans or programs ?	No		
Office Hours :			
Monday			
Start Time :	8:00 AM	End Time :	5:00 PM
Tuesday			
Start Time :	8:00 AM	End Time :	5:00 PM
Wednesday			
Start Time :	8:00 AM	End Time :	5:00 PM
Thursday			
Start Time :	8:00 AM	End Time :	5:00 PM
Friday			
Start Time :	8:00 AM	End Time :	5:00 PM
Saturday			
Start Time :	None	End Time :	None
Sunday			
Start Time :	None	End Time :	None
Patients :			

Do you accept new patients at this practice location? **Yes**

Do you accept existing patients with change of payor at this location? **Yes**

Do you accept all new patients at this location? **Yes**

Do you accept new Medicare patients at this location? **No**

Do you accept new Medicaid patients at this location? **Yes**

Do you accept new CHIP patients at this location? **Yes**

Do you accept new patients from physician referrals (i.e., referring letter) at this location? **Yes**

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan ? **No**

Colleagues :

Do you have any Partners/Associate at this location ?

Covering Colleagues :**Mid-Level Practitioners :**

Do you have any mid-level practitioners at this location?

Office Manager or Business Staff Contact :

First Name :	Jennifer	Last Name :	Guzman
Middle Name :		Suffix :	
Phone Number :		Fax Number :	
E-mail Address :	jmguzman@acesaba.com		

Is Office Manager Credentialing

Contact :

Billing Contact :

Office Manager & Billing Contact are same ?

Payment and Remittance :

Billing department name : Check Payable to :

Electronic billing capabilities ?

Office Manager & Payee Contact are same ?

Practice Limitations and Patient Populations :

Are there any Practice Limitations ? **Yes**

Gender Limitations :

Are there any Age Limitations? **Yes**

Age Minimum :	0	Age Maximum :	17
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Only Native Americans:

Only Enrolled Students:

Other Limitations :

Accessibility :

Does this office meet ADA accessibility requirements ? **Yes**

Does this office provide handicapped accessibility ? **Yes**

Please specify how this location meets handicapped accessibility requirements:

Exterior Building	Yes
Interior Building	No
Wheelchair access to exam room	No
Exam table/scale/chair	No
Gurneys & Stretchers	No
Portable Lifts	No
Radiologic Equipment	No
Signage & documents	No
Parking	Yes
Restroom	Yes
Other Handicapped Access :	

Does this office have other services for the disabled ?	Yes
Please specify other services for the disabled:	
Text Telephony (TTL) :	No
American Sign Language :	No
Mental/Physical Impairment Services :	Yes
Other Disability Services :	
Is this office accessible by public transportation ?	Yes
Please specify how this office is accessible by public transportation:	
Bus Transportation:	Yes
Subway :	No
Regional Train :	No
Other Transportation :	
Does this Location Provide Child Care Services?	No
Does this office meet all state and local fire, safety and sanitation requirements?	No
Do you have TDD(hearing impaired device) available :	No
Do you accept Workers' Compensation Patients?	No
Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy?	No
Modified or alternative duty is actively evaluated for each Workers' Compensation claimant?	No
Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible	No
Staff are available and willing to provide compensation representatives information regarding a claimant's care.	No
Telehealth :	
I provide telehealth services at this location:	Yes
Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)?	Yes
Telehealth Service Type:	
Audio :	No
Online Adaptive Interviews :	No
Remote Monitoring :	No
Are you willing and able to support family caregivers?	No
Services :	
Does this location provide any of the following services:	
Laboratory Services? :	No
Radiology Services :	No
X-Ray Certification Type :	
Care of Minor Lacerations? :	No
Allergy Injections :	No
Office Gynecology?	No
Drawing Blood?	No
Asthma Treatment?	No
Flexible Sigmoidoscopy?	No
Osteopathic Manipulation?	No
Cardiac Stress Test?	No
Treadmill?	
Is anesthesia administered in your office ?	No
Anesthesia Administered by First Name :	
Other Services :	
Special Skills By The Practitioner :	Special Skills By The Staff :
Non-English language spoken by office personnel :	
Employee Type :	
Do you have any interpreters at this location?	No
General Information :	
Confirmed Date :	9/2/2025
Office Type :	Primary Practice
Do you practice at this location?:	No, I do not practice here
Providers's Start Date :	9/16/2024

Please Explain:	I no longer practice at this location		
End Date :	3/15/2025		
Provider Directory Classification :	None of the above		
Specialty :	Behavior Analyst	Subspecialty :	
Will you continue to practice at this location			
Type of Service provided :			
Provide a narrative description of your clinical practice including special interests :			
Practice Name :	Behavior Frontiers, LLC		
Street 1 :	1100 W Town and Country Rd Ste 1250		
Street 2 :			
City :	Orange	Country :	United States
County :	Orange County	State :	CA
Zip Code :	92868-4633	Province :	
Can general correspondence be sent to this location?	No	Email Address :	intake@behaviorfrontiers.com
Practice Location Website			
Mailing Address :			
Street1 :	100 N. Pacific Coast Highway	Street2 :	Suite 1400
City :	El Segundo	State :	CA
County :	Los Angeles County	Province :	
Country :	United States	Zip Code :	90245
Type of Practice :	Single Specialty Group	Organization (Type 2) NPI:	1245539394
Do you have an organization (Type 2 NPI)? :	Yes	Organization (Type 2) NPI:	1245539394
Group Medicaid Number :	Group Medicare Number :		
Phone Numbers :			
Appointment Phone Number :	949-357-2556	Phone Extention :	
Fax Number :	855-568-2494		
Back Office Phone Number :	310-856-0800		
Phone Coverage :			
Does this location provide 24hour/7day a week phone coverage?:	No		
Phone Coverage Type :			
Tax Information :			
Practice Name as it appears on the W-9 :	Behavior Frontiers, LLC		
Tax ID :	200939510	Type of Tax ID :	Group
Is this the primary Tax ID for this practice location?	Yes		
Group Name :	Behavior Frontiers, LLC		
Network Denial :			
Have you closed your practice to any plans or programs ?	No		
Office Hours :			
Monday			
Start Time :	8:00 AM	End Time :	8:00 PM
Tuesday			
Start Time :	8:00 AM	End Time :	8:00 PM
Wednesday			
Start Time :	8:00 AM	End Time :	8:00 PM
Thursday			
Start Time :	8:00 AM	End Time :	8:00 PM
Friday			
Start Time :	8:00 AM	End Time :	8:00 PM
Saturday			
Start Time :	9:00 AM	End Time :	4:30 PM
Sunday			
Start Time :	None	End Time :	None
Patients :			
Do you accept new patients at this practice location?	Yes		

Do you accept existing patients with change of payor at this location? **Yes**

Do you accept all new patients at this location? **Yes**

Do you accept new Medicare patients at this location? **No**

Do you accept new Medicaid patients at this location? **Yes**

Do you accept new CHIP patients at this location? **Yes**

Do you accept new patients from physician referrals (i.e., referring letter) at this location? **Yes**

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan? **No**

Colleagues :

Do you have any Partners/Associate at this location? **Yes**

Partners/Associates :

Colleague Type : **Associate**

First Name : **Deanna**

Middle Name :

Last Name : **Bautista**

Suffix :

NUCC Grouping :

Specialty : **Behavior Analyst**

Provider Type : **ABA**

License Number : **1-04-1866**

Does this partner/associate provide coverage for you : **Yes**

Covering Colleagues :

Mid-Level Practitioners :

Do you have any mid-level practitioners at this location? **No**

Office Manager or Business Staff Contact :

First Name : **Cindy**

Last Name : **Williams**

Middle Name :

Suffix :

Phone Number : **310-856-0800**

Fax Number : **855-568-2494**

E-mail Address : intake@behaviorfrontiers.com

Is Office Manager Credentialing

Contact :

Billing Contact :

Office Manager & Billing Contact are same ?

