Physician Credentialing Agreement

This agreement (the "Agreement"), dated _____, is between ClaimTek Systems ("Company") and _____ ("Client").

Company hereby agrees to provide credentialing services as outline below:

	Quantity	Unit Price	Total
Setup Fee (Required)	1	99.00	**99.00**
NPI Registration		49.00	
Medicare Credentialing		349.00	
Medicaid Credentialing		349.00	
Insurance Credentialing:	**Name:**		
Insurance Company #1		199.00	
Insurance Company #2		199.00	
Insurance Company #3		199.00	
Insurance Company #4		199.00	
Insurance Company #5		199.00	
Insurance Company #6		199.00	
Insurance Company #7		199.00	
Insurance Company #8		199.00	
Insurance Company #9		199.00	
Insurance Company #10		199.00	
Total			

Client hereby appoints Company as its authorized representative for purposes of completing the services listed above and further agrees to provide information necessary to complete services outlined in a timely manner as requested by the Company. Company hereby agrees to complete the credentialing services in a timely and professional manner.

There is no guarantee that Client will be successful in obtaining credentials as outlined above since Client must meet certain minimum qualifications, however this in no way impacts the fees owed to the Company so long as it completes the applications and information necessary for the respective applications.

The signature below (either electronic or written) acknowledges acceptance of the Agreement by Client.

Signature: _____

Print Name: _____

Please complete this Agreement and return by Fax to (800) 503-9461 or by email to info@physician-credentialing.com

3943 Irvine Blvd., #39, Irvine, CA 92602
Phone: (800) 224-7450 Fax: 800-503-9461

Billing Information

Business name: _____

Name on Card: _____

Address: _____

City: _____ State: _____ Zip: _____

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number: _____

Card Security Code (CVC2 Number): _____

Expiration Date: _____

I hereby authorize ClaimTek Systems to charge my credit card for services indicated in this Agreement.

Signature: _____ Date: _____

Print Name: _____

Please complete this Agreement and return by Fax to (800) 503-9461 or by email to info@physician-credentialing.com

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