PMC
Professional Medical Corporation

2425 S. Linden Road, Suite B • Flint, MI 48532

Dear Provider:

Thank you for your interest in becoming a member of Professional Medical Corporation (PMC); a network of over 475 independent physicians dedicated to quality improvement and efficiency of patient care.

Attached, please find a complete membership packet that will assist PMC in your enrollment process. Please **fully** complete the packet, including the $1500 one-time only membership fee, and all the information requested. Failure to do so may delay the credentialing process for the various health plans. Once the information is received, the applications will be submitted to the health plans. Applications received without the membership fee included will be held until the fee is received. Please keep in mind credentialing may take anywhere from 60-120 days for processing (for brand new credentialing). PMC is not responsible for the time frame in which the health plans process any credentialing paperwork. It is recommended practices review and/or confirm participation with the health plans before scheduling those patients.

If you are a physician joining the Blue Cross Blue Shield PGIP program, a practice consultant will reach out to you to review the program and expectations.

If you have any questions completing the attached, please feel free to email Membership@medadvgrp.com or call 734-904-9604.

We look forward to working with you,

PMC Membership Department

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2425 S. Linden Rd., Flint, MI 48532 • Phone: (800) 594-6115 • Fax: (866) 396-9257

PROVIDER REQUEST FOR AFFILIATION

Printed Physician Name: _____

This form will be used to initiate enrollment with Professional Medical Corporation (PMC). Completing this form and submission of the documents below is the first step in the enrollment process. Please be advised as a PMC provider you must have a practice location within the Genesee/Lapeer County area and if you are a Primary Care Provider (PCP) you cannot belong to more than one PO/PHO. All documents are enclosed in the packet, unless otherwise noted.

Please indicate the hospital affiliations you currently have or are applying to. Please check all that apply:

- ☐ Currently have Hurley Medical Center Privileges
- ☐ Applying for Hurley Medical Center Privileges
- ☐ Currently have McLaren Regional Medical Center Privileges
- ☐ Applying for McLaren Regional Medical Center Privileges
- ☐ Currently have Genesys Regional Medical Center Privileges
- ☐ Applying for Genesys Regional Medical Center Privileges
- ☐ Other: _____

Please supply all documents listed:

- ☐ CAQH Summary (NOT full application) *Provided* by physician
- ☐ EFT Authorization form
- ☐ PGIP Agreement
- ☐ W-9
- ☐ Specialist Agreement – if applicable
- ☐ Current Copy of Malpractice Professional Liability Insurance face sheet
- ☐ Check for Stock Shares - $1500.00
- ☐ PMC Physician Information Form
- ☐ Stock Subscription agreement
- ☐ Network participation agreement
- ☐ PCP Expectation form – if applicable
- ☐ PMC Data Sharing, Access and Use Agreement
- ☐ PGIP Physician Acknowledgement form

Blue Care Network and Blue Cross Complete

- ☐ BCN MCG Practitioner Affiliation Agreement
- ☐ BCN Medicaid Compliance Attestation
- ☐ BCN MCG Commercial Medicare Agreement
- ☐ BCC Enrollment Application

HAP

- ☐ HAP Physician Information form
- ☐ HAP Mid West
- ☐ HAP Physician Acknowledgement and Consent form (HMO, Commercial & SR)

Humana

- ☐ Letter of Agreement

McLaren Health Plan

- ☐ Physician Affiliation Acknowledgement

Meridian Health Plan

- ☐ Physician Acknowledgement
- ☐ Provider Disclosure Information Request

Molina

- ☐ Disclosure Form

Priority Health

- ☐ Supplemental Credentialing Form
- ☐ Physician Acknowledgement

Total Health Care

- ☐ Total Health Care Physician Agreement
- ☐ Total Health Care Provider Disclosure

USA Managed Care

- ☐ Provider Credentialing Application
- ☐ HCFA 1500 Claim Form
- ☐ Provider Application

Please contact the membership department if you have any questions at membership@medadvgrp.com. Return these forms to: Membership, fax: (866)396-9257 2425 S. Linden Rd., Flint MI 48532

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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 **(THIS IS APPLICABLE TO PRIMARY CARE PHYSICIANS ONLY)**

  *Please check below the health plans you are currently contracted with. If you are **not** contracted, please circle those health plans you would like to contract with through PMC.*

- ☐ BCBSM PGIP
- ☐ Blue Care Network
- ☐ Blue Cross Complete
- ☐ Health Alliance Plan / Health Plus
- ☐ Humana
- ☐ Meridian Health Plan
- ☐ McLaren Health Plan
- ☐ Molina
- ☐ Priority Health
- ☐ Total Health Care
- ☐ USA Managed Care

- A physician must pay a membership fee of $1,500. – Please make check payable to **Professional Medical Corporation**

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 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.om or fax to (866) 396-9257 to be considered for membership.

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Physician Information Form

Personal Information

Last Name:_____

First Name:_____

Middle Initial: _____

Provider Type (MD, DO, etc.): ____

PCP: (Yes/No) _____

Date of Birth: _____

Practice Information

Practice Name: _____

Address: _____

City: _____

State:_____

ZIP: _____

County: _____

Phone: _____

Alt. Phone: _____

Fax: _____

Email: _____

Tax ID#: _____
(PLEASE ATTACH W-9)

Pay to Information:

(if different than practice information)

Practice Name: _____ __ ____

Address: _____ ____

_____ ____

City/State/Zip: _____

Tax ID#: _____ _____ _____

Office Manager Information

Office Manager: _____

Office Manager Phone: _____

Office Manager Fax: _____

Office Manager E-Mail:_____

Additional Information

Practice Specialty: _____

Board Certified Specialty:_____

Board Eligible: (Yes/No) _____

State License #_____

DEA#_____

NPI# Number #: _____

Type 2 NPI#_____

CAQH ID: _____

Accepting New Patient (Yes/No)

Hospital Affiliations: _____

_____

Medical Malpractice Carrier: _____

Office Technologies

Practice Management System: _____

EMR System: _____

E-Prescribing Vendor: _____

Patient Registry Vendor: _____

Patient Portal Vendor:_____