



**Please Follow These Steps to Enroll:**

- 1) Complete Both Sections
- 2) Fax Form & Voided Check to: 949/502-6768

**Questions?**  
**888-444-1025**

**PROVIDER ENROLLMENT**

Physician's Name		Practice Name		
Practice Address		City	State	Zip
Telephone ( )		Fax Number ( )		
Web Site Address		Contact Email Address		
Federal Tax ID Number	Years in Business	Medical License Number	State Issued	
Key Contact Title		Phone Number/Extension		

I have received and read, and I understand and agree to be bound by, the "Provider-Bank Confidentiality Standards" (52269 v 2/8-2-07) and "Provider Performance Standards" (DM52268 v 2/8-2-07), all being effective as of the first day of my participation in the plan.

X \_\_\_\_\_

Physician / Authorized Signature Print Name

**INTERNET / WEB SITE**

<p>Cosmeticcredit offers providers a custom Web link, which tracks applications submitted to Cosmeticcredit and ensures your client's Web applications originated from your practice. In most cases, our IT Department will need to contact your Web master to ensure proper integration.</p> <p>Would you like to link your Web site to the Cosmeticcredit Site?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 100px;"><input type="checkbox"/> No</span></p>	<p>Webmaster Name: _____</p> <p>Phone: _____</p> <p>Email: _____</p>
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**ACH ENROLLMENT**

Bank Routing Number	Bank Account Number
Financial Institution Name	

The undersigned does hereby authorize Cosmeticcredit, LLC, its partners, transferees, and assignees, to automatically deposit (in the financial institution account listed above) any funds owed to the undersigned by Cosmeticcredit, LLC. The undersigned certifies the above information to be accurate and agrees with the provisions written herein.

X \_\_\_\_\_

Physician / Authorized Signature Print Name Date  
 Fax Completed Form with Copy of Voided 5031 Birch ST Suite I  
 Check To: Newport Beach, CA 92660  
 949/502-6768 888-444-1025 • [www.cosmeticcredit.com](http://www.cosmeticcredit.com)