

# PMC

Professional Medical Corporation

P.O. Box 1068 • East Lansing, MI 48826-1068 • Phone: (800) 594-6115 • Fax: (517) 336-4177

In order to be considered for membership with Professional Medical Corporation, all interested physicians must meet the basic membership criteria, which include:

- A physician must be board-certified or show evidence of board-eligibility with intent to seek board certification.
- A physician must commit to participate in health plan contracts only through PMC.

*Please check below which health plans you are currently contracted with, and those you anticipate contracting with through PMC.*

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- |   |   |                                 |
|---|---|---------------------------------|
| <input type="checkbox"/> BCBSM PGIP                         | <input type="checkbox"/> McLaren Health Plan  | <input type="checkbox"/> Humana |
| <input type="checkbox"/> Blue Care Network                  | <input type="checkbox"/> Meridian Health Plan |                                 |
| <input type="checkbox"/> Blue Cross Complete                | <input type="checkbox"/> Priority Health      |                                 |
| <input type="checkbox"/> Molina                             | <input type="checkbox"/> Total Health Care    |                                 |
| <input type="checkbox"/> Health Alliance Plan / Health Plus | <input type="checkbox"/> USA Managed Care     |                                 |
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- A physician must implement PMC's registry.
- A physician must be willing to have the services he/she provides be monitored and reviewed by the PMC MMC and Medical Director.
- A physician must be willing to have a probationary period of at least one year. At the end of this period, the MMC will review the cost, utilization and quality performance of the physicians. In its discretion, the MMC may permit the physician to become a member of PMC, may deny the physicians membership in PMC, or may extend the physician's probationary period.
- A physician must pay a membership fee of \$1,500.

By signing and dating below, the physician certifies that they have read the new physician criteria and that to the best of their knowledge; they meet all of the above requirements.

Physician Name (PRINTED):

Date:

\_\_\_\_\_

\_\_\_\_\_

Physician Signature:

\_\_\_\_\_

Practice Name:

\_\_\_\_\_

This document must be returned with the Physician Information Form and W-9 to membership at [membership@medadvgrp.com](mailto:membership@medadvgrp.com) or fax to (517) 336-4177 to be considered for membership.