

Model Contract with Medical Practices

**MEMBER PROVIDER PARTICIPATION AGREEMENT
SIGNATURE AND DECLARATIONS PAGE**

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The undersigned, consisting of only members or shareholders or individuals who are duly licensed and qualified to practice medicine in the State of _____ and in active medical practice, ("Provider") agree with _____, Individual Practice Association (IPA) and through IPA to render assurance to those intermediaries listed on Attachment A, as follows:

1. Provider agrees to accept cash or assignment of insurance benefits for provision of medical services arranged for patients of certain health plans pursuant to this agreement and agreement between IPA and such intermediaries with whom IPA may contract.
2. Provider agrees to such payment schedules as shown in Exhibits A for the latest effective date when issued by the Managers of IPA.
3. Provider instructs any intermediary with whom IPA contracts to accept such schedules when issued by the managers of the IPA.
4. Provider further agrees to be bound by the terms of the Provider Agreement that follows, and instructs any party with whom IPA contracts to make all payments due Provider to IPA at IPA's lockbox account for further distribution pursuant to agreement between Provider and IPA and its members.
5. Provider agrees that any party or Intermediary may accept instruction on Provider's behalf when issued by IPA without further inquiry, and hereby appoints IPA its representative for communication and contracting with such intermediaries for all such purposes, which appointment shall not be terminated without IPA's consent while Provider is a member of IPA.
6. Provider instructs the following intermediaries:

as follows:

All prior contracts with me either directly or through another IPA are superseded by my agreement with this IPA and this IPA's group provider agreement with your company. This is effective now and continues until my agreement with this IPA terminates and IPA has been given proper advanced notice of such termination in accordance with the terms of the agreement between me and IPA.

7. The companies with whom IPA contracts and for which I have agree to be a participating provider are as follows: (check conditions)

Application Checklist

Plan	Participation	
1. _____:	Yes ___ No ___	Current Resume including work history..... ___
2. _____:	Yes ___ No ___	List of continuing medical education credits..... ___
3. _____:	Yes ___ No ___	Copy of state medical license..... ___
4. _____:	Yes ___ No ___	Copy of current DEA Certificate..... ___
5. _____:	Yes ___ No ___	Copy of current DPS Certificate..... ___
- _____: (CHIP):	Yes ___ No ___	Copy of current Liability Insurance face sheet..... ___
- _____: (STAR PLUS)	Yes ___ No ___	Copy of liability claims history..... ___
6. _____:	Yes ___ No ___	Copy of medical Board Certification or Elig..... ___
7. _____:	Yes ___ No ___	Copy of medical School Diploma..... ___
8. _____:	Yes ___ No ___	Copy of residency Certificate..... ___
9. _____:	Yes ___ No ___	Copy of ECFMG (if applicable)..... ___
10. _____:	Yes ___ No ___	Copy of CLIA (if applicable)..... ___
		Completed and signed Standardized Application... ___
		Completed and signed W-9 Form..... ___

IN WITNESS WHEREOF, the foregoing Agreement between the Association and Provider, is entered into by and between the undersigned parties, to be effective this ___ day of _____, 200__.

IPA SIGNATURE

By: _____
Name: _____
Title: Manager

PROVIDER SIGNATURE:

By: _____
Name (print) _____

**SIGN AND RETURN
THIS DECLARATIONS PAGE**

Address: _____
City: _____ State: _____ Zip: _____

IPA Medical Provider Agreement

Provider and IPA enter this agreement in recognition that IPA has or shall have entered into agreements for its members and contracting parties to provide necessary medical services for plan participants including agreements with Patient Associations and Intermediaries, and that it is necessary for the parties to coordinate their agreements with those of the Intermediaries to assure each other for coordinated contract administration. Accordingly the parties in recognition also agree that IPA does not itself practice medicine but has arranged with its Members and contracting parties and with Intermediaries for IPA Members and contracting parties to perform medical services and to receive payment for the provision of medical services.

IPA and Provider further agree that in consideration of the mutual promises and assurances of each to the other, confirm that all provisions of the Declaration/Signature Page which names the IPA and the Provider and is attached hereto are binding upon the Parties and further Agree as follows:

Definitions:

"Association" means Member Associations offering Health coverage to individuals and groups

"Intermediary" means each entity with whom IPA has obtained a contact or agreement by which IPA Member's provide necessary medical services for Plan Participants including those Intermediaries listed on Schedule A hereto.

"Lockbox" means the bank account maintained by IPA at Compass Bank or such other Federally Insured Depository Institution selected by IPA's Managers for the receipt of payments and issue of sub-payments to Members and IPA's contracting parties entitled thereby to receive sub-payments.

Provider and IPA agree that Provider shall present relevant credentials, information, and claims called for by the following agreement directly to IPA who shall make such information available to Intermediary.

Provider and IPA agree that Provider shall participate in such utilization reviews, conferences, training and other events as are called for by this agreement and shall do so at the request of IPA or jointly at the request of Intermediary and IPA.

ARTICLE 1 DEFINITIONS

Covered Persons shall mean those employees or members and their dependents who have elected to receive care from Participating Providers and who are covered by a cash payment plan or an insurance benefit plan.

1.2 **Covered Services** shall mean all services within Provider's capabilities, that Provider is licensed to provide, and that are rendered to a Covered Person by Provider for which the Patient or his or her insurer is obligated to pay or reimburse pursuant to the cash payment plan or insured benefit plan.

1.3 **Necessary** shall mean those Covered Services and/or supplies from a Provider required to identify or treat a Patient's condition, disease, ailment or injury and which, as determined by IPA and the insurer, are (1) consistent with the symptoms or diagnosis and treatment of the Covered Person's condition, disease, ailment, or injury; (2) appropriate with regard to standards of good medical practice established by the local medical community; (3) not solely for the convenience of the Covered Person, his or her provider, facility, or another health care provider; and (4) the most appropriate supplies or level of service needed to provide to the

Covered Person. When specifically applied to a Covered Person, it further means that the Covered Person's symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the Covered Person as an outpatient.

1.4 **Emergency Services** shall mean those Covered Services and/or supplies as provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate professional attention could reasonably be expected to result in:

1.4.1 Temporary or permanent loss or impairment of functions; or

1.4.2 Temporary or permanent damage or dysfunction.

1.5 **Legal Entity** shall mean a professional corporation or association, partnership, limited liability Association or other entity authorized under applicable state law to provide medical services through physicians and other allied professional personnel.

1.6 **Payor Agreement** means an agreement between IPA and the Association and/or a Payor whereby a Payor agrees to offer to Covered Persons one or more Payor Plans and IPA agrees to arrange for the provision of Covered Services specified in such Plan or Plans.

1.7 **Participating Provider** shall mean a licensed professional, practitioner, Legal Entity, or facility that has entered into a written agreement with IPA to participate in any provider panel established by IPA and to comply with the reimbursement mechanisms and utilization management procedures established by IPA and/or Payor.

