Medical Group Pennsylvania

Membership Application

Last Name: First Name: Title:

Home Address:

City: State: Zip Code: NPI #:

Cell Phone: Email Address:

Preferred Method of Contact: Email ☐ Text ☐ Phone ☐ Other ☐

Primary Worksite Location:

City: States: Zip Code:

Board Certification:

Specialty:

How Many Years Have You Been in Practice:

Practice Group Name:

Practice Group Address:

City: State: Zip Code: NPI #:

Phone: Fax: Website:

Number of Physicians in Group:

Number of PA/CNPR in Group:

Does your office have an EMR? (if so list it here):

Office Manager Name:

Office Manager Email: Office Manager Phone:

Are you employed by a Hospital System?

Do you have a valid license to practice in PA?

Are you approved by Medicare?

Are you accepting new patients?

Medical Group Pennsylvania

Please list all hospital affiliations:

Please check all insurances accepted:

☐ Aetna ☐ Capital Blue Cross ☐ Cigna ☐ Highmark Blue Shield

☐ Medicaid ☐ Medicare ☐ No Insurance ☐ United Health Care

☐ Vibra Health Plan ☐ Other:

Have you been charged with a felony in the past 10 years? ☐ Yes ☐ No

If yes, please explain:

Have you ever had your license revoked or suspended? ☐ Yes ☐ No

If yes, please explain:

Have you ever had your hospital privileges declined, suspended or revoked? ☐ Yes ☐ No

If yes, please explain:

Please list 3 Physician References we may contact:

Name:

Email:

Phone:

Name:

Email:

Phone:

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Name:

Email:

Phone:

I attest and confirm the foregoing information is true and correct.

Signature: _____ Date: _____