January 2023

Dear Physician,

For over 20 years, EPMN has supported independent physicians in El Paso by providing valuable managed care contracting and credentialing administration services for our Members. In 2023, EPMN is expanding our service offerings to further support physicians in the community.

What does EPMN offer to you and your practice?

- *"One-Stop Shop" for Health Plan Credentialing/Enrollment, Medicare and Medicaid Enrollment, and Managed Care Contracting.*
- ***Exclusive discounts of 30-40% for Medical Malpractice Insurance Premiums offered to qualifying Members.***
- *Access more than 20 valued Managed Care Agreements, with ongoing provider relations support.*

***INCOMPLETE CREDENTIALING APPLICATIONS AND/OR PACKETS CANNOT BE PROCESSED**

Applications must be 100% complete in order for our staff to initiate the primary source verification and credentialing process. Incomplete Applications will be returned to the Applicant following three (3) attempts to obtain missing information or documents. The non-refundable Application Fee will be forfeited and new fees to re-active a de-activated Credentialing Application File will be required.

Enclosed with this letter your will find the following information:

- A roster of active Managed Care Agreements contracted with EPMN
- Detailed instructions for submitting an Application to Join EPMN
- Invoicing Details and Payment Options

I am pleased to extend my personal invitation for you to join EPMN and support like-minded physicians who share a passion to remain independent in their practice of medicine. I look forward to having you as an EPMN Member and hope to meet you personally in the near future.

Sincerely,

Manuel Borrego, MD
Board President

January 2023

Exclusive Savings on Medical Malpractice Coverage for EPMN Members

Dear EPMN Member:

In 2020, EPMN launched an exclusive initiative to reduce the cost of medical malpractice insurance for our El Paso Members.

By partnering with Coverica/Agape Insurance, EPMN Members who qualify can save up to 40% on medical malpractice and other property & casualty coverages.

During our first year with the program, we saw many of EPMN's members save thousands on their malpractice premiums, with some saving more than $20,000.

- ✓ If you have not received a quote on your policy renewal, please contact the Coverica/Agape team directly at **469-399-2362**.
- ✓ You can also learn more about these exclusive discounts by visiting EPMN's updated website at http://www.epmedical.com.

Thank you!

EPMN Board of Directors
Manuel Borrego, MD, President and Chairman

EPMN
% Cypress Healthcare Consultants
2929 N Central Expressway, Suite 205
Richardson, Texas 75080
(972) 424-1360

EPMN Bi-Annual RATE CARD

Calendar Year 2023

- **<u>Pay 100% of your Annual Dues by February 3, 2023 and receive an additional 10% off!</u>**
- Members will be invoiced on a bi-annual basis and must remain current to remain Members of EPMN and active in their Managed Care Contract Participation.
- Failure to pay Membership Dues on or before the due date will result in immediate termination from both EPMN and all Managed Care Plan Participation.
- Online payment is available at www.epmedical.com

Menu of Available Services and Fees

SERVICES AND FEES	EPMN
Annual Membership Dues	$990.00 (bi-annual *see below*)
January – June	$495.00
July – December	$495.00
Non Refundable Application Fee (Initial Credentialing)	$525.00 for MD, DO, OD, DPM, DC $425.00 for *non-physician providers*
Expedited Credentialing Fee (in addition to base credentialing fee)*	**$175.00**
Non- Refundable Recredentialing (triennial) Fee	$330.00
Expedited Recredentialing Fee*	**$175.00**
Credentialing Reactivation Fee	$175.00
Medicare Enrollment†	$350.00
Group Medicare Enrollment†	$350.00
Medicaid Enrollment†	$350.00
Group Medicaid Enrollment†	$350.00
Bundled (CMS/TMHP)Enrollment†	$650.00
Group Bundled (CMS/TMHP)Enrollment†	$650.00

*Upon Provider's Request, must be an MD, DO, OD, DPM, DC.

†Upon provider's request; with management approval.

****Expedited Re-Credentialing Fee*** will be charged in the event a provider's documentation for recredentialing is received by the Credentialing staff with fewer than twenty (20) business days to process prior to the deadline for submission to Committee. Expedited processing becomes necessary in that situation to avoid the provider's mandatory termination from the IPA for missing the re-credentialing deadline as defined by NCQA regulations.

Expedited Credentialing does not guarantee expedited contract approval from the health plans.

CREDIT CARD /Check Authorization Form El Paso Medical Network, Inc. (EPMN)

2929 N Central Expressway, Suite 205
Richardson, Texas 75080
P:(469) 661-0771 F:(469) 757-8883

INVOICE #: _____

Pay By: (Circle One) **CREDIT CARD** or **CHECK**

Paying by Check:

Date:_____ Check number:_____

Please Make Checks Payable to: EPMN

Paying by Credit Card (Visa, MC, Discover, Am Ex):

I,_____, authorize El Paso Medical Network, Inc. (EPMN) to
(Name Must be Printed Here)
charge the following amount, or amounts (if more than one service is being purchased) to my credit card:

$_____Description:_____

Please include the total dollar amount authorized and indicate that you are submitting payment for membership dues, and for what time period.

Confirm Total Amount Authorized to be Charged on this Authorization: $_____

Type of Card (Visa, MC, Discover, Am Ex):_____Card Number: _____

Name on Card:_____Exp Date:_____3-Digit Security: _____
PRINT NAME (4-Digit for Am Ex)

Billing Address:_____Zip Code: _____
MANDATORY

By my signature hereto, I affirm my understanding and agreement I will be charged upon receipt of signed credit card agreement, and this authorization will remain in effect until I cancel it in writing. I agree to notify EPMN in writing of any change in my account information or termination of this authorization at least 15 days prior to the next billing date, if applicable. I agree not to dispute this billing with my bank so long as the transaction corresponds to the terms indicated in this authorization form.

Email Address:_____Phone:_____

Signature:_____Date:_____

How to Apply for Participation

Thank you for your interest in joining El Paso Medical Network (EPMN); we look forward to reviewing your participation application.

We have included a useful credentialing checklist for your convenience. Please return the complete package to us as soon as possible. The credentialing process may be delayed if the information you provide is incomplete or inaccurate.

Completed documents should be returned to our Credentialing Verification Organization (CVO), Cypress Healthcare Consultants by mail, e-mail, or fax to:

El Paso Medical Network (EPMN)
% Cypress Healthcare Consultants
Attn: EPMN Credentialing
2929 N Central Expy, Ste 205
Richardson, TX 75080
EPMNcred@cypresshcc.com
(469) 757-8884

If you are a new group to EPMN:

If your application is approved by the EPMN Board of Directors, we will send you a Combined Messenger Notice and applicable accompanying payor documents for you to review, complete, sign, and return to EPMN. The Messenger details each of the payor plans that you may choose to opt into when accepted to the EPMN panel.

If you are joining a group currently participating with EPMN:

If your application is approved by the EPMN Board of Directors, you will receive a packet containing a list of the plans your group has opted into, along with the necessary documents required for participation with the applicable payors.

Upon receipt of the completed documents, EPMN will finalize the process and include you in the network panel. You have the right to receive information on the status of your application during the credentialing process, the right to review information submitted to support your credentialing application, and the right to correct erroneous information.

If you have questions regarding the status of your application during the credentialing process, you may contact Cypress Healthcare Consultants at (972) 424-1360. Or via email at EPMNCred@cypresshcc.com.

CREDENTIALING CRITERIA CHECKLIST

Please use this checklist to ensure that you have completed and submitted all of the Information weneed to process your membership in Physician Optimal Network, Inc.

PLEASE BE SURE TO COMPLETE THE CREDENTIALING APPLICATION IN ITS ENTIRETY
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED – No Exceptions

INITIAL AND RECREDENTIALING SERVICES REQUIRE PAYMENT PRIOR TO PROCESSING – Submit Payment at the Time Application is Submitted

Practitioner Name _____ Specialty _____

Practice Name _____ TIN _____

Contact Person _____ Phone _____

Contact Email _____ Website _____

Application and Signatures

Download a current Texas Standardized Credentialing Application (TSCA)

CAQH # _____

All required lines of the application MUST be completed.

Any line that is not applicable MUST be marked "NA." YOU MUST RETURN ALL PAGES OF THE APPLICATION EVEN IF THEY ARE NOT USED.