1.8 **Payor** shall mean any Group, including, but not limited to, employers, union groups, associations, insurers, and health maintenance organizations, that has contracted with IPA to use any program established by IPA.

1.9 **Payor Plan** shall mean all programs established by IPA with the Association or any Payor, involving a panel of Participating Providers that has been selected by IPA and that has agreed to comply with certain reimbursement mechanisms and utilization management procedures of IPA and the Association and/or the Payor.

1.10 **Primary Provider** means a physician or legal entity who provides Covered Services in the fields of general medicine, family practice, internal medicine (if not practicing a subspecialty of internal medicine such as cardiology, pulmonology, etc.), obstetrics/gynecology, or pediatrics or as may be so designated in any applicable Payor Agreement.

1.11 **Specialty Provider** means a physician or legal entity who provides Covered Services and who is not a Primary Provider.

ARTICLE 2 DUTIES AND OBLIGATIONS OF IPA

2.1 **Functions.** IPA, independently and in conjunction with or through others, intends to market a provider network, consisting of certain Participating Providers, to the Association members and to Payors. IPA shall furnish Provider a written summary of the terms and conditions of each Agreement for which IPA proposes that Provider participate on the provider panel thereof, which summary shall include at a minimum the payment terms, utilization review requirements, and claims filing procedures. IPA, at its discretion, may establish for certain Association and Payor Plans provider panels which do not include Provider. Proposed agreements with

Payors shall contain no obligations of the Provider other than those set forth herein, unless agreed to by Provider. Summaries of all Association and Payor Agreements accepted by Provider pursuant to Section 5 shall become Appendices to this Agreement.

2.2 Payor Agreements. The Association agrees to use reasonable efforts to enter into Association and Payor Agreements that will obligate the Association Members (as individuals, not collectively) and the Payor:

2.2.1 to make payments to the Provider for Covered Services rendered by Provider to Covered Persons.

2.2.2 to make payments for Covered Services on the basis of a reimbursement methodology negotiated by IPA and communicated to and accepted by Provider in accordance with Section 5 hereof.

2.2.3 to make payments to provider within thirty (30)days after receipt of a completed claim form from Provider, or if a member of the Association covered by a cash payment plan then pay the provider at the time of service unless otherwise agreed by Provider.

2.2.4 to agree that, in the event payment is denied, to provide Provider with notice thereof and an opportunity to substantiate the right of payment.

2.2.5 to identify Covered Persons of a Payor Plan, and to identify the scope of Covered Services applicable to such patients.

2.3 Utilization Review and Quality Assurance. IPA shall provide Provider with written information concerning any Utilization Review and Quality Assurance Plan administered by IPA and the Association or a Payor and any modifications thereto.

2.4 Medical Records. IPA shall, and shall seek Payor's agreement to, maintain any medical records to which it or Payor has access under this Agreement in confidence and in accordance with applicable law.

2.5 Marketing Materials. IPA shall use its best efforts to arrange for the Association and Payors to list Provider as a Participating Provider in marketing and informational materials developed and distributed by those Payors whose contracts Provider has accepted pursuant to Section 5.

2.6 Administrative Services. IPA shall perform Services applicable to the Payor Agreements included herein at such reasonable cost as may be determined by IPA and Provider, which cost shall also cover the marketing, data collection and analysis, utilization review/quality assurance, and other administrative expenses of IPA.

2.7 Provider-Patient Relationship. IPA agrees that it shall not intervene in any way or manner with the rendition of services by Provider, it being understood and agreed that the traditional relationship between the Provider and patient will be maintained.

ARTICLE 3 PROVIDER REPRESENTATIONS AND WARRANTIES

3.1 Warranties. Provider warrants that he/she: (a) is fully licensed to practice medicine in the State in which he or her resides; (b) is board certified, if so stated; and (c) shall maintain good professional standing at all times. If Provider is a Legal Entity, rather than an individual, Provider warrants that the individuals listed on Schedule A to this Agreement shall be and remain licensed appropriately under the laws of the State and that those

individuals listed in Schedule A to this Agreement who will provide services on behalf of the Provider meet and shall continuously satisfy the requirements set forth in the preceding sentence. Evidence of such licensing shall be submitted by Provider to IPA upon request. Provider further warrants and represents that the information set forth in the Provider Application submitted by Provider to IPA is true and accurate and Provider shall amend the information set forth in that application if there is any material change.

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

3.2.1 Any action taken to restrict, suspend or revoke Provider's and/or a member's license(s) to provide the services required by this Agreement;

3.2.2 Any suit or arbitration action for malpractice against Provider and/or a member (provide also a summary of the final disposition of such action);

3.2.3 Any felony information or indictment naming Provider and/or a member (provide also a summary of the final disposition of such action);

3.2.4 Any disciplinary proceeding or action involving Provider and/or a member before any administrative agency;

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

3.2.6 Any loss of medical staff privileges; or

3.2.7 Any other material adverse change to Provider's ability to perform under this Agreement. Such notice shall include copies of any complaints, petitions, lawsuits or other documents filed or prepared in connection with such proceeding.

ARTICLE 4 DUTIES AND OBLIGATIONS OF PROVIDER

4.1 Participation in Association and Payor Plans. Provider agrees to participate in Association and Payor Plans entered into by IPA according to the provisions of Section 5.1, and to use his/her best efforts to deliver promptly Necessary Covered Services to Covered Persons. Provider and Provider's staff and administrative personnel shall treat Covered Persons promptly, fairly and courteously. IPA and Provider shall portray each other in a positive light to Covered Persons and the public. Provider shall, consistent with the peer review, utilization review and quality assurance programs of IPA and the Association and the Payor, provide a level of care that is both Necessary as defined under Section 1.3 of this Agreement and consistent with the quality of care established by IPA guidelines.

4.2 Cooperation with Utilization Review, Quality Assurance and Other Provider Requirements. Provider further agrees to comply with the utilization review, quality assurance, peer review and other provider requirements and procedures established by IPA and the Association and/or Payor, including but not limited to pre-

certification of admissions and outpatient services, concurrent review and discharge planning of inpatient admissions, prior authorization of referrals, claims review, and peer review as IPA and the Association or Payor from time to time notifies Provider. Each party agrees to use its best efforts to assure that activities conducted pursuant to any quality assurance and utilization review plan shall be conducted to the extent possible, in such a manner as to be subject to and obtain the benefits of applicable laws conferring immunity on peer review committees and their members and rendering peer review documents and information confidential and non-discoverable. Provider understands and agrees that amounts payable to Provider for Covered Services hereunder may be forfeited to the extent such services are not in accordance with IPA operating policies or procedures or are determined in accordance with any applicable utilization review and quality assurance plan not to be or have been Necessary Covered Services.

4.3 Managed Care Efforts. Provider agrees to the appropriate utilization of such managed care methods and practices as are consistent with sound medical practice and in accordance with accepted community professional standards for rendering quality care. Provider further agrees to utilize the procedures and criteria adopted by IPA and the Association or Payor to monitor the necessity and quality of care provided and to cooperate fully in the development of appropriate approaches to managed care consistent with sound medical practice.

