

AHP Application Packet

Fiscal Year 2021-2022

CREDENTIALING FEES & ANNUAL PARTICIPATION DUES

There are no refunds issued for any services that have started or completed.

Application Fees

Application fee includes two TINs per Member
Additional TINs are $350 each

Application Fees - MD, DO, DPM, DDS, OD, DC, DPT	$850
Application Fees - Allied Health Professionals	$550

REMINDER: NO APPLICATION IS PROCESSED UNTIL APPLICATION FEE IS PAID

Annual Participation Dues

Membership Dues include TIOPA managing 2 TINs per member. Additional TINs will be charged $100 each, per year. When billing is sent out in September each year, the TIN charges will be added for more than 2 TINs and member is responsible for paying for the TINs that are billed at that time. We will not discount if TINs are termed after billing is sent out.

MD, DO, DPM, DDS, OD & DC.	$950
(Waiver of Dues for physician providers listed above within first year after medical training)	
Occupational Therapists & PT (including DPT for annual dues)	$750
Allied Health Professionals (RN, NP, PA)	$750
Licensed Professional Counselor, Ph.D., Registered Dietitian	$750
Additional TIN charge for members with more than 2 TINs	$100 each TIN

Please note that when you join, you will receive a prorated invoice with your welcome letter. You will also receive an invoice in September for the following fiscal year October 1st through September 30th.

Recredentialing