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

Please contact the membership department if you have any questions at PMCMembership@medicaladvantage.com.

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 check those health plans you would like to contract with through PMC. *

☐ BCBSM PGIP ☐ Blue Care Network

☐ Blue Cross Complete ☐ Health Alliance Plan

☐ Humana ☐ Meridian Health Plan

☐ McLaren Health Plan ☐ Molina

☐ Priority Health

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:

Date:

Practice Name:

Physician Signature: