



## Group Practice Application

Please complete this form along with the roster template found on our Resources Page & email it to [providerservices@credmaxpmd.com](mailto:providerservices@credmaxpmd.com).

<b>Primary Contact Name:</b>	<b>Primary Contact Email:</b>	<b>Today's Date:</b>
<b>Primary Contact's Title:</b>	<b>Group Legal Name:</b>	
<b>Group NPI:</b>	<b>Tax ID:</b>	<b>Effective Date:</b>
<b>Primary Practice Location Name:</b>		
<b>Primary Practice Address:</b>		<b>City, State &amp; Zip:</b>
<b>Group Primary Specialty:</b>	<b>Group Secondary Specialty:</b>	
<b>Group Medicare ID:</b>	<b>Group Medicaid ID:</b>	

<b>Payor Enrollment</b>	
<b>Please list all the health plans which you have an established contract for.</b>	
<b>Please list all the health plans in which you would like to have a contract initiated with.</b>	

Please visit [www.credmaxpdm.com](http://www.credmaxpdm.com) and from the Resources page download the roster template to add your providers to your group. (If you need to add or terminate a provider, there is another form also found in the resources page.)