First Name : **Tara**

Middle Name :

Last Name : **Bechtle**

Street 1 :

100 N. Pacific Coast Highway

Billing Company Name :

Street 2 : **Suite 1400**

City :

El Segundo

State: **CA**

Province :

90245

Country :

Zip Code :

855-568-2494

Phone Number : **310-856-0800**

Fax Number :

E-mail Address : billing@behaviorfrontiers.com

Payment and Remittance :

Billing department name :

Check Payable to :

Electronic billing capabilities ?

Office Manager & Payee Contact are same ?

First Name :

Middle Name :

Last Name :

Street 1 :

Street 2 :

City :

State:

Province :

Country :

Zip Code :

Phone Number :

E-mail Address :

Fax Number :

Practice Limitations and Patient Populations :

Are there any Practice Limitations ? **Yes**

Gender Limitations : **No**
 Are there any Age Limitations? : **Yes**
 Age Minimum : **2** Age Maximum : **25**

Only Native Americans:
 Only Enrolled Students:
 Other Limitations :

Accessibility :

Does this office meet ADA accessibility requirements ? **Yes**

Does this office provide handicapped accessibility ? **Yes**

Please specify how this location meets handicapped accessibility requirements:

Exterior Building **Yes**
 Interior Building **Yes**
 Wheelchair access to exam room **No**
 Exam table/scale/chair **No**
 Gurneys & Stretchers **No**
 Portable Lifts **No**
 Radiologic Equipment **No**
 Signage & documents **No**
 Parking **Yes**
 Restroom **Yes**

Other Handicapped Access :

Does this office have other services for the disabled ? **Yes**

Please specify other services for the disabled:

Text Telephony (TTL) : **No**
 American Sign Language : **No**
 Mental/Physical Impairment Services : **Yes**

Other Disability Services :

Is this office accessible by public transportation ? **Yes**

Please specify how this office is accessible by public transportation:

Bus Transportation: **Yes**
 Subway : **No**
 Regional Train : **No**

Other Transportation :

Does this Location Provide Child Care Services? **No**
 Does this office meet all state and local fire, safety and sanitation requirements? **Yes**

Do you have TDD(hearing impaired device) available : **No**

Do you accept Workers' Compensation Patients? **No**

Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? **No**

Modified or alternative duty is actively evaluated for each Workers' Compensation claimant? **No**

Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible **No**

Staff are available and willing to provide compensation representatives information regarding a claimant's care. **No**

Telehealth :

I provide telehealth services at this location: **Yes**
 Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)? **Yes**

Telehealth Service Type:

Audio :	Yes	Audio/Video :	Yes
Online Adaptive Interviews :	No	Secure Text Messaging :	
Remote Monitoring :	Yes	Store-and-Forward :	

Are you willing and able to support family caregivers? **Yes**

Services :

Does this location provide any of the following services:

Laboratory Services? :	No	Accrediting/Certifying Program :	No
Radiology Services :	No	X-ray?	No
X-Ray Certification Type :		EKG Services?	No
Care of Minor Lacerations? :	No	Pulmonary Function testing?	No
Allergy Injections :	No	Allergy Skin Testing :	No
Office Gynecology?	No		
Drawing Blood?	No		

Asthma Treatment?	No	Age Appropriate Immunizations?	No
Flexible Sigmoidoscopy?	No	Tympanometry/Audiometry Screening?	No
Osteopathic Manipulation?	No	IV Hydration treatment?	No
Cardiac Stress Test?	No	Physical Therapy?	No
Treadmill?			
Is anesthesia administered in your office ?	No	What class/category of anesthesia is used ?	
Anesthesia Administered by First Name :		Anesthesia Administered by Last Name :	
Other Services :			
Special Skills By The Practitioner :		Special Skills By The Staff :	
Non-English language spoken by office personnel :			
Employee Type :			
Do you have any interpreters at this location?	No		

HOSPITAL AFFILIATIONS**General :**

Do you have admitting privileges at one or more hospitals?	No
Do you have an admitting arrangement where another provider admits for you?	No
Do you have any non-admitting hospital affiliations?	