4.4 No Guarantee of Utilization. Provider acknowledges that IPA and the Association neither warrants nor guarantees that if selected, Provider will be utilized by a Covered Person or any number of Covered Persons within any Payor Plan.

4.5 Referrals. Consistent with sound medical practice and in accordance with accepted community professional standards for rendering quality medical care, Provider agrees to make referrals of Covered Persons to Participating Providers in the Payor Plans. The Association will provide a list of Participating Providers to Provider. Provider may refer a Covered Person to a provider who is not a Participating Provider only if the Covered Person requires medical services not available through a Participating Provider and if IPA approves such referral in advance. Participating Provider and/or Covered Person will be responsible for payment of any services incurred from a non-Participating Provider, unless prior approval is obtained from IPA.

4.6 Closing of Practice. Provider may request that he/she does not wish to accept additional Covered Persons (excluding persons already in Provider's practice who are covered by a Payor Plan as a Covered Person) by giving IPA written notice of such intent ninety (90) days in advance of the effective date of such closure.

4.7 Provider Services. Provider will provide professional service to Covered Persons in accordance with the terms set forth in the relevant Association or Payor Agreements in the same manner, in accordance with the same standards, and within the same time availability as provided to his/her other patients. Provider shall not be obligated to accept an individual Covered Person as a patient; provided, however, that Provider shall not refuse to accept any Covered Person as patient on the basis of race, color, religion, sex, age, national origin, Payor Plan or health status or medical condition of such patient. Provider shall assist IPA in monitoring accessibility of care for Covered Persons, including scheduling of appointments and waiting times. Provider shall provide only those services that he/she customarily and usually provides his/her other patients.

4.8 Provider Locations. Provider agrees to render Covered Services only at locations approved by IPA.

4.9 Coordination and Delivery of Provider Services. The Primary Provider shall be responsible for the continuity and coordination of the care of those Covered Persons who have selected such Provider as their Primary Provider. The Primary Provider must be accessible to such Covered Persons on a 24 hour per day, seven day per week basis or shall provide for comparable accessibility through his/her designated on-call provider(s), who shall also be a Primary Provider. The Specialist Provider shall render Necessary Covered Services to Covered Persons only upon referral from the Primary Provider when required in the applicable Payor Agreement. The Specialist Provider may decline a referral by informing the Primary Provider of the inability to accept additional patients at that time. The Specialist Provider understands and acknowledges that he/she will not receive payment from Payors for service rendered in the absence of a referral from a Primary Provider except for Emergency Services. The Specialist Provider agrees to submit a report to the Primary Provider periodically during the course of treatment or upon completing the course of evaluation, diagnosis or treatment.

4.10 Nondisclosure. Provider shall not disclose the terms of this Agreement or any Payor Agreement, including but not limited to any fee schedule, without the prior written consent of IPA. This paragraph shall survive the termination of this Agreement.

4.11 Reporting Changes of Provider Information. Provider shall use Provider's best efforts to notify IPA and the Association 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, malpractice insurance carrier or coverage, state license number or DEA registration number.

4.12 Facility Utilization. Provider agrees that all Facility admissions of Covered Persons must be authorized in advance by IPA and the Association. In the case of Emergency Services facility admissions, Provider agrees to notify IPA and the Association and the Primary Provider of the Covered Person orally or in writing of a Covered Person's admission in such circumstances within 24 hours of the time of the admission. Certain outpatient procedures will also be subject to prior authorization pursuant to protocols of IPA. Failure to obtain prior authorization may result in a warning to the Provider, the Provider's fee(s) being disallowed or this Participation Agreement being terminated.

4.13 Participation Fee. There is no fee at this time but the IPA reserves the right to a provider participation fee in an amount as may be determined from time to time by the Board of Directors of IPA.

4.14 Delegation of Duties. Provider shall not delegate any duties under this Agreement to any member of the Provider or other agent or employee whose credentials have not been approved by IPA and no delegation or assignment shall be permitted without IPA's advance written approval.

ARTICLE 5 ACCEPTANCE OF PAYOR AGREEMENTS

5.1 Contract Authority. IPA shall have the authority to negotiate and enter into contracts with the Association and with Payors for the provision of Covered Services to Covered Persons. Provider agrees that IPA has the right to bind Provider to Association and Payor Plans that match or exceed the reimbursement schedule contained in Exhibit A, as it may from time to time be amended, and other terms and conditions of this Agreement. IPA will notify Provider not less than thirty (30) days in advance of the effective date of any such contract and will give Provider a summary of terms and conditions of that contract. If a new Association or Payor Agreement or amendment to an existing Payor Agreement

does not match or exceed the reimbursement schedule contained in Exhibit A, IPA will furnish Provider with a summary of such contract, together with the applicable reimbursement methodology and other terms and conditions. Provider shall have thirty (30) days from receipt of such materials to notify IPA in writing of his/her decision not to accept the new Agreement or the amendment to an existing Agreement. Unless IPA receives timely, written notice from Provider rejecting such Agreement or amendment, Provider shall be deemed to have accepted such Agreement or amendment and to have agreed to provide Covered Services to the Covered Persons of such Plan pursuant to the terms of this Agreement. Rejection of a Payor Agreement or of amendments to an existing agreement shall not terminate Provider's obligations under this Agreement with respect to Covered Services to be provided to Covered Persons of other Payors under Payor Agreements previously or subsequently accepted by Provider.

5.2 Agreement Compliance. Provider agrees to comply with all operational and procedural rules and regulations promulgated by those Payors whose Payor Agreements Provider has accepted under Section 5.1 or that are otherwise applicable pursuant to regulations promulgated by the State Board of Insurance (the "Board") having jurisdiction over the Payor's insurance Association-sponsored preferred provider plans. IPA shall notify Provider in writing of any changes that such Payors may make to their operational and procedural rules and regulations.

ARTICLE 6 PROVIDER CHARGES, REIMBURSEMENT PROCEDURE AND BILLINGS

6.1 Provider Charges. Association Patients and or Payors shall pay Provider for Covered Services provided to Covered Persons hereunder based on the Payment Schedule set forth in Exhibit A. Provider understands there will be a separate Exhibit B for each Association or Payor Plan accepted by Provider, which shall state the name of the Payor, the reimbursement schedule, if different from that set out on Exhibit A, and any other information deemed to be relevant by IPA and each Exhibit B will be numbered sequentially. Patients or Payors shall pay to Provider and Provider shall accept as full compensation for Covered Services provided to Covered Persons the lesser of (1) Provider's billed charges; or (2) the reimbursement schedule set forth on Exhibit A or B, as applicable. Provider shall bill only for Covered Services personally performed by Provider and by professional employees of Provider.

6.2 Withhold of Fees. In accordance with policies and procedures which shall be adopted by IPA, IPA may establish separate Withhold Funds per Payor Agreement and by provider categories. It is recognized that not all Payor Agreements will or should require any withhold. The amount of the withhold, if any, for each Payor Agreement will be determined annually by IPA. IPA will also review periodically the aggregate amount of withheld fees and the financial obligations of IPA and the Provider. Provider agrees that during each fiscal year IPA may withhold an amount not to exceed 20% for any one Payor Agreement from any allowable fee for Covered Services, to supplement the amounts withheld from all other Participating Providers in the same Payor Agreement to establish a contingency reserve fund or funds (the "Withhold Fund") that may be used to meet the financial obligations of IPA and the Provider. If at any time the amount of any Withhold Fund is insufficient to cover the financial obligations of IPA and the Provider, then the Provider's proportionate share of the amount of the deficit shall be subtracted from Provider's next professional fee payment in addition to the regular monthly withholding. With respect to each Payor Agreement, IPA shall distribute to Provider at the end of the contract term of the Payor Agreement the Provider's proportionate share of any balance remaining in the Withhold Fund established for such Payor Agreement and applicable to Provider after a settlement of all applicable

outstanding claims, including but not limited to the payment of provider fees, payment of administrative and capital expenses of IPA and the establishment of any reserve funds deemed necessary by the Board of Directors of IPA .

6.3 Reimbursement Procedure. Provider agrees to comply with the reimbursement and billing procedures as required by IPA. IPA agrees to notify Provider of the names of the Payors and Covered Persons that use the Payor Plans and to provide a means for determining the Covered Services in a Payor Plan, for determining the eligibility for Covered Services of Covered Persons and for determining the amounts of copayments and deductibles applicable. Provider understands and agrees that prior to payment, a completed claim form must be submitted to Payor for services provided to Covered Persons.

6.4 Payment in Full. Provider shall accept as payment in full, for services which he/she provides, the compensation specified in Exhibit A or Exhibit B, as appropriate. Provider agrees that in no event, including, but not limited to Payor's refusal to pay for services or supplies deemed by it not to meet contractual definitions of Necessary Services in Payor Plans as interpreted by Payor, Payor insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the Payor, Covered Persons, or other persons acting on a Covered Person's behalf for Covered Services provided pursuant to this Agreement.

6.5 Copayments and Deductibles. Provider is entitled to bill and has the responsibility to collect from a Covered Person any applicable copayments or deductibles for Covered Services according to the terms of the applicable Payor Plan. Provider understands and agrees that the Payor or Association has no responsibility to pay any amount except as described in Paragraph 6.1 above and Provider shall bill and collect copayments, deductibles and any other fees that are the Covered person's responsibility.

6.6 Assignment of Benefits Forms. The obligations of the Payor to make payments directly to Provider under this Agreement is subject to Provider first obtaining a valid assignment of benefits from the Covered Person and providing evidence of such assignment to the Payor in a form acceptable to the Payor.

6.7 Billing Forms. Provider will use claim forms acceptable to IPA and the Association and/or Payor to bill for services rendered. The HCFA1500 or UB92 forms used for the filing of Medicare claims are acceptable forms. Further the electronic filing of claims in formats that are acceptable to Medicare is also approved. Provider will submit completed claim forms to Payors, unless otherwise instructed by IPA and the Association. Provider agrees to cooperate in completing such forms and not to charge for this service, except where coordination of benefits or other special reports are required by a Payor that is not the primary carrier.

6.8 Covered Persons Identification. The Payor or the Association will provide Covered Persons with appropriate identification indicating their participation in a Payor Plan.

6.9 Final Bills. Provider will make every effort to submit all bills for services rendered to Covered Persons within thirty (30) days from the end of the month in which the service was rendered. All billings by Provider will be considered final unless adjustments are requested in writing by Provider within ninety (90) days after receipt of payment explanation from IPA or the Association and/or Payor. Provider agrees that his/her failure to submit bills within the time required by the applicable Payor Plan may result in their disallowance for purposes of payment unless such failure on the

Provider's part was with good cause as may be permitted under the Payor Plan.

ARTICLE 7 COORDINATION OF BENEFITS

7.1 Permission. Provider agrees to cooperate with IPA and the Association and Payor in coordination of benefits, to provide IPA and the Association and Payor relevant information relating to any other coverage held by Covered Person and to abide by the coordination of benefits, subrogation and duplicate coverage policies and procedures of IPA and the Association and Payor. Provider consents to the release of medical information by IPA and the Association or Payor other group health plans necessary and lawful to accomplish coordination of benefits.

7.2 The Payor as Primary Carrier. If IPA and the Association or Payor determines that the Payor is the primary carrier, then Provider compensation will be on the basis specified in this Agreement.

7.3 The Payor as Other than Primary Carrier. If IPA and the Association or Payor determines that the Payor is other than the primary carrier, and Provider's bill to the primary carrier(s) was not computed on the basis specified in this Agreement, then, if the Payor Agreement so specified, any further reimbursement to Provider 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 this Agreement.

ARTICLE 8 COMPLIANCE WITH THE ASSOCIATION AND PAYOR PLAN RULES

8.1 Policies. Provider agrees to be bound by all of the policies, rules, and regulations adopted by IPA and the Association and/or Payor from time to time in connection with Payor Plans and their provider panels, as they relate to this Agreement, including amendments thereto. The Association or Payor will notify Provider of such policies, rules, regulations and amendments thereto.

8.2 Copies. Copies of IPA and the Association and Payor policies, rules and regulations and any other pertinent documents pertaining to the Payor Plans shall be provided to and be available for examination by Provider upon request.

ARTICLE 9 MEDICAL RECORDS AND CONFIDENTIALITY

9.1 Maintenance of Medical Records. Provider shall maintain at least five (5) years after the date of delivery of services, and readily make available to IPA and the Association, Payor, and governmental agencies with regulatory authority, medical and all related administrative records of Covered Persons that receive Covered Services, as required by IPA in accordance with this Agreement or pursuant to applicable law.

9.2 Transferability. Provider agrees, upon request of the Covered Person or his/her Participating Provider, and subject to applicable disclosure and confidentiality laws, to transfer the medical records of the Covered Person to such other Participating Provider. The obligations shall survive any subsequent termination or expiration of this Agreement.

9.3 Access to Medical Records. Subject to applicable disclosure and confidentiality laws, Provider shall upon request provide IPA and the Association, Payor, or any duly designated third party with reasonable access to medical records, books, and other records of Provider relating to Covered Services provided to Covered Persons, and to the cost thereof during the term of this Agreement

and thereafter for a period in conformance with state and federal law. IPA, The Association and the Payor shall be entitled to obtain copies of Covered Person's medical records. The provisions of this paragraph shall not operate to waive or limit any restriction on release or disclosure of patient records established in any other provisions of this Agreement or as otherwise required by law.

9.4 Confidentiality of Medical Records. Provider agrees that information concerning Covered Persons shall be kept confidential and shall not be disclosed to any person except as authorized by state and federal law. This confidentiality provision shall remain in effect notwithstanding any subsequent termination or expiration of this Agreement. Provider will provide IPA with all records necessary to carry out IPA's utilization review and quality assurance programs.

9.5 Association Information. Provider may, from time to time, receive proprietary information from IPA. Provider agrees that such information and the information contained herein shall be kept confidential and, unless otherwise required by law, shall not be disclosed to any person except as authorized in writing by IPA.

ARTICLE 10 INDEPENDENT RELATIONSHIP

None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between IPA and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the Parties, nor any of their respective officers, directors or employees, shall be construed to be the agent, employee or representative of the other. Neither party is authorized to represent the other for any purpose whatsoever without the prior consent of the other.

ARTICLE 11 INSURANCE

Provider, including individual Providers providing services to Covered Persons under this Agreement if Provider is a Legal Entity, at his/her sole cost and expense shall provide and maintain for the entire scope of practice such policies of professional liability insurance as shall be deemed necessary by IPA to insure the Provider and his/her employees against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any service by Provider. The amounts and extent of such insurance coverage and the insurer providing the coverage shall be subject to the approval of IPA. All policies described above shall be effective no later than the effective date of this Agreement, and shall remain in effect thereafter until the termination of this Agreement. Provider shall, upon execution of this Agreement and at such times thereafter as IPA may request, furnish IPA evidence of such insurance either in the form of certificates from the insurer of such insurance or photocopies of the policy itself. Provider's insurer shall agree to notify, IPA and the Association in writing thirty (30) days prior to any modifications, cancellations or terminations of any such insurance coverage for any reason whatsoever.

ARTICLE 12 ADVERTISING REFERENCES TO PROVIDER

Provider agrees that IPA may use his/her name, address, telephone number and a description of specialty in any roster of Participating Providers published by IPA and the Association or Payor. The roster may be inspected by and is intended for the use of prospective and existing Participating Providers and Payors as well as for advertising purposes.

ARTICLE 13 RELATIONSHIP WITH PAYOR

Provider is aware of and acknowledges that IPA intends to contract with Payors for the use of Payor Plans and that the services he/she has agreed to provide herein are for those Payors that contract with IPA. Provider understands and agrees that Payors may offer various other groups the opportunity to enter into agreement with it for the use of Payor Plans

ARTICLE 14 TERM AND TERMINATION

14.1 **Termination Date.** This Agreement shall have an initial term which shall expire one (1) year from the signature date herein below indicated (the "Termination Date") unless terminated in accordance with Section 15.2, this Agreement shall automatically renew for successive terms of one (1) year each.

14.2 **Termination by Notice.** Either party may terminate this Agreement, with or without cause, at any time by giving the other party ninety (90) days written notice.

14.3 **Termination by IPA.** Following receipt by IPA of a notice from Provider as required by Section 3.2 hereof or if IPA becomes aware that Provider has made a misrepresentation with respect to the warranties set forth in Section 3.1 or of the occurrence of one of the events about which Provider should give notice pursuant to Section 3.2, IPA may, in its sole option, terminate this Agreement effective upon notice to the Provider.

14.4 **Continuation.** If at the termination of this Agreement in accordance with either Section 15.1, 15.2 or 15.3, Provider has accepted any Payor Agreement through IPA extending after the date of termination, IPA, at its option, may extend this Agreement with respect to the provision of Covered Services by Provider under one or more such Payor Agreements by giving written notice to Provider of the extension of this Agreement until the earliest to occur of (1) the termination of such Payor Agreements, or (2) the date which is twelve (12) months from and after the date of the notice, and Provider shall continue to provide Covered Services to Covered Persons under such Payor Agreements during the extension term of this Agreement.

14.5 **Post-Termination Matters.** Notwithstanding termination of this Agreement, IPA and the Association and Payor shall continue to have access to the records maintained by Provider in accordance with Section 9.3 for a period of five (5) years from the date of the last provision of the Covered Services to Covered Persons to which the records refer for purposes consistent with their rights, duties and obligations under this Agreement and Payor Agreement. After the effective date of termination, this Agreement shall be deemed to remain in effect for the resolution of all matters unresolved at that date. Termination of this Agreement shall not effect the rights, obligations and liabilities of the parties arising out of the transactions occurring prior to termination.

14.6 **Other Remedies.** Nothing contained herein shall be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

ARTICLE 15 MISCELLANEOUS

15.1 **Modification of this Agreement.** This Agreement may be amended or modified in writing as mutually agreed upon by the parties. In addition, IPA may modify any provision of this Agreement upon thirty (30) days prior written notice to Provider. Provider shall be deemed to have accepted IPA's modification if Provider fails to object to such modification, in writing, within the thirty (30) day notice period. In the case of modifications that

materially affect the responsibilities or rights of Provider, Provider shall have the right to terminate this Agreement upon thirty (30) days prior written notice to IPA, such notice to be received by IPA no more than thirty (30) days after IPA issues such modifications. Amendments required by legislative, regulatory or other legal authority as determined by IPA, do not require the consent of IPA or Provider and will be effective immediately upon Provider's receipt of notice of amendment.

15.2 **Assignment.** This Agreement, being intended to secure the services of and be personal to the Provider, shall not be assigned, sublet, delegated or transferred by Provider without the prior written consent of IPA. IPA may assign the Agreement (including the rights, duties and obligations of IPA. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties hereto.

15.3 **Notice.** Any notice required to be given pursuant to the terms and provisions hereof shall be sent by hand delivery or by certified mail, return receipt requested, postage prepaid, to IPA or to the Provider at the respective addresses indicated below. Notice shall be deemed to be effective when mailed or hand delivered, but notice of change of address shall be effective upon receipt.

To:

**To Provider: At address as shown on Declarations Page # 1
With a copy to: Relevant Intermediaries at addresses shown in Attachment A.**

15.4 **Governing Law and Venue.** This Agreement shall be governed in all respects by the laws of the State of _____. The venue of any legal action arising from the Agreement shall be in _____, and IPA and Provider specifically waive any right of venue that either might otherwise have.

15.5 **Arbitration.** Any claim, controversy or dispute arising out of or relating to this Agreement, except as set forth herein, shall be settled by arbitration in Houston, _____ in accordance with the rules for arbitration of the National Health Lawyers Association Alternative Dispute Resolution Service. Any arbitration shall be undertaken pursuant to the Federal Arbitration Act, where possible, and the decision, and the decision of the arbitrations shall be final, binding, and enforceable in any court of competent jurisdiction. In any dispute in which a party seeks in excess of \$25,000 in damages, three arbitrators shall be employed. Otherwise, a single arbitrator shall be employed. All costs relating to the arbitration shall be borne equally by the parties, other than their own attorneys' and experts' fees. The arbitrators will not award punitive, consequential or indirect damages. Each party hereby waives the right to such damages and agrees to receive only those actual damages directly resulting from the claim asserted. In resolving all disputes between the parties, the arbitrators will apply the laws of the State of _____. Except as needed for presentation in lieu of a live appearance, depositions will not be taken. The parties will be entitled to conduct document discovery by requesting production of documents. The arbitrators will resolve any discovery disputes by such pre-hearing conferences as may be needed. Either party may be entitled to pursue such remedies for emergency or preliminary injunctive relief in any court of competent jurisdiction, provided that each party agrees that it will consent to the stay of such judicial proceedings on the merits of both this Agreement and the related transactions pending arbitration of all underlying claims between the parties immediately following the issuance of any such emergency or injunctive relief.

15.6 Severance of Invalid Provisions. If any provision of this Agreement is held to be illegal, invalid or unenforceable under present or future laws effective during the term hereof, such provision shall be fully severable. This Agreement shall be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part hereof, and the remaining provision shall remain in full force and effect unaffected by such severance, provided that the invalid provision is not material to the overall purpose and operation of this Agreement.

15.7 Waiver. The waiver by either party of any breach of any provision of this Agreement or warranty representation herein set forth shall not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

15.8 Entire Agreement. This Agreement contains all the terms and conditions agreed upon by the parties hereto regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

Addendum to Provider Participation Agreement

This addendum is entered into between Provider and IPA and is supplementary to and made a part of the provider Participation Agreement entered into between Provider and IPA ("Agreement"), effective January 1, 2004 to include certain required terms and provisions in the service agreement relating to services provided to Medicaid Members Provider through various contracts with Health Plans which IPA has entered into on behalf of the Provider.

The agreement is amended as follows:

1. The parties acknowledge and agree that the _____ Department of Health, or such other duly authorized agency or entity, has final authority over all aspects of the provision of services to Medicaid Members, including not limited to determination of benefits and/or eligibility, termination of coverage, and structure and operation of the complaint resolution system utilized by Health Plan or Association for said Members. In addition, the parties acknowledge that Medicaid Members may choose to resolve a complaint directly through the _____ Department of Health Fair Hearing process at any time.
2. Provider and Association must comply with all state and federal laws and regulations relating to the _____ Medicaid program and all rules relating to the Medicaid managed care program adopted by _____ Department of Health (TDH), _____ Department of Human Services (TDHS), _____ Department of Insurance (TDI), _____ Health and Human Services Commission (THHSC), _____ Department of Mental Health and Mental Retardation (TDMHMR) and any other state agency delegated authority to operate Medicaid or Medicaid managed care programs.
3. Provider warrants that Provider has not been excluded from participation in any program under Title XVIII or the _____ Medical Assistance Program under any of the provisions of Section 1128(a) or (b) of the Social Security Act (42 USC Section 1320-a-7) or Executive Order 12549. Provider must notify Association within three (3) days of the time Provider receives notice of any action being taken against Provider which could result in exclusion from the Medicaid program.
4. All Medicaid Member information, records and data collected or provided by TDH or another state agency is protected from disclosure by state and federal law and regulations. Provider must

safeguard all Medicaid member information, and disclose information only as authorized in writing by the Member, or to establish eligibility for services, provided services and coordinate the Member's care, or as required by any agency authorized to investigate and prosecute fraud and abuse in the Medicaid program, or other state and federal laws.

5. Provider agrees to comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and all requirements imposed by the regulations implementing these acts and all amendments to the laws and regulations. The regulations provide in part no person in the United States shall on the grounds of race, color, national origin, sex, age, disability, political belief or religion be excluded from participation in, or denied, and aid, care, service or other benefits, or be subjected to any dissemination under any program or activity receiving federal funds.

6. Provider agrees to comply with _____ Health and Safety Code relating to workplace and confidentiality guidelines regarding AIDS and HIV.

7. Provider agrees comply with provisions of Executive Order 11246, as amended, by 11375, relating to Equal Employment Opportunity.

8. The parties acknowledge that _____ Family Code requires TDH to withhold contract payments from any for-profit entity or individual who is at least 30 days delinquent in child support obligations. It is the HMO's responsibility to determine and verify that no owner, partner, or shareholder who has at least a 25% ownership interest is delinquent in child support obligations. The HMO must submit a list of the names and Social Security numbers of all Shareholders, partners or owners who have at least a 25% ownership interest in the HMO. Under the Family Code, the vendor or applicant certifies that the individual or business entity named in this contract may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support interest of at least 25% is not eligible to receive the specified grant, loans or payment and acknowledges that this contract may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to IPA receive the specified grant, loan or if TDH is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25% ownership interest; it will withhold any payments due under this contract until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has entered into a written repayment request.

9. Provider understands and agrees that Payor or Patient has the sole responsibility for payment of services rendered by Provider under the Agreement. In the event of Payor insolvency or cessation of operation, Provider's sole recourse shall be against Payor through the bankruptcy or receivership estate of the Payor.

10. Provider understands and agrees that neither the State nor the Medicaid managed care recipient is liable or responsible for payment for any services provided under this Agreement.

11. Provider agrees that any modify action, addition or deletion of the provisions of this Agreement will become effective no earlier than 30 days after TDH is notified of the change in writing. If TDH does not provide written approval within 45 days from receipt of notification, then changes can be considered provisionally approved. Modifications, additions or elections which are required

by TDH or by changes in state or federal law are effective immediately.

12. The parties acknowledge that this Agreement is subject to state and federal laws relating to fraud and abuse in health care and the Medicaid program. Provider must cooperate and assist TDH and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse. Provider must provide any and all requested originals and/or copies of any all information, allow access to premise and provide records to TDH or is authorized agent(s), THHSC, HCFA, the U.S. Department of Health and Human Services, FBI, TDI and The _____ Attorney General's Medicaid Fraud Control Unit upon request, and free of charge. Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by Association to TDH for referral to THHSC.

13. The parties acknowledge that the _____ Medicaid Fraud Control Unit may conduct private interviews, of HMO personnel, Subcontractors and their personnel, witness, and patients, Request are to be complied with in the form and the language requested. HMO Personnel and Subcontractors and their personnel are to cooperate fully in making HMO personnel, Subcontractors and their personnel available in person for interviews, consultation, grand jury proceeding, pretrial and in any other process, including investigations at HMO's and Subcontractor own expense.

14. The parties acknowledge that the HMO must prohibit network Physicians from interfering with or placing liens upon the states right or the HMO's right, acting the state's agent, to recovery from third party resources, HMO must prohibit network Physicians from seeking recovery in excess of the Medicaid payable amount or otherwise violating state and federal laws.

15. Payor must pay Provider's clean claims within thirty (30) days of receipt. Payor must pay Provider interest on all clean claims which are not paid within 30 days at a rate of 1.5% per month (18% annual) for each month the claim remains unpaid.

16. Both parties must make a good faith effort to resolve any disputes arising during the term of this Agreement. If they are unable to resolve any disputes through informal discussions, either party may submit a written complaint to the other party describing the nature of the dispute and a proposal for resolving the dispute party receiving a complaint must respond by accepting, rejecting, or modifying the proposed resolution, in writing, within sixty (60) days of the date and the party receives the complaint. If the parties are still unable to resolve the dispute, either party may submit the dispute to binding arbitration in accordance with the rules and regulations of the American Arbitration Association, unless the parties mutually agree to some other binding procedure. The cost for arbitration will be apportioned equally among all parties to the dispute.

17. Provider must comply with TDH mandated education and training provided by HMO's regarding the scope of benefits available in the THSteps Program. Training must include THSteps benefits, the periodically schedule for THSteps checkups and immunizations, and services available under the THSteps program which are not scheduled, including but not limited to transportation, dental checkups, and CCP. Physicians must also be educated and trained regarding the requirements imposed upon the department and contracting HMOs under the Consent Decree entered in Frew v. McKinney. Et al, Civil Action No 3.93CV65, In the United States District Court for the Eastern District of _____, Paris Division. Physicians should be educated and trained to treat each THSteps visit as an opportunity for a comprehensive assessment of the Member.

Attachment A: Intermediaries

Exhibit A

PROVIDER COMPENSATION FOR RISK PAYERS

Fees are based on the current Year RBRVS published by CMS for applicable Counties in _____ for all services provided by the Physician and it's affiliated Physicians based on the following annual dollar volume of services referred by IPA:

Medicare Advantage Plans* & Medicaid	Commercial Plans
at least 100% of RBRVS	120% of RBRVS

or, if prepaid based on capitation:

the Capitation Rate shall be determined based on at least the RBRVS published by CMS for service area of IPA paid in advance not later than the 25th of each month in which it becomes due. The capitation rate shall be reviewed every six months and adjusted to at least RBRVS equivalent as stated above for the next six month period exclusive of any bonuses paid in the period reviewed.

The beginning capitation rate PMPM for the first six month period shall be shown in Payor Exhibit B.

* The monthly PMPM rates are based on an analysis of the population to be assigned to the centers and are derived from the Medicare RBRVS for service area.

General Release of Information Authorization

I have applied to IPA for eligibility to contract as a plan provider. I hereby authorize IPA and its representatives to consult with the administration and members of the medical staffs of hospitals, institutions, health care facilities, professional licensing/registration/certification bodies, professional liability insurance carriers, and professional organizations with which I am or have been associated and with others who may have information bearing on my professional qualifications and competence, By signing this authorization, I release from liability all representatives of IPA as well as all representatives of hospitals, institutions, health care facilities, professional licensing/registration/certification bodies, professional liability insurance carriers, and professional organizations with which I am or have been associated for their acts performed in good faith and without malice in connection with evaluating my application, my credentials, and my qualifications. A photocopy of this authorization is to be accepted with the same authority as this original. I further acknowledge that IPA is represented by the following medical care provider organizations

and that these organizations are included in this authorization.
(Signature on File)

Application Checklist

Below is a list of items which must be returned in order to process your application in the Independent Practice Association. Please check to assure that all expiration dates on the certificates you provide are current. Please do not use correction fluid on your application.

- 1. Current Resume including work history
- 2. List of continuing medical education credits
- 3. Copy of current State Medical License
- 4. Copy of current DEA Certificate
- 5. Copy of current DPS Certificate
- 6. Copy of current Professional Liability Insurance Face Sheet
- 7. Professional Liability Insurance claims history
- 8. Copy of Medical Board Certification or Statement of Eligibility
- 9. Copy of Medical School Diploma
- 10. Copy of Residency Certificate
- 11. Copy of ECFMG (if applicable)
- 12. Copy of CLIA (if applicable)
- 13. Completed and Signed Standardized Application
- 14. Signed Physician's Agreement
- 15. W-9 Form

As a minimum month and year (e.g. CV, Standardized, etc.) must be indicated on all documents.

If you cannot make a copy of your certificates please submit a signed letter that states what type of certificate that cannot be copied.

Please make sure ALL questions are answered on the _____ Standardized even if you do not provide that service.

SIGNATURE AND DECLARATIONS PAGE

The undersigned, consisting of only members or shareholders or individuals who are duly licensed and qualified to practice medicine and are in active medical practice, ("Provider") agree with IPA as listed on the Signed Declarations Page of this agreement, a Local Provider Organization hereinafter called IPA to render assurance to those intermediaries listed on Exhibit A, as follows:

1. Provider agrees to accept Cash and/or assignment of insurance benefits for provision of medical services arranged for patients of certain health plans pursuant to this agreement and agreement between IPA and such associations or intermediaries with whom IPA may contract.
2. Provider agrees to accept as compensation for all covered services the payment from the patient and/or his or her insurance company based upon the fee schedule referred to in Exhibit A of this agreement.
3. Provider instructs any intermediary with whom IPA contracts to accept such schedules when issued by the Managers of IPA.
4. Provider further agrees to be bound by the terms of the Provider Agreement that follows, and instructs any party with whom IPA contracts to make all payments due Provider, except cash payments from Patient members, to Provider at IPA 's lockbox account for further distribution to Provider

pursuant to agreement between Provider and IPA and its members.

5. Provider agrees that any party or Intermediary may accept instruction on Provider's behalf when issued by IPA without further inquiry, and hereby appoints IPA its representative for communication with such intermediaries for all such purposes, which appointment shall not be terminated without IPA 's consent while Provider is a member of IPA. The intermediaries for this IPA are:

IN WITNESS WHEREOF, the foregoing Agreement between IPA and Provider, is entered into by and between the undersigned parties, to be effective as of date of signing of original declarations Page.

IPA

PROVIDER

Signature:(Signature on File with Original Declaration Page)

File Copy of
Your Provider Agreement
Please retain
for future reference

IPA's Example of Charges from Participating Physicians

All codes not listed are priced at Medicare Rates for People age 65+ and at 126% of Medicare rates for Commercial and MBC Members

CPT	Description	Usual Billed Charges	2007 Medicare	Commercial Rates	Special MBC cash Price
Office Visit - New Patients					
99201	Brief - 10 Minutes	\$45.00	\$36.49	\$45.61	\$30.00
99202	Limited - 20 Minutes	\$87.50	\$63.64	\$79.55	\$65.00
99203	Expanded - 30 Minutes	\$150.00	\$94.45	\$118.06	\$100.00
99204	Comprehensive - 45 Minutes	\$225.00	\$143.26	\$179.08	\$150.00
99205	Comprehensive - 60 Minutes	\$300.00	\$179.75	\$224.69	\$200.00
Office Visit - Established Patients					
99211	Brief - 5 Minutes	\$37.50	\$20.51	\$25.64	\$25.00
99212	Limited - 10 Minutes	\$60.00	\$37.64	\$47.05	\$40.00
99213	Expanded - 15 Minutes	\$105.00	\$60.75	\$75.94	\$70.00
99214	Comprehensive - 25 Minutes	\$150.00	\$92.13	\$115.16	\$100.00
99215	Comprehensive - 40 Minutes	\$195.00	\$124.77	\$155.96	\$130.00
Preventive Exam - New Patients					
99381	Preventive Medicine <1 Year	\$165.00	\$96.37	\$120.46	\$110.00
99382	Preventive Medicine 1-4 Years	\$172.50	\$103.88	\$129.60	\$115.00
99383	Preventive Medicine 5-11 Years	\$172.50	\$102.14	\$127.68	\$115.00
99384	Preventive Medicine 12-17 Years	\$187.50	\$111.10	\$138.88	\$125.00
99385	Preventive Medicine 18-39 Years	\$187.50	\$111.10	\$138.88	\$125.00
99386	Preventive Medicine 40-64 Years	\$225.00	\$129.68	\$162.10	\$150.00
99387	Preventive Medicine 65+ Years	\$240.00	\$140.84	\$176.05	\$160.00
In-Patient Care					
99217	Observation care discharge	\$105.00	\$67.59	\$84.49	\$70.00
99218	Observation care	\$97.50	\$63.74	\$79.68	\$65.00
99219	Observation care	\$155.00	\$105.33	\$131.68	\$110.00
99220	Observation care	\$240.00	\$148.46	\$185.58	\$160.00
99221	Initial hospital care	\$135.00	\$86.94	\$108.68	\$90.00
99222	Initial hospital care	\$195.00	\$121.89	\$152.36	\$130.00
99223	Initial hospital care	\$300.00	\$177.83	\$222.04	\$200.00
99231	Subsequent hospital care	\$60.00	\$36.49	\$45.61	\$40.00
99232	Subsequent hospital care	\$105.00	\$65.08	\$81.35	\$70.00
99233	Subsequent hospital care	\$150.00	\$93.00	\$116.25	\$100.00
99234	Observ/hosp same date	\$217.50	\$128.34	\$160.43	\$145.00
99235	Observ/hosp same date	\$262.50	\$168.07	\$211.34	\$175.00
99236	Observ/hosp same date	\$337.50	\$210.58	\$263.20	\$225.00
99238	Hospital discharge day	\$105.00	\$67.10	\$83.88	\$70.00
99239	Hospital discharge day	\$165.00	\$96.95	\$121.19	\$110.00
Initial Nursing Facility Care					
99304	Annual assessment	\$105.00	\$62.48	\$78.10	\$70.00
99305	New Problem	\$150.00	\$83.09	\$103.86	\$100.00
99306	Initial Admit to NH	\$180.00	\$102.15	\$127.69	\$120.00
Subsequent Nursing Facility Care					
99307	Stable NH Visit	\$60.00	\$32.64	\$40.80	\$40.00
99308	Minor problem	\$90.00	\$53.91	\$67.39	\$60.00
99309	Major problem	\$135.00	\$75.67	\$94.59	\$90.00
Consultations - Office					
99241	Brief - 10 Minutes	\$45.00	\$49.78	\$62.23	\$30.00
99242	Limited - 20 Minutes	\$150.00	\$91.85	\$114.81	\$100.00
99243	Expanded - 30 Minutes	\$202.50	\$125.65	\$157.06	\$135.00
99244	Comprehensive - 45 Minutes	\$315.00	\$184.08	\$230.10	\$210.00
99245	Comprehensive - 60 Minutes	\$397.50	\$228.47	\$285.59	\$265.00
Consultations - Hospital					
99251	Brief - 10 Minutes	\$75.00	\$47.08	\$58.85	\$50.00
99252	Limited - 20 Minutes	\$120.00	\$75.58	\$94.48	\$80.00
99253	Expanded - 30 Minutes	\$187.50	\$111.59	\$139.49	\$125.00
99254	Comprehensive - 45 Minutes	\$270.00	\$160.30	\$200.38	\$180.00
99255	Comprehensive - 60 Minutes	\$337.50	\$200.07	\$250.09	\$225.00
Home Visit - New Patient					
99341	Brief - 10 Minutes	\$90.00	\$55.55	\$69.44	\$60.00
99342	Limited - 20 Minutes	\$135.00	\$81.55	\$101.94	\$90.00
99343	Expanded - 30 Minutes	\$187.50	\$118.04	\$147.55	\$125.00
99344	Comprehensive - 45 Minutes	\$255.00	\$154.53	\$193.16	\$170.00
99345	Comprehensive - 60 Minutes	\$330.00	\$190.63	\$238.29	\$220.00
Home Visit - Est. Patient					
99347	Brief - 10 Minutes	\$67.50	\$43.13	\$53.91	\$45.00
99348	Limited - 20 Minutes	\$112.50	\$67.97	\$84.96	\$75.00
99349	Expanded - 30 Minutes	\$165.00	\$104.85	\$131.06	\$110.00
99350	Comprehensive - 45 Minutes	\$262.50	\$154.53	\$193.16	\$175.00
Chiropractic					
98940	Chiropractic manipulation	\$37.50	\$24.74	\$30.93	\$25.00
98942	Chiropractic manipulation	\$75.00	\$44.86	\$56.08	\$50.00
Procedures					
94640	Airway Inhalation	\$22.50	\$13.29	\$16.61	\$15.00
46600	Anoscopy	\$132.00	\$78.66	\$98.33	\$88.00
92551	Audiometry	\$16.50	\$10.11	\$12.64	\$11.00
10080	I&D Abscess/Cyst, Simple	\$165.00	\$96.67	\$120.84	\$110.00
10061	I&D Abscess/Comp or Mult	\$300.00	\$169.28	\$211.80	\$200.00
11200	Skin Tag Removal up to 15	\$120.00	\$71.24	\$89.05	\$80.00
11201	Skin Tag Removal ea addl 10	\$30.00	\$17.14	\$21.43	\$20.00
17000	Dest. Ben Lesion any meth 1st	\$112.50	\$64.60	\$80.75	\$75.00
17003	2nd - 14th lesions each	\$12.00	\$7.03	\$8.79	\$8.00
17004	Dest. Ben Lesion any meth >15	\$262.50	\$158.18	\$197.73	\$175.00
93000	EKG Complete	\$45.00	\$25.32	\$31.65	\$30.00
93005	EKG Tracing only	\$30.00	\$15.75	\$20.94	\$20.00
20550	Inj Tendon/Ligament/Cyst/Trigger PT	\$97.50	\$56.72	\$70.90	\$65.00
20600	Inj Small JT/Bursa/Cyst	\$90.00	\$52.00	\$65.00	\$60.00
20605	Inj Int. Joint/Bursa/Cyst	\$93.00	\$56.62	\$70.78	\$62.00
20610	Inj major joint/Bursa/Cyst	\$112.50	\$70.39	\$87.99	\$75.00
94150	Vital capacity, Separate Proc	\$34.50	\$21.76	\$27.20	\$23.00
69210	Removal Impacted Cerumen	\$82.50	\$47.08	\$58.85	\$55.00
45330	Sigmoidoscopy, Flexible	\$202.50	\$126.70	\$158.38	\$135.00
94010	Spirometry W/Graphic Record	\$60.00	\$33.78	\$42.24	\$40.00
Injections					
90772	Sub Q or IM Injection of Med	\$33.00	\$19.74	\$24.68	\$22.00

Acknowledgement of Agreed Fees

Practice Name

Signature of Provider

Date

F