- ○ Individual Information (page 1)
- ○ Practice Information (pages 1-3)
- ○ Board Certifications (page 4)
- ○ Hospital and Education Information (page 5)
- ○ Work History (page 6)
- ○ Licenses and References (page 7)
- ○ Professional Liability Insurance (page 8)

○ All General Questions "Y" or "N" (page 8)
You MUST submit written explanations for any General Questions for which you have answered "Y"

(1) Provider Statement to Release Information
- o Signatures and Date

Attachments

Attach legible copies of the following documents. Do not send originals.

- ○ Current Texas License
- ○ Current Curriculum Vitae (CV)
- ○ Current DEA Certificate *(as applicable)*
- ○ Certificate of ECFMG (*if marked "yes" on page 2*)
- ○ Current Lab and X-Ray Certificates *(as applicable)*
- ○ Current Complete IRS Form W-9
- ○ Current Form CMS 1500
- ○ Attachment G (*if box 16 marked "yes"*)
- ○ Current insurance declaration page or certificate with coverage amounts and dates
- ○ Mid-level Supervision form
- ○ Participation Agreement *(as applicable)*
- ○ Disclosure of Ownership and Control Interest Statement
- ○ Business Associate Agreement
- ○ Texas Workers' Compensation Required Information Form
- ○ New Provider Invoice

Provider Name:_____
Provider NPI:_____
Provider/Group TIN: _____

EPMN Payor Agreements

Our professional contract management team maintains each payor agreement to ensure the best options for your practice and payor compliance with state and federal requirements.

You MUST mark any/all plans to which you want to be reported!

- **Amerigroup**
  - Amerivantage MA
  - CHIP
  - MMP
  - Perinate
  - STAR
  - Star Kids
  - Star Plus
- **Clover Health**
  - Medicare (PCP ONLY)
- **Corvel**- Workers Compensation (WC)
- **Coventry/ First Health**
  - PPO
  - Auto
  - Workers Compensation (WC)
- **Friday Health Plan**
- **Galaxy Health Network**
  - PPO
  - WC
- **Health Care Highways**
  - PPO
  - WC
- **Healthnet Federal Services**
  - Tricare
- **HealthSmart Complete**
- **HealthSmart Preferred Care (HSPC)**
  - PPO
  - Accel
  - Workers Compensation (WC)
- **Humana**
  - Medicare Advantage (MA)
  - PPO
- **Imperial Insurance Company of Texas**
  - Medicare Advantage HMO
- **IMS**
  - PPO
- **Molina Healthcare of Texas, Inc.**
  - Chip (Medicaid)
- **Molina(Cont.)**
  - Exchange
  - Medicare Advantage (MA)
  - Medicare/ Medicaid Dual Eligible (MMP)
  - Perinate (Medicaid)
  - STAR (Medicaid)
  - STAR- PLUS (Medicaid)
- **MultiPlan/ PHCS**
  - PPO
  - Savility
  - Medicare Advantage (MA)
- **Provider Networks of America (PNOA)**
  - PPO
- **Prime Health Services, Inc**
  - Workers Compensation (WC)
- **Superior**
  - Allwell (Medicare Advantage)
  - Ambetter (Exchange)
  - CHIP (Medicaid)
  - Foster Care (Medicaid)
  - Medicare/ Medicaid Dual Eligible (MMP)
  - Perinate (Medicaid)
  - STAR (Medicaid)
  - STAR Kids (Medicaid)
  - STAR Plus (Medicaid)
- **Triwest** CCN- Must have BCBSTX ID
  - VA
- **Three Rivers Provider Network**
  - PPO
- **USA MCO**
  - PPO
- **Wellcare**
  - Medicare Advantage (MA)

- EPMN limits our members to a maximum of 2 plan changes per year per provider. (Fiscal Year January 1st – December 31st) If you need to change more than 2 times in a year's period, not counting new solicitations (Messenger Notices) that are offered, there is a

SUPPLEMENTAL CREDENTIALING INFORMATION FORM

This form includes all the information we report to payors. Please provide all the information requested below.
Please complete and submit a separate form for each practice location and/or TIN. Also please complete and submit an IRS Form W-9 for each TIN.

PROVIDER FULL NAME (First Middle Last)	DEGREE (MD, DO, DPM, etc)	INDIVIDUAL NPI	INDIVIDUAL MEDICARE NUMBER	INDIVIDUAL MEDICAID NUMBER(S)

ADDITIONAL INFORMATION

Primary Practice Location – This is where your practice sees patients. Please report additional practice locations on a separate form.

PRACTICE OR BUSINESS LEGAL NAME	TAX IDENTIFICATION NUMBER (TIN)			GROUP NPI(S)
STREET ADDRESS (MUST be a physical address - PO Boxes are not acceptable)	CITY	STATE	ZIP	GROUP TAXONOMY CODE(S)
PHONE (including area code)	FAX (including area code)	CONTACT NAME		E-MAIL ADDRESS
GROUP MEDICARE NUMBER(S)	GROUP MEDICAID NUMBER(S)			

Correspondence Location - This is where your practice receives general correspondence. Check here _ if it is the same as the address as above.

PRACTICE OR BUSINESS LEGAL NAME	CONTACT NAME			EMAIL ADDRESS
STREET ADDRESS OR PO BOX	CITY	STATE	ZIP	PHONE

Credentialing Location - This is where your practice receives credentialing correspondence. Check here _ if it is the same as the address as above.

PRACTICE OR BUSINESS LEGAL NAME	CONTACT NAME			EMAIL ADDRESS
STREET ADDRESS OR PO BOX	CITY	STATE	ZIP	PHONE

Pay-To Address - This is where your practice receives reimbursement payments. Check here _ if it is the same as the address as above.

PRACTICE OR BUSINESS LEGAL NAME	CONTACT NAME			EMAIL ADDRESS
STREET ADDRESS OR PO BOX	CITY	STATE	ZIP	PHONE

Notice Address (E-mail Only) - This is where your practice receives notices about fee schedule changes and other news important to your practice.

PRACTICE OR BUSINESS LEGAL NAME	CONTACT NAME	EMAIL ADDRESS

SUPERIOR SUPPLEMENTAL INFORMATION FORM

Practitioner Name _____ Specialty _____

TIN _____ NPI _____

Contact Person _____ Phone _____

This form includes additional information requested by Superior. Please provide all the information requested below.

CIRCLE THE APPROPRIATE ANSWERS TO THE QUESTIONS

Do you provide tele-health services?	Yes	No
Do you have experience treating patients with Intellectual and Developmental Disabilities (IDD)?	Yes	No
Are you a minority business owner?	Yes	No
Are you a Prescribed Pediatric Extended Care Center PPECC?	Yes	No
Has the provider completed cultural competence training? If the answer is Yes, annotate culture in the space below.	Yes	No
Does your location offer Non-English languages (including American Sign Language) on site by qualified healthcare interpreters? If the answer is Yes, annotate languages in the space below.	Yes	No
Do you supply translation services for written materials?	Yes	No
Is your location on an accessible public transportation route?	Yes	No

FOR FOSTER CARE PROVIDERS ONLY:
Do you have experience in treating any of the following:

Children with sexual abuse?	Yes	No
Children with physical abuse?	Yes	No
Children with developmental disabilities?	Yes	No
Patients with Special Healthcare Needs (MSHCN)?	Yes	No
Children with Post-Traumatic Stress Disorder?	Yes	No
Evidence-based practices (EBPs) modalities or promising practices such as TIC?	Yes	No

Do you have specialized training and experience in treating the following?

Physical disabilities	Yes	No
Chronic illness	Yes	No
HIV/AIDS	Yes	No
Serious mental illness	Yes	No
Substance abuse	Yes	No
Homelessness	Yes	No
Deafness or hard-of-hearing	Yes	No
Co-occurring disorders	Yes	No
Other. If the answer is Yes, annotate in the space below	Yes	No

Indicate what accessible types of options you have for individuals with physical disabilities

Parking spaces	Yes	No
Curb ramps	Yes	No
Loading zones at building entrance	Yes	No
Doorways wide enough to ensure safe passage by individuals in wheelchairs	Yes	No
Accessible restrooms with grab bars	Yes	No
ASL signage and raised tactile text characters at office, elevator, and medical equipment accessible to patients using mobility aids	Yes	No
Exam rooms accessible to patients using mobility aids	Yes	No
Other. If the answer is Yes, annotate in the space below	Yes	No

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted to Physicians Optimal Network Incorporated ("PONI") within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

Practice Information

Check one that describes you: ☐ Individual Practitioner ☐ Group Practice ☐ Disclosing Entity	
Name of Individual Practitioner, Group Practice, or Disclosing Entity (" Provider")	
DBA Name:	
Address:	
TIN or SSN:	NPI:

Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the Provider (e.g. an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the Definition of "person with ownership or control interest" in the Instructions), list the name, address, date of birth (DOB) and Social Security Number (SSN) for each s u c h individual.

For entities with an ownership or control interest in the Provider, list the name, Tax Identification Number (TIN), and each address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if an individual) TIN (if an entity)

Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the Provider has an ownership or control interest of 5% or more? ☐Yes ☐No

If yes, list the name, address, DOB and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if listing an individual) TIN (if listing an entity)

Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other? ☐Yes ☐No If yes, list the individuals who are related to each other, and the type of relationship (spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet ifnecessary.

Names	Type of relationship

Section IV: Convictions

Has any person who has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN

Section V: Business Transactions

Has the Provider had any financial transactions with any subcontractors totaling more than $25,000 with any subcontractors during the previous 12 months? ☐Yes ☐No

Has the Provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous 5 years? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the previous twelve-month period, and any significant business transactions between the Provider and any wholly owned supplier or between the Provider and any subcontractor during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI: Managing Employees

Does the Provider have any managing employees? ☐Yes ☐No

If yes, list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and percent of interest. (42 CFR 455.104) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN	% Interest

If "Group Practice" or "Disclosing Entity" is checked in the Practice Information section above, the undersigned hereby represents that he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate, and on behalf of each physician and practitioner listed on Exhibit A attached to this Statement, and the undersigned represents that he, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed physician and practitioner.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading, inaccurate, or incomplete data may result in a denial of participation for the affected providers.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Supervising/Collaborating/Monitoring Physician

Protocols/Duties/Scope of Practice Supplemental Attestation

Mid-level providers (physician assistants and nurse practitioners) are statutorily required to collaborate with or be supervised and/or monitored (the "Supervision") by a physician licensed to practice in the state where the Mid-level provider currently practices and who is designated as the primary Supervising Physician (or the "Supervisor"). The Mid-level provider may have an alternate Supervisor.

Section 1 – Collaborating/Supervising/Monitoring Physician

In my current position with a Collaborating/Supervising/Monitoring Physician, I have reviewed, understand, agreed upon and signed along with my Supervising Physician, protocols or other written authorization which defines my professional duties, protocols and scope of duties as a Mid-level provider in a manner that promotes professional judgment commensurate with my education, certification, and experience. A copy of the protocols/duties/scope of practice is maintained onsite at my primary practice location.

Supervisor Name *_____Degree _____

Medical License Number_____State _____

Alternate Supervisor Name *_____Degree _____

Medical License Number_____State _____

Section 2 – DEA and CDS Credentials

[ ] Applicant does have a current, valid DEA and Texas CDS credentials ("Credentials") within the State of Texas.

[ ] Applicant does not have current, valid Credentials within the State of Texas because I have moved from out-of-state, or because I am starting a new practice, or because I will not be prescribing medications. The Supervising Physician listed below will write all prescriptions on my behalf until such time that I obtain and provide current and valid Credentials to the network. I acknowledge it is my responsibility to immediately notify the network at the address above upon my receipt of the Credentials.

Section 3 – Attestation By Applicant

I certify the information provided herein is true, correct, and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission concerning my collaborating/supervising physician and the established protocols/duties/scope of practice may constitute grounds for withdrawal of my application for consideration.

Applicant Signature_____Date _____

Applicant's Name_____Specialty _____

Section 4 – Supervising Physician Certification

I consent to serving as the Supervising Physician for the Applicant named above.

Supervising Physician Name and Degree*_____ TIN _____

Physician Signature_____Date_____DEA Nbr_____CDS Nbr _____

** Supervisors MUST be physicians licensed in the same state of the Mid-level providers practice and MUST participate in the same network(s) as the applicant. Information provided here may be subject to verification.*

2929 N Central Expressway, Suite 205 Richardson, Texas 75080 (972) 424-1360

BlueCross BlueShield of Texas

TRIWEST COMMUNITY CARE NETWORK (CCN) PARTICIPATION REQUEST

Please complete all applicable data fields and returned completed form to attention Network Management:
Fax 972-238-7252 OR E-mail: VA_TriWest@bcbcstx.com

1. BCBSTX Provider Record ID:	2. Provider Name/Title:
3. Tax ID:	4. Individual-Type 1 NPI:
5. Date of Birth (DOB):	6. CAQH ID: ***(If registered with CAQH)***
7. Primary Specialty:	Secondary Specialty:
8. **Provider Type**: ***(You may only select one type)*** *MD/DO:* Select PCP and/or SCP *Non MD/DO:* Select Healthcare Professional Provider or Behavioral Health Provider	☐ Primary Care Physician (PCP) ☐ Hospital Based Provider ☐ Specialty Care Physician (SCP) ☐ Healthcare Professional Provider ☐ Behavioral Health Provider

9. If Mid-Level Practitioner (APN/PA), will you be providing Primary Care Services? ☐ Yes ☐ No

10. If Mid-Level Practitioner (APN/PA), list the BCBS TriWest CCN in-network supervising physician name and Type 1 NPI

Supervising Physician Name: _____TYPE 1 NPI:_____

11. Practice Address, City, State, Zip *Note*: This address will be listed in directory and should reflect as such on CAQH application:

12. Practice Appointment Phone #:	13. Referral Fax #:

14. Practice Email:

15. Billing Address: ***(Where your checks/EOBS are sent)***

16. Group Name:

17. Group-Type 2 NPI:

18. TAX ID:

19. Hospital Affiliations: List all hospitals to which you refer or admit patients.	a.
	b.
	c.

20. **Individual provider agreements** require the provider's signature or the signature of the provider's designee with written authorization from the provider. **Group agreements** require the signature of an authorized representative of the group who is the CEO, President, Executive Director, Managing Director, or Administrator. Otherwise a written authorization from such an officer designating the representative who is authorized to sign is required.

Name/Title of Signature Authority:

21. Provider or Authorized Representative Signature/Date:

22. Credentialing Contact Phone# and Email Address (where agreements, follow-up information, and additional documentation request from Network Management will be sent):

Cypress Healthcare Consultants

Credentialing Acknowledgement and Authorization

The IPA in which you participate has retained Cypress HealthCare Consultants (CHCC) to provide credentialing services on its behalf.

Like other health care organizations, each Independent Physician Association (IPA) is legally responsible for knowing that individuals providing patient care are qualified and competent to do so. The Centers for Medicare and Medicaid Services (CMS), National Committee on Quality Assurance (NCQA), State Departments of Health and Human Services and other oversight organizations require that members of the medical and allied health staff be credentialed before working as part of the IPA.

Credentialing activities include primary source verification (PSV) of providers' education, training, work history, license(s), State and Federal exclusions, insurance coverage, peer references, and malpractice/participation restriction history.

PSV is the process of verifying credentials directly with the source in order to ensure that CHCC does not receive fraudulent documents from applicants or other non-primary sources. A credentialing office cannot accept any verification that comes through a third party rather than the primary source. PSV is a requirement by accrediting bodies as well as the cornerstone of a good credentialing process.

As part of PSV, personal identifying information including date of birth, social security number, and addresses are required.

By signing below, you acknowledge that you have read the above information and authorized Cypress Healthcare Consultants to conduct credentialing activities on your behalf for the above-named IPA.

_____
Provider Name

_____ _____
Provider Signature Date

2929 N. Central Expwy, Suite 205 Richardson, TX 75080
(P) 972.424-1360 I (F) 469-757-8884

Cypress Healthcare Consultants

Texas Workers' Compensation Required Information Form

This form must be completed and returned. Submit this form with your *current Texas* Standardized Credentialing Application (TSCA), including documents listed on the enclosed check list, to the address listed on the cover letter.

__ I **am currently accepting workers' compensation patients or plan to accept workers' compensation patients.** I plan to continue to accept workers' compensation patients as a member of a certified workers' compensation network (CWCN). I understand that consistent with Texas law, a current list of clients accessing my contract is available through worker's compensation payor websites. If you check this box, please complete, sign and return this form with your credentialing application to acknowledge that you are agreeing to participate in a CWCN.

__ I **do not currently accept workers' compensation patients,** or I plan to discontinue my workers' compensation practice as of this date _____. If you check this box, you do not need to complete questions 1-6, but please do sign and return this form.

1. My practice, for workers' compensation patients:

   a. Can best be described as *(check one box that best applies):*

   __Initial injury care for workers

   __Initial visit for area of specialty care only (describe specialty):

   __Specialty and/or referral care only (describe specialty):

   b. Is currently accepting legacy claims *(existing workers' comp claims that may be transitioned in to the network)* ..... Yes No

   c. Accommodates urgent walk-ins and or appointments within 48 hour ..... Yes No

   d. Has a physician on duty during all normal business hours ..... Yes No

   e. Has the following services directly available in my office or immediately available on site *(circle all that apply):* Lab Tests Lab Drawing only Drug Screen Routine Radiology Minor Surgery

2. My office staff is trained in the identification and care of occupational illness and injury ..... OYesONo

3. My office staff will promptly provide information, consistent with state requirements, to workers' compensation representatives regarding a claimant's condition and care ..... OYes ONo

4. My office staff maintains an active return to work philosophy including cooperation on light or modified duty assessment ..... OYesONo

5. Did you submit a disclosure of financial interests in other health care providers to the state (if applicable) OYesONo ONA

6. Please certify as to completion of required training to perform *Maximum Medical Improvement and Evaluation of Permanent Impairment?* ..... OYesONo ONA

_____	_____
Provider Name	*NP/*
Printed Name of Person Completing Form	*Contact Phone Number*
Signature of Person Completing Form	*Date*

Please contact Cypress Healthcare Consultants Credentialing at (972) 424-1360, or via email at EPMNCred@cypresshcc.com with questions regarding this or any other credentialing matter.

This form is a sample of Form CMS-1500 (02/12) and is used to report information to payors that is necessary to process reimbursement properly. Please provide a completed and redacted sample Form CMS-1500 (02/12) form currently used in your practice, or, complete this sample form typing or neatly printing all of the following information:

24j - Your individual NPI
25 - Your tax identification number (SSN or EIN) used when billing payors (this MUST match your attached IRS Form W9)
31 - The practitioner's full name and degree or credentials such as M.D., D.O., CRNA, or P.A.
32 - The complete practice location information including NPI and taxonomy code
33 - Complete billing information including NPI (individual NPI if you are not part of a group practice; otherwise use your group NPI)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PROVIDER PARTICIPATION AGREEMENT

This agreement is subject to binding arbitration.

This Provider Participation Agreement ("Agreement") is made and entered into as of the Effective Date set forth on the signature page of this Agreement between EPMN (dba "El Paso Medical Network")

("Network"), and_____("Provider").
(TYPE or PRINT NAME of PROVIDER)

RECITALS

WHEREAS, Network is a provider network that has contracts with Physicians and other healthcare providers; and

WHEREAS, Network may from time to time enter into contractual arrangements with certain insurers, HMOs, and other Payors for the purpose of providing or arranging for the delivery of Health Care Services to Covered Persons of such Payors by Participating Providers; and

WHEREAS, Provider desires to participate as a Participating Provider in Network to provide Health Care Services coordinated and arranged by Network pursuant to this Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual covenants contained herein, the receipt and adequacy of which are acknowledged, it is agreed as follows:

I. DEFINITIONS

1.1. Clean Claim means a request for payment for Covered Services submitted by a Participating Provider or his or her designee on a HCFA 1500 form (or successor form), or the electronic equivalent of this form when billing claims electronically, that contains all of the elements as required pursuant to the Texas Department of Insurance regulations.

1.2. Compensation Schedule means the schedule of payments to a Participating Provider for Covered Services.

1.3. Complementary Care Professional means a non-Physician practitioner licensed under a recognized state licensing authority including, but not limited to, chiropractors who may be contracted by Network to provide Covered Services as required by a Payor or Health Benefit Plan.

1.4. Confidential Information means all materials, information and ideas of Network, without limitation, operation methods and information, accounting and financial information, marketing and pricing information methods and materials, internal publications and memoranda, and other matters, which have been developed by the Network and includes all information relating to the present or planned business of Network that has not been released publicly by authorized representatives of Network. Such confidential information may include, for example, contractual terms, trade secrets and inventions, marketing and sales programs, business plans, customer lists, customer referral sources, financial arrangements, financial data, pricing information, programs, data and other information pertaining to Network's past, current and planned business activity.

1.5. Covered Person(s) means any person who is eligible to receive Covered Services paid for by a Payor or whom a Payor is legally obligated to indemnify for the cost of Covered Services.

1.6. Covered Services means those healthcare services and supplies which are authorized for payment under the Health Benefit Plan sponsored by a Payor.

1.7. Credentialing Standards means the minimum professional standards established by Network or Payor for credentialing and recredentialing of Participating Providers.

1.8. Health Benefit Plan means a Payor's medical benefits and hospitalization plan, workers compensation or auto liability plan or a governmental plan whereby Payor agrees to make payments to Participating Providers for Covered Services as defined in such Health Benefit Plan, and whereby the Payor offers incentives for Covered Persons to use Participating Providers, if applicable.

1.9. Identification System means the system of Payor to verify the eligibility of a Covered Person to receive Covered Services under this Agreement.

1.10. Non-Covered Services means those healthcare services which are not benefits under a Health Benefit Plan.

1.11. Participating Provider means Physicians, Providers and Complementary Care Professionals who have entered into written agreements with Network.

1.12. Payor means an insurance company, government program, managed care plan, third party administrator, union, employer or employee group which is responsible for the payment of Covered Services under this Agreement.

1.13. Payor Agreement means the separate agreement between Network and a Payor defining the terms and conditions under which Participating Providers are paid for Covered Services to Covered Persons.

1.14. Physician means an individual duly licensed to practice in the State(s) who maintains privileges on the medical staff of a hospital if applicable to Physician's specialty and who is an employee or owner of Provider.

1.15. Provider means the above named entity that is a party to this Agreement and which consists of Providers listed on Attachment C hereto to include changes as mutually agreed to between the parties from time to time after the Effective Date of this Agreement.

1.16. Utilization Management Program means a program established by a Payor which is designed to oversee and manage the utilization of Covered Services based on appropriate medical necessity criteria.

II. DUTIES OF NETWORK

2.1. Representations and Warranties. Network represents to Provider that:

A. It is a duly organized corporation in good standing under the laws of the State in which it is organized or operates, and is authorized to enter into this Agreement;

B. It shall maintain in effect during the term of this Agreement such policies of Directors and Officers insurance coverage to insure against liability for damages, directly or indirectly, related to the activities of Network and its officers; and

C. It shall use best efforts to enter into Payor Agreements with Payors to market the services of Participating Providers.

2.2. Marketing Materials. Network will use its best efforts to arrange for Payors to list Provider and other Participating Providers in provider directories and other marketing and informational materials as developed and distributed by Payor.

2.3. Patient-Physician Relationship. Neither Network nor Payor shall, in any manner, prohibit, attempt to prohibit, or discourage Physician from (i) discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding that patient's healthcare, including but not limited to the patient's medical condition or treatment options; or (ii) discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the provisions, terms, requirements, or services of the Health Benefit Plan as they relate to the medical needs of the patient.

2.4. Credentialing and Recredentialing. Network shall be responsible for obtaining credentialing and recredentialing information from Participating Providers and may delegate the verification of such information to a credentialing verification organization. Network shall provide to Provider, upon request, its Credentialing Standards for participation in Network. Network shall maintain all credentialing and recredentialing information in confidence and consistent with applicable state and federal law. Provider agrees to furnish all information and documentation as required by the Credentialing Standards. Provider understands and agrees that failure to cooperate with credentialing procedures or furnishing inaccurate information will be sufficient grounds for denial or termination of participation.

2.5. Eligibility and Benefit Verification. Network's duties are limited to those specifically set forth herein. Network does not determine eligibility or benefits for Covered Persons under Health Benefit Plans. Network is not liable for reimbursement of Provider for services rendered pursuant to this Agreement, and does not exercise any control with respect to Payors' Health Benefit Plan assets, policies, practices, procedures, or payment of claims.

III. OBLIGATIONS OF PROVIDER

3.1. Services and Responsibilities. Provider agrees to provide Covered Services in accordance with the terms of this Agreement and any Payor Agreement to Covered Persons of Health Benefit Plans.

3.2. Representations and Warranties. Provider represents to Network that:

A. Provider is and, at all times during this Agreement, shall be eligible to participate as a Participating Provider consistent with the Credentialing Standards; and

B. Provider currently maintains professional and general liability insurance coverage in an amount satisfactory to Network and that Provider will continue to maintain such coverage for the duration of this Agreement as follows:

1) Professional liability insurance in minimum amounts as determined by Network to insure Provider's employees or independent contractors from and against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the provision of any service by Provider under this Agreement and the use of any property and facilities of Provider. In the event that such coverage is "claims made" coverage, such coverage shall be maintained by the way of "tail" coverage, for at least five (5) years following termination of this Agreement.

2) A policy or program of comprehensive general liability insurance with minimum limits as determined by Network.

3) Provider shall notify Network of any claims made or actions filed by Covered Persons or Payors arising out of, or relating to, services provided by Provider to a Covered Person, within seven (7) days of Provider's receipt of notification or becoming aware of such claim or action.

3.3. Compliance with Credentialing Standards. Provider shall comply, at all times during the term of this Agreement, with all applicable federal, state or municipal statutes or ordinances, including all applicable rules and regulations of the State Board of Medical Examiners and the ethical standards of the American and the applicable state Medical Association. If at any time during the term of this Agreement a Physician shall have his or her license to practice medicine suspended, conditioned or revoked, Physician shall immediately cease to provide Covered Services pursuant to this Agreement. Provider agrees to immediately notify Network if a Physician's medical staff membership or privileges are suspended, limited or revoked at any hospital, if a hospital initiates any adverse peer review action against Physician, or if Physician voluntarily or involuntarily relinquishes his/her U.S. Drug Enforcement Administration (DEA) or state certification. Provider agrees to notify Network within seven (7) days of the occurrence of any disciplinary proceedings

against Physician of sufficient gravity to be reported to or initiated by the applicable state Board of Medical Examiners or other similar body or any action which may be brought against Physician by any medical society or hospital, any action taken against Physician by any governmental agency, or any material adverse change to Provider's ability to provide Covered Services per this Agreement. Such notice shall include copies of any complaints, petitions, lawsuits or other documents filed or prepared in connection with such proceeding.

3.4. Compliance with State and Federal Statutes. Provider shall cooperate with Network so that Network may meet any requirements imposed on Network by state and federal law, and all regulations issued pursuant thereto. Provider shall agree to provide such records and information to Health Benefit Plans, and to applicable state and federal regulatory agencies for compliance, as may be required. Such obligations shall survive the expiration or termination of this Agreement. Provider shall permit Health Benefit Plans at all reasonable times to have access upon request to books, records and other papers relating to Covered Services and access to the amounts of any payments received from Covered Person or from others on Covered Person's behalf. Provider shall retain such books and records for a term of at least ten (10) years (or such longer period as may be required by law) from and after the termination of this Agreement. Provider shall make such records available to other Participating Providers, subject to applicable confidentiality and privacy requirements, when such records are necessary for treating a Covered Person. Provider shall, in conformance with applicable law and this Agreement, permit access to and inspection by Health Benefit Plans, the United States Department of Health and Human Services, the Comptroller General of the United States, and any other federal or state regulatory agency having jurisdiction over the delivery of healthcare services at all reasonable times and upon demand, of all of those facilities, books and records maintained or utilized by Provider in the performance of Covered Services pursuant to this Agreement. Provider agrees to comply with the specific terms and provisions required by the Center for Medicare and Medicaid Services ("CMS") for participation in Medicare Advantage plans as per Attachment D hereto to include any revisions thereto as required by CMS without further notice to Provider. Services to Covered Persons. Provider may arrange with one or more similarly licensed and qualified Participating Providers to provide services to Covered Persons during Provider's temporary unavailability. In all events, all such substitutes must be Participating Providers or must satisfy the same requirements as are imposed on Provider. Further, Provider agrees to use best efforts not to utilize the services of a non-Participating Provider to provide Covered Services pursuant to this Agreement unless such non-Participating Provider is fully qualified to perform the Covered Services and agrees to the following:

A. Accept peer review, utilization and quality management/ improvement procedures of Payors;

B. Not bill Covered Persons for Covered Services and to look solely to Participating Provider for payment;

C. Maintain professional liability coverage in amounts no less than those required of Participating Providers; and

D. Fully comply with the terms of this Agreement in providing services to Covered Persons as if the non-Participating Provider were a party to it.

3.5. Medical Records. The following obligations shall survive any subsequent termination or expiration of this Agreement:

A. Provider shall maintain appropriate medical records, charts, and diagnostic test results for each Covered Person as is usual and customary in the industry, and under applicable license, certification and accrediting standards.

B. Provider shall maintain all information contained in the medical records of Covered Persons under strictest confidence and in compliance with federal and state laws related to privacy and security of identifiable patient information. Provider shall refrain from disclosing such

information, except with the consent of the Covered Person or as otherwise permitted under applicable federal and state privacy and security laws.

C. To the extent permitted by law, Provider shall cooperate and communicate freely with other persons providing Covered Services to a Covered Person. Provider consents, to the extent permitted by law and as otherwise provided in this Agreement, to release such records as are deemed necessary or appropriate by the Covered Person or a Payor.

D. Provider agrees, upon request of the Covered Person, and subject to applicable disclosure and confidentiality laws, to transfer the medical records of Covered Person to another Participating Provider.

3.6. Utilization Management Program. Provider agrees to cooperate with the Utilization Management Program of each Health Benefit Plan. Network will use best efforts to request Payors to provide material changes to the Utilization Management Program to Provider in writing at least thirty (30) days prior to any material change. Provider agrees that Health Benefit Plans shall have the right to oversee and review the care administered to Beneficiaries. Provider agrees to the appropriate utilization of such managed care methods and practices as are consistent with sound healthcare practice and in accordance with accepted community standards of quality care.

3.7. Grievance Program. Provider shall cooperate with Network and fully participate in the development and implementation of a grievance and complaint program designed to process and consider questions, complaints, and other matters, as appropriate, from Beneficiaries.

3.8. Hold Harmless/Compliance with Health Maintenance Organization Regulations. If applicable to a Payor Agreement, Provider agrees to be bound by all applicable laws and regulations including, but not limited to, the Health Maintenance Organization Act of 1973 (42 U.S.C. Sec. 300e, et. seq.) and applicable regulations thereunder, the Employee Retirement Income Security Act (29 U.S.C. Sec. 1001, et. seq.) and applicable regulations thereunder, and Titles XVIII and XIX of the Social Security Act and applicable regulations thereunder, as amended from time to time. Provider agrees that in no event, including, but not limited to nonpayment or insolvency of Payor shall Provider bill, charge, seek compensation or reimbursement from or have recourse against Covered Person(s) for Covered Services. This provision shall survive termination of this Agreement and shall be construed in favor of Covered Person(s).

3.9. Reporting Changes of Provider Information. Provider will use best efforts to notify Network in writing, at least thirty (30) calendar days prior to any change in Provider's business address, business telephone number, office hours, tax identification number, insurance carrier or coverage or Physician's DEA registration number as applicable. Provider shall notify Network in advance of the effective date of any change in ownership or control.

3.10. Nondisclosure. Provider shall not disclose the terms of this Agreement or the Payor Agreement, including but not limited to the compensation arrangement, methodologies or other price-sensitive terms, without the prior written consent of Network. Such information shall be included as Confidential Information as defined by this Agreement. Notwithstanding anything contained herein to the contrary, nothing in this Section shall be construed to conflict with state or federal laws related to patient protection and communication of medical information by Provider. As such, Provider acknowledges that:

A. Any information related to this Agreement shall not be disclosed to an individual or entity other than Network or its designee, and shall be utilized for the sole and exclusive purposes of fulfilling the obligations specified in this Agreement. Provider shall at no time reveal to any person or entity any Confidential Information furnished by Network or Payor to Provider or otherwise coming into Provider's possession as a result of Provider's relationship with Network or Payor.

B. Money damages would not be a sufficient remedy for any breach of this section and Network shall be entitled, in addition to any other relief available in law or equity, to obtain equitable relief, including injunction and specific performance, to enforce this covenant, without the necessity of proving irreparable damage and without the posting of a bond, cash or otherwise.

C. The foregoing paragraphs of this Section of this Agreement shall survive the expiration or termination of this Agreement.

3.11. Disciplinary Action. Provider agrees to notify Network within five (5) calendar days of the occurrence of any disciplinary proceedings initiated by a State Board of Medical Examiners in any state in which Physician is licensed or any action that may be brought against Physician by any professional society or facility acting through its professional staff, directors, trustees or otherwise, or any action taken against Physician by any governmental agency, including, but not limited to, the following:

A. Any action taken to restrict, suspend or revoke Physician's license(s);

B. Any suit or arbitration action for malpractice against Physician;

C. Any felony information or indictment naming Physician;

D. Any disciplinary proceeding or action involving Physician before any administrative agency;

E. Any cancellation or material modification of Provider's professional liability insurance;

F. Any loss of medical staff privileges by Physician; or

G. Any other material adverse change to Provider's or Physician's ability to provide Covered Services under this Agreement.

Such notice shall include copies of any complaints, petitions, lawsuits or other documents filed or prepared in connection with such proceeding.

3.12. Referrals. Consistent with sound medical practice and in accordance with accepted community professional standards for providing medical care, Provider agrees to make referrals of Covered Persons to Participating Providers in the Payor's Health Benefit Plan. Provider should refer a Covered Person to a healthcare provider who is a non-Participating Provider only if the Covered Person requires medical services not available through a Participating Provider. Provider agrees to use best efforts to notify Covered Person in advance that a different payment or benefit schedule may apply as per the Health Benefit Plan.

3.13. Provider Services. Provider will provide Covered Services to Covered Persons in accordance with the terms set forth in the relevant Payor Agreement in the same manner, in accordance with the same standards, and within the same time availability as provided to other patients, including accessibility on a twenty-four (24) hour-per-day, seven (7) day-per-week basis, either personally or by covering arrangements with Participating Providers or non-Participating Providers who agree to comply with the terms of this Agreement. Provider shall not be obligated to accept an individual Covered Person as a patient; provided, however, Provider shall not refuse to accept any Covered Person as a patient on the basis of race, color, ancestry, religion, sex orientation, age, national origin, handicap (except to the extent that different treatment is medically necessary because of the Covered Person's medical condition), Health Benefit Plan or health status or medical condition of such patient. Provider shall assist Network in monitoring accessibility of care for Beneficiaries, including scheduling of appointments and waiting times. Provider shall provide only those services that Provider customarily and usually provides to its patients.

3.14. Name, Symbols and Service Marks. Provider agrees to permit Network or its designee to use Physician's name, specialty, office address, telephone number, and description of services in any directory of Participating Providers or other listing distributed by Network. Provider agrees not to

use the name, symbols, trademarks, services marks, designs, data, procedures or information of Network unless prior approved in writing by Network.

3.15. Membership Fees. Provider agrees, as a condition of initial and continued membership in Network, to pay on behalf of each of its Physicians an annual membership fee and any other fees for credentialing and recredentialing services as determined solely by the Board of Directors. Provider agrees to make payment of such fees on a timely basis and per the policies and procedures of Network which will be made available to Provider upon request.

IV. COMPENSATION

4.1. Compensation – Special Provisions. Network shall have the authority to enter into Payor Agreements for the provision of Covered Services to Covered Persons and to bind Provider to Payor's Health Benefit Plan subject to the following contracting guidelines:

A. Conforming Agreements. Provider authorizes and appoints Network as Provider's agent and attorney-in-fact to enter into and to amend Payor Agreements which do not materially vary from the rights and obligations of Provider under this Agreement and which are consistent with the contracting guidelines adopted by Network and the Compensation Schedules included herein as Attachment A as approved by Provider.

B. Non-Conforming Agreements. If a Payor desires to enter into a Payor Agreement or if a Payor desires to modify any existing Payor Agreement in such a way that the rights or obligations of Provider would materially vary from this Agreement, Network shall provide written notice to Provider of the Payor's proposal ("Messenger Notice"). Provider shall have the option of accepting or rejecting the Payor Agreement as presented in the Messenger Notice by providing written notice to Network within the time period specified in the Messenger Notice, which period of time shall be not less than ten (10) days or such other time as identified by Network. Provider shall make an independent decision whether to accept or reject the proposed Payor Agreement. Upon receipt of Provider's response to the Messenger Notice, Provider agrees to provide Covered Services as required by the Payor Agreement. Failure of Provider to respond to the Messenger Notice within the time period specified shall be deemed a rejection by Provider of the Messenger Notice. Network shall notify the Payor of Provider's acceptance or rejection of the Payor Agreement. Rejection of a new or modified Payor Agreement shall not terminate Provider's obligations under this Agreement with respect to Covered Services to be provided to Covered Persons under other Payor Agreements as previously accepted by Provider. For Non-Conforming Agreements, Network and Provider agree to comply with the policies and procedures set forth in Attachment B.

4.2. Antitrust Compliance. All review of Payor Agreements by Network for either Conforming or Non-Conforming Agreements (together referred to hereafter as "Payor Agreements") shall be in accordance with the Network's Antitrust Policy, which is attached as Attachment B. Such policy may be amended from time to time by Network to reflect changes in laws or regulations.

4.3. Reasonable Assurances. Network shall use best efforts to enter into Payor Agreements that obligate the Payor to:

A. Make payments for Covered Services on the basis of the applicable payment methodology as agreed to by Provider;

B. Make payments to Provider within forty-five (45) days after receipt of a Clean Claim, unless otherwise agreed; and

C. Provide an Identification System to assist in the identification of Covered Persons and the scope of Covered Services applicable to Covered Persons if applicable to the Payor Agreement.

4.4. Provider Compensation. Network shall secure from Payor a commitment to pay Provider, based on the terms and conditions of reimbursement under a Payor Agreement. Provider shall bill only for Covered Services performed by Provider. Provider agrees to accept as payment in full for Covered Services the Compensation Schedule specified in the Payor Agreement or as specified and accepted in Attachment A of this Agreement. Provider agrees that in no event, including, but not limited to non-payment, Payor's refusal to pay for services or supplies deemed not to meet contractual definitions of medical necessity in Health Benefit Plans as interpreted by Payor, Payor's insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, or have any recourse against Beneficiaries, or persons other than the Payor acting on Covered Person's behalf for Covered Services provided pursuant to this Agreement other than that which is provided for in the applicable Health Benefits Plan. Provider agrees that for Covered Services rendered prior to the termination of this Agreement, this Section shall survive the expiration or termination of this Agreement regardless of the reason for termination, including insolvency of a Payor, and shall be construed to be for the benefit of Beneficiaries.

4.5. Claims Submission. Provider agrees to submit Clean Claims within ninety-five (95) days from the date of service. Provider agrees that failure to submit Clean Claims within the time required by the Health Benefit Plan may result in disallowance of payment.

4.6. Coordination of Benefits. Provider agrees to cooperate with Payors in the coordination of benefits, to provide Payor any relevant information that Provider may have relating to any other coverage held by a Covered Person, and to abide by the coordination of benefits, subrogation and duplicate coverage policies and procedures of Payor. Provider consents to the release of medical information by Payor as necessary and lawful to accomplish coordination of benefits as permitted by law. If Payor determines that Payor is not the primary carrier, and Provider's bill to the primary carrier(s) was not computed on the basis specified in this Agreement, any further reimbursement to Provider from a Payor may not exceed an amount which, when added to amounts shown on the explanation of benefits from the primary carrier(s), equals the amounts specified in the Compensation Schedule.

4.7. Copayments and Deductibles. Provider is entitled to bill and has the responsibility to collect from a Covered Person any applicable copayments, coinsurance or deductibles for Covered Services according to the terms of the applicable Health Benefit Plan. Provider shall bill and collect copayments, deductibles and any other fees that are the Covered Person's responsibility. Provider may bill Covered Person or other responsible party at Provider's usual and customary charge for non-Covered Services. Provider agrees to use best efforts to notify Covered Person, in advance of providing any non-Covered Service that the service is not covered by the Health Benefit Plan and that Covered Person will be responsible for all charges.

V. RELATIONSHIP OF PARTIES

5.1. Independent Contractors. In the performance of the work, duties and obligations of the parties pursuant to this Agreement, each of said parties shall at all times be acting and performing as an independent contractor, and nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee, partnership, joint venture, or principal and agent.

5.2. Non Exclusive Participation. None of the Participating Providers, including Provider, be or consider themselves to be exclusive or guaranteed Participating Providers to Network or any Payor hereunder. Participating Providers, including Provider, may participate in any other provider network or contract direct with a Payor(s) to and provide medical and healthcare services independent of and apart from the Covered Services to be provided to Covered Persons pursuant to this Agreement, as long as such participation or practice does not preclude Provider from complying with the terms of this Agreement.

5.3. No Guarantee of Utilization. Provider acknowledges that there is no warranty or guarantee that (1) Provider will be selected to participate as a member of any particular Health Benefit Plan, or (2) if

selected, Provider will be utilized by a Covered Person or any number of Covered Persons within the Health Benefit Plan.

5.4. Confidential Information. Both parties acknowledge that each has developed certain symbols, trademarks, trade names, service marks, designs, data, processes, plans, procedures and information, all of which is proprietary information and trade secrets of each party, and may not be used by either, or by any other person or entity except as contemplated by this Agreement, or with the prior express written consent of the other party. Upon termination of this Agreement, both parties shall cease any and all usage of any Confidential Information.

VI. TERM AND TERMINATION

6.1. Term. This Agreement shall remain in force and effect for a period of twelve (12) months from the effective date as set forth on the signature page of this Agreement ("Initial Term"). At the end of the Initial Term, this Agreement shall automatically renew for one (1) year periods thereafter unless terminated as provided in this Agreement.

6.2. Without Cause Termination. In the event either party shall, with or without cause, at any time give to the other party at least ninety (90) days advance written notice, this Agreement shall terminate on the future date specified in such notice.

6.3. Termination for Breach. This Agreement may be terminated by either party for the failure, by omission or commission in any substantial manner, of the other party to keep, observe or perform any covenant, agreement, term or provision of this Agreement by either party and such default shall have continued for a period of thirty (30) days after receipt of written notice thereof from the non-defaulting party to the defaulting party.

6.4. Effect of Termination. Upon termination of this Agreement, neither party shall have any further obligation hereunder, except that termination of this Agreement shall not affect the rights and obligations of the parties hereto either arising out of transactions occurring prior to termination or obligations, promises and covenants expressly made to extend beyond the term of this Agreement, including without limitation Confidential Information.

6.5. Post-Termination Obligations. Following termination of this Agreement, other than for reasons concerning Provider's medical incompetence, professional status or behavior, Provider shall continue to provide Covered Services to, and will cooperate in arranging for appropriate referrals for, any Covered Person who is under active treatment either until such treatment is completed or responsibility is assumed by another Participating Provider. Provider shall be compensated for such Covered Services per the applicable Compensation Schedule. Disputes regarding the necessity for continued treatment by Provider in situations involving termination shall be resolved in accordance with the state and federal rules and regulations.

VII. MISCELLANEOUS

7.1. No Indemnity. The parties agree that any liability arising from this Agreement shall be borne by the responsible party. Each party shall be responsible for its own defense and resolution of any claims against that party.

7.2. Governing Law. This Agreement has been executed and delivered, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Texas. El Paso, Texas shall be the sole and exclusive venue for any litigation, special proceeding, or other proceeding between the parties that may be brought or arise out of or in connection with or by reason of this Agreement.

7.3. Third Party Covered Person. This Agreement is entered into by and between the parties hereto for their sole benefit. Unless explicitly provided in this Agreement, there is no intent by either party to create or establish third party Covered Person status or rights by any Covered Person, or other third

party to this Agreement, and no such third party shall have any right to enforce any right or enjoy any benefit created or established under this Agreement. This Agreement shall inure to the benefit of and be binding upon only the parties hereto and not to their respective legal representatives, successors and assigns, without the prior written consent of the other party.

7.4. Assignment. No assignment of this Agreement or the rights and obligations hereunder shall be valid without the specific written consent of both parties hereto, which consent shall not be unreasonably withheld, except that Network may assign this Agreement and all of Network's rights, duties and obligations hereunder to a successor organization. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties thereto.

7.5. Waiver of Breach. The waiver by either party of any breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof.

7.6. Force Majeure. Neither party shall be liable nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from any cause beyond the reasonable control of either party, including without limitation, acts of God, civil or military authority, acts of public enemy, fires, floods, strikes or regulatory delay or restraint.

7.7. Notice. Any material notice affecting the terms of this Agreement shall be in writing and shall be deemed to have been made three (3) days after it is deposited in the United States mail, postage prepaid, return receipt requested, and addressed as follows:

To Provider:
to the address shown in the most current Network Provider Directory.

To Network:

EPMN
% Cypress Healthcare Consultants
2929 N Central Expressway, Suite 205
Richardson Texas 75080
or to such other address as shall have been given in writing by either party to the other.

7.8. Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason and in any respect, such invalidity, illegality or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall be in full force and effect and enforceable in accordance with its terms.

7.9. Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

7.10. Divisions and Headings. The divisions of this Agreement into sections and subsections and the use of captions and headings in connection therewith are solely for convenience and shall have no legal affect whatsoever in construing the provisions of this Agreement.

7.11. Entire Agreement. This Agreement and all Attachments shall constitute the entire agreement relating to the subject matter between the parties. Each party acknowledges that no representation, inducement, promise or agreement has been made, orally or otherwise, by the other party, or anyone acting on behalf of the other party, unless such representation, inducement, promise or agreement is embodied in this Agreement, expressly or by incorporation.

7.12. Amendments. This Agreement may be amended or modified in writing as mutually agreed upon by the parties. Network may modify any provision of this Agreement upon thirty (30) days prior written notice to Provider. Provider agrees to accept the Network's modification if Provider fails to object to such modification, in writing, within the thirty (30) day notice period. Amendments or

modifications of this Agreement that would materially affect the responsibilities or rights of Provider shall require the written consent of both parties. . This Agreement and the amendments thereto, if any, shall be in writing and executed in two or more counterparts by officials of each party specifically authorized to execute such instruments.

The parties agree that applicable state and/or federal laws and/or regulations may make it necessary to include in this Agreement specific provisions relevant to the subject matter contained herein. In the event state and/or federal laws and/or regulations enacted after the Effective Date expressly require specific language be included in this Agreement, such provisions are hereby incorporated by reference without further notice or action of the parties and such provisions shall be effective as of the effective date stated in such laws, rules or regulations.

7.13. Dispute Resolution. Any controversy, dispute or disagreement arising out of or relating to this Agreement or the breach of this Agreement shall first be referred to mediation through the American Health Lawyers Association using the dispute resolution procedures of the applicable state Civil Remedies Code. Any issue or dispute remaining unresolved through mediation shall be submitted to binding arbitration, which shall be conducted within the county of El Paso in the state of Texas in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and judgment on the award rendered by the arbitrator shall be binding, and may be entered in any court having jurisdiction.

7.14. Access to Books and Records. If this Agreement is determined to be subject to the provisions of Section 952 of P.L. 96-499, or its equivalent, which governs access to books and records of subcontractors of services to Medicare providers where the cost or value of such services under the contract exceeds $10,000 over a 12-month period, Provider agrees to permit representatives of the Secretary of the Department of Health and Human Services and the Comptroller General, in accordance with criteria and procedures contained in applicable federal regulations, to have access to its books, documents and records as necessary to verify the cost of services provided under this Agreement.

The individual executing this Agreement on behalf of Provider hereby represents that such individual has all necessary authority to enter into this Agreement and to bind the Physicians of Provider to the terms of this Agreement.

---------- ***The Remainder of this Page Intentionally Left Blank***----------

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date set forth below.

I certify that I am authorized to bind this practice and the individual providers, if applicable, to the terms and conditions of this agreement

PROVIDER	**EPMN**
Signature:	Signature:
Print Name:	Print Name:
Title:	Title:
Date:	Date:

(The Effective Date shall be the date of execution by Network)

ATTACHMENT A

REIMBURSEMENT METHODOLOGY

A list of Conforming Agreements and Non-Conforming Agreements will be provided to Participating Physicians as requested or periodically as provided for in EPMN's policies and procedures. Non-Conforming Payor Agreements requiring individual Physician acceptance are incorporated into this Attachment A by reference.

DISCOUNT FROM BILLED CHARGES METHODOLOGY

Physician agrees to accept the following as payment in full for Covered Services. Reimbursement will be at the lesser of Physician's usual and customary charges less any amounts specified in the applicable Health Benefit Plan for deductibles, copayments or coinsurance as the responsibility of the Covered Person.

PHYSICIAN SERVICES

SERVICE	
1. Global	80% of billed charges

Signature (only if accepted by Provider)_____

RBVRS REIMBURSEMENT METHODOLOGY

Physician agrees to accept the following RBRVS conversion factors as payment in full for Covered Services. Reimbursement will be at the lesser of Physician's usual and customary charges less any amounts specified in the applicable Health Benefit Plan for deductibles, copayments or insurance as the responsibility of the Covered Person.

Reimbursement will be based on an RBRVS methodology. The following minimum conversion factor or factors will be based on RBRVS as available from Ingenix or successor entity.

SERVICE	REIMBURSEMENT
By Service	
A. Evaluation and Management	130%
B. All Other	130%
C. HCPCS	100%

Signature (only if accepted by Provider) _____

ATTACHMENT B

ANTITRUST POLICIES AND PROCEDURES

1. Purpose: Network will facilitate Payor Agreements as follows:

   A. Offering payors the competitive advantage of a Participating Provider panel for managed care plans while minimizing the need for extensive administrative costs from contracting with individual healthcare providers.

   B. Offering payors a new product--a diverse panel of Participating Providers from a variety of locations and specialties who agree to participate in the Payor Agreement through Network.

   C. Offering payors a single, more efficient source to contract for a variety of healthcare providers by affiliating with Network for purposes of managed care contracting.

2. Role of Network in Conforming Agreements.

   A. Provider shall authorize Network, or Network's designee, to execute on Provider's behalf any Payor Agreement that conforms to the Provider's established criteria (Conforming Agreements), which criteria has become Network's approved contracting criteria.

   B. If requested in writing by a Payor, Network will provide information on the Provider's approved reimbursement methodologies.

   C. Upon execution of a Conforming Agreement, Network shall notify each Participating Provider of the Payor Agreement.

   D. Payors remain free at all times to contract direct with Provider for Conforming Agreements.

3. Role of Network in Non-Conforming Agreements.

   In all dealings with Payors involving contract opportunities that do not conform to the criteria established by Participating Providers (Non-Conforming Agreement), Network will facilitate Payors' attempts to assemble Participating Provider panels as follows:

   A. Network will designate a non-Participating Provider employee or agent or independent third party "(Liaison") to objectively convey all price information between Payor and Participating Providers. The Liaison will not negotiate for the Participating Provider, communicate to any Participating Provider the Liaison's or any other Participating Provider's views or intentions as to the proposal, or otherwise facilitate any agreement among Participating Providers on prices or other competitive terms under a Non-Conforming Agreement.

   B. Network may present objective information to each Payor regarding current market forces, including an indication of the historical rates in the market and the rates Participating Providers might be likely to accept if requested by the Payor.

   C. Network may review non-price elements of the Non-Conforming Agreements that are not competitively sensitive (e.g., timeliness of payment, mechanics of payments) on behalf of the Participating Providers.

   D. The Liaison will objectively convey each Non-Conforming Agreement to each Participating Provider without recommending acceptance or rejection of any offer or otherwise indicating "disapproval."

   E. The Liaison will solicit clarifications of any information regarding the Non-Conforming Agreement and convey to Participating Providers any response from the Payor.

   F. The Liaison will convey to the Payor the acceptance, rejection or specific views from each Participating Provider regarding the Non-Conforming Agreement.

G. Each individual Participating Provider will make a separate, independent and unilateral decision to accept or reject a Non-Conforming Agreement.

H. Any information on prices or other competitive terms and/or any decision to accept or reject a Non-Conforming Agreement will be obtained separately from each individual Participating Provider and conveyed by the Liaison to the Payor in a neutral manner.

I. Payors remain free at all times to contract direct with Provider for Non-Conforming Agreements.

4. Restrictions: In all circumstances Network will not:

A. Promote, condone or participate in collective decisions by competing Participating Providers to participate in or refuse Payor's fee-for-service plans;

B. Dictate terms (price or otherwise) on which Participating Providers will participate in Payor's fee-for-service plans;

C. Share information among competing Participating Providers as to terms (price or otherwise) on which they will contract or do business with any Payor's fee-for-service plan, whether a Conforming Agreement or a Non-Conforming Agreement, other than disclosing the terms agreed to with a particular Payor in the course of discussions as described above; or

D. Deny Payors direct access to Participating Providers nor inhibit Participating Providers' direct contracting with Payors.

ATTACHMENT C

LIST OF PROVIDERS IN PROVIDER AS OF THE EFFECTIVE DATE OF THIS AGREEMENT

ATTACHMENT D

MEDICARE ADVANTAGE HMO, PPO, POS and PFFS
AMENDMENT TO THE EPMN d/b/a EL PASO MEDICAL NETWORK
PROVIDER PARTICIPATION AGREEMENT

CMS requires that specific terms and conditions be incorporated into the Physician Agreement to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Publ. L. No. 108-173, 117 Stat. 2006 ("MMA") and except as provided herein, all other provision of the Agreement not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA Organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, papers records or other documents (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with the applicable MA Organization through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
3. Physician will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner,

and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Physician or Downstream Entity may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a MA Organization. Providers will: (1) accept the MA Organization payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreements by Physician or a Downstream Entity are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

7. Physician and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. Physician agrees to provide to Medicare Advantage Members the health care services for which Physician is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Physician shall make Covered Services available and accessible to Medicare Advantage Members, including telephone access to Physician, on a twenty-four (24) hours, seven (7) days per week basis.

9. Physician understands and agrees that payments received by the MA Organization Medicare Advantage MA Organization from CMS pursuant to MA Organization's contract with CMS are Federal funds. As a result, Physician, by entering into this Agreement and the terms of the Product Attachment, is subject to laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

10. In the event MA Organization's Medicare Advantage contract with CMS terminates or MA Organization becomes insolvent, Physician shall continue to provide Covered Services to Medicare Advantage Members who are hospitalized through the later of: (a) the date for which premiums were paid, or (b) through the date of discharge. Physician is prohibited by law from billing Medicare Advantage Members for such Covered Services. This provision shall survive the termination of this Agreement or Product Attachment, regardless of the reason for termination, including the insolvency of MA Organization, and shall supersede any oral or written agreement between Physician and a Medicare Advantage Member.

11. Physician agrees to comply with MA Organization's policies and procedures which operationalize many of the requirements of the Agreement, this Product Attachment, and the Medicare Advantage program. Physician agrees to comply with MA Organization's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies the MA Organization may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a MA Organization policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

12. Physician shall preserve records applicable to Medicare Advantage Members or to MA Organization's participation in the Medicare Advantage Program, for the longer of: (i) the period of time required by State and Federal law, including the period required by Medicare programs and contracts to which MA Organization is subject, or (ii) ten (10) years from the date this Agreement ends or from the date of completion of any audit, whichever is longer, or longer if so required by CMS.

13. Physician shall require all of its subcontractors, if any, to comply with all applicable Medicare laws, regulations and CMS instructions. If Physician arranges for the provision of Covered Services from other health care providers for Medicare Advantage Members, such contracts shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that MA Organization delegates

to Physician a selection of providers, MA Organization retains the right to approve, suspend or terminate such delegation. The term "Subcontractor" as used in this section shall not refer to employees or other individuals that perform services on behalf of Physician for which Physician bills such services under this Agreement. Physician represents and warrants that such persons are subject to all terms and conditions of this Amendment.

14. Physician understands and agrees that no person that provides health care services under this Amendment, or persons that provide utilization review, medical social work or administrative services in support of services billed under this Amendment by Physician may be an individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Physician hereby certifies that no such excluded person will provide such services under this Amendment and no such excluded persons will be employed by or utilized by any "downstream" entity with which Physician contracts relating to the furnishing of these services to Medicare Advantage Members.

15. Physician hereby acknowledges that MA Organization is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Physician and a Medicare Advantage Member. Physician agrees to cooperate with MA Organization and to provide MA Organization with all such information in such form and manner as requested by MA Organization.

16. Physician recognizes that as a Medicare Advantage organization, MA Organization is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to MA Organization by its contractors and subcontractors. Physician and its subcontractors, if any, hereby certify that any such data submitted to MA Organization will be accurate, complete and truthful. Upon request, Physician shall make such certification in the form and manner prescribed by MA Organization.

17. Physician agrees to cooperate with MA Organization in resolving any Medicare Advantage Member complaints related to coverage for the provision of Covered Services. MA Organization will notify Physician as necessary concerning all Medicare Advantage Member complaints involving Physician. Physician shall, in accordance with the Physician's regular procedures, investigate such complaints and respond to MA Organization in the required time. Physician shall use best efforts to resolve complaints in a fair and equitable manner.

18. Physician shall (and shall cause its subcontractors to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse relating to the operation of MA Organization's Medicare Program. Such compliance program shall be appropriate to Physician's or subcontractor's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws; and
(b) for all officers, directors, employees, contractors and agents of Hospital or subcontractor, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations.

19. MA Organization shall arrange for Physician to be compensated for health care services rendered to Medicare Advantage Members in accordance with Section 2 of this Product Attachment. The MA organization shall promptly pay the Physician in accordance with [42 C.F.R. §§ 422.520(b) (1) and (2)]. In accordance with 42 CFR 422.520(a)(1), MA Organization shall pay clean claims submitted by Physician for Covered Services provided to Medicare Advantage Members within thirty (30) calendar days of receipt. The term "clean claim" shall have the meaning assigned in 42 CFR 422.500. MA Organization shall pay interest on clean claims that are not paid within thirty (30) calendar days of such receipt by MA Organization at the rate of interest established by the Secretary of the Treasury of the United States, and published in the Federal Register for the most recent period. 42 CFR 422.520(b)(1) and (2).