CREDENTIALING INFORMATION

First Name :	Michael	Middle Name :	
Last Name :	Lange	Street 1 :	7108 S Kanner Hwy
Street 2 :		City :	Stuart
State :	FL	Zip Code :	34997-7462
Country :	United States	Province :	
Phone Number :	855-832-6727	Fax Number :	
Email Address :	mlange@teampbs.com		
Primary Credentialing Contact :	Yes		
Location Type :			

INSURANCE INFORMATION

Policy Number :	6799172		
Covered Practice Locations :	Positive Behavior Supports Corporation - LA Metro		
Original Effective Date :	01/31/2025		
Current Effective Date :	01/31/2025		
Current Expiration Date :	01/31/2026		
Carrier/Self Insured Name :	Banack Insurance Agency LLC		
Street 1 :	800 Virginia Ave, #27	Street 2 :	
City :	Fort Pierce	Province :	
State :	FL	Country :	United States
Zip Code :	34982	Phone Number :	772-464-8833
Phone Extension :		Fax Number :	772-464-8966
Do you have unlimited coverage with this insurance carrier?	No		
Type of coverage :	Occurrence		
Amount of coverage per occurrence :	\$1,000,000.00	Amount of coverage aggregate :	\$3,000,000.00
If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?			
Individual Coverage :	No		
Self-Insured?	No		
Policy Number :	ZDDD263686		
Covered Practice Locations :			
Original Effective Date :			
Current Effective Date :	07/22/2024	Street 2 :	
Current Expiration Date :	07/22/2025	Province :	
Carrier/Self Insured Name :	Hanover Ins Co	Country :	
Street 1 :	100 North Pkwy	Phone Number :	
City :	Worcester		
State :	MA		
Zip Code :			

Phone Extension : Fax Number :

Do you have unlimited coverage with **No**
this insurance carrier?

Type of coverage : **Occurrence**

Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?

Individual Coverage : **No**

Self-Insured? **No**

Policy Number : **852843713**

Covered Practice Locations :

Original Effective Date : **11/26/2023**

Current Effective Date : **11/26/2024**

Carrier/Self Insured Name : **Starnet Insurance Company**

Street 1 : **475 Steamboat Road** Street 2 :

City : **Greenwich** Province :

State : **CT** Country :

Zip Code : **06830** Phone Number :

Phone Extension : Fax Number :

Do you have unlimited coverage with **No**
this insurance carrier?

Type of coverage :

Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?

Individual Coverage : **No**

Self-Insured? **No**

Policy Number : **ZDDD263686**

Covered Practice Locations :

Original Effective Date : **07/22/2023**

Current Effective Date : **07/22/2024**

Carrier/Self Insured Name : **Hanover Ins Co**

Street 1 : **100 North Pkwy** Street 2 :

City : **Worcester** Province :

State : **MA** Country :

Zip Code : Phone Number :

Phone Extension : Fax Number :

Do you have unlimited coverage with **No**
this insurance carrier?

Type of coverage : **Occurrence**

Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?

Individual Coverage : **No**

Self-Insured? **No**

WORK HISTORY INFORMATION**Employment Information Record**

Practice/Employer Name :	PBS Corporation	Department :
Street 1 :	7108 S Kanner Hwy	Street 2 :
Country :	United States	
City :	Stuart	State : FL
Province :		Zip Code : 34997
Phone Number :		Phone Extension :
Fax Number :		
Start Date :	09/2025	
Is this your current employer?	Yes	
Practice/Employer Name :	Behavior Frontiers, LLC	Department :
Street 1 :	1100 Town & Country Rd	Street 2 : Suite 1250
Country :	United States	
City :	Orange	State : CA
Province :		Zip Code : 92868
Phone Number :	949-357-2556	Phone Extension :
Fax Number :	855-568-2494	

