RELYMD MEDICAL GROUP CREDENTIALING APPLICATION

Please print clearly or type.

Personal / Practice Information	
Name:	U S. Citizen: ☐Yes ☐No
Social Security Number:	Place of Birth:
Specialty:	MD ☐ DO ☐
Home Street Address:	Home phone:
Home City, State, Zip:	Cell phone:
Email:	Cell Provider (required for consult alerts)
Languages (other than English) in which you are fluent and would like conduct consults in that language:	
Medicare Number:	NPI Number:

Are you registered as a provider with Medicaid? ☐Yes ☐No
If yes, please provide a list of all Medicaid registration numbers and corresponding state(s) of registration.

Medicaid #: _____ **State of Registration:** _____
Medicaid #: _____ **State of Registration:** _____
Medicaid #: _____ **State of Registration:** _____
Medicaid #: _____ **State of Registration:** _____
Attach a separate sheet, if necessary.

Are you a provider for any Health Plans? ☐Yes ☐No

If yes, please list:
☐UHC/OPT ☐Aetna ☐BCBS ☐Cigna ☐Amerigroup ☐Humana ☐MultiPlan ☐Other:_____

Education and Training (Please provide a copy of diploma / certificate of completion)	
College or University:	Address:
Degree:	Major:
Dates of Attendance: From: To:	Program successfully completed? ☐Yes ☐No
Post-Graduate Education (Institution):	Address:
Degree:	Major:
Attendance Dates: From: To:	Program successfully completed? ☐Yes ☐No
Post-Graduate Education (Institution):	Address:
Degree:	Major:
Dates of Attendance: From: To:	Program successfully completed? ☐Yes ☐No
Post-Graduate Education (Institution):	Address:
Degree:	Major:
Dates of Attendance: From: To:	Program successfully completed? ☐Yes ☐No