Start Date :	09/2024	Reason for departure :	Started school again and wanted to find part time BCBA
Is this your current employer?	No		
End Date :	03/2025		
Practice/Employer Name :	Aces	Department :	
Street 1 :	16782 Von Karman	Street 2 :	
Country :	United States		
City :	Irvine	State :	CA
Province :		Zip Code :	92606
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	11/2023		
Is this your current employer?	No		
End Date :	09/2024	Reason for departure :	New role
Practice/Employer Name :	Soliant Healthcare	Department :	
Street 1 :	21801 Winding Way	Street 2 :	
Country :	United States		
City :	Lake Forest	State :	CA
Province :		Zip Code :	92630
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	10/2023		
Is this your current employer?	No		
End Date :	10/2023	Reason for departure :	Better opportunity in field of study
Practice/Employer Name :	The Stepping Stones Group LLC	Department :	
Street 1 :	1835 W Orangewood Ave	Street 2 :	
Country :	United States		
City :	Orange	State :	CA
Province :		Zip Code :	92868
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	03/2023		
Is this your current employer?	No		
End Date :	09/2023	Reason for departure :	Location
Practice/Employer Name :	Smart Start Jungbong	Department :	
Street 1 :	Daero 586Beon-gil,	Street 2 :	
Country :	Korea, South		
City :	15 Seo-gu Incheon	State :	
Province :		Zip Code :	
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	09/2021		
Is this your current employer?	No		
End Date :	12/2022	Reason for departure :	CAREER GROWTH
Practice/Employer Name :	Center for Autism and Related Disorders	Department :	
Street 1 :	106 Discovery STREET	Street 2 :	
Country :	United States		
City :	Irvine	State :	CA
Province :		Zip Code :	92618
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	11/2018		
Is this your current employer?	No		
End Date :	07/2021	Reason for departure :	CAREER GROWTH
Employment Gap Record :			
Start Date:	12/2022	End Date:	03/2023
Gap Explanation:	Medical leave		
Start Date:	04/2021	End Date:	12/2022
Gap Explanation:	Academic/Training leave		
Military :			
Are you currently on active military duty?	No	Are you currently in the Reserves or National Guard?	

REFERENCES INFORMATION

Provider Type :	Applied Behavioral Analyst
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First Name :	Adrienne	Middle Name :	
Last Name :	Tran	Street 2 :	
Street 1 :		State :	CA
City:	Costa Mesa	Zip Code :	
Province :		Email Address :	At7128@centerforautism.com
Country :			
Phone Number :	714-757-9714		
Fax Number :			
Provider Type :	Applied Behavioral Analyst		
First Name :	Julie	Middle Name :	
Last Name :	Polanco	Street 2 :	
Street 1 :		State :	NY
City:	Brooklyn	Zip Code :	
Province :		Email Address :	juliepolanco@gmail.com
Country :	United States		
Phone Number :	347-415-7049		
Fax Number :			
Provider Type :	Applied Behavioral Analyst		
First Name :	Cathy	Middle Name :	
Last Name :	Tran	Street 2 :	
Street 1 :		State :	
City:	Santa Ana	Zip Code :	
Province :		Email Address :	Cathy.tran@ssg-healthcare.com
Country :	United States		
Phone Number :	714-675-3259		
Fax Number :			

DISCLOSURE INFORMATION

CAQH :

Licensure :

1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, No suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?

2. Has there been any challenge to your licensure, registration or certification? No

Hospital Privileges and Other Affiliations :

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? No

4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? No

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? No

Education, Training and Board Certification :

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? No

7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? No

8. Have any of your board certifications or eligibility ever been revoked? No

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? No

DEA or CDS :

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? No

Medicare, Medicaid or other Governmental Program Participation :

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? No

Other Sanctions or Investigations :

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offence or sexual misconduct? No

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? No

14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? **No**

15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? **No**

16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? **No**

Professional Liability Insurance Information and Claims History :

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? **No**

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? **No**

Malpractice Claims History :

19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case. **No**

Criminal/Civil History :

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? **No**

21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct? **No**

22. Have you ever been court-martialed for actions related to your duties as a medical professional? **No**

Ability to Perform Job :

23. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. Illegal use of drugs refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the controlled Substances Act or other provision of Federal law. The term does include, however, the unlawful use of prescription controlled substances.) **No**

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? **No**

25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? **No**

26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? **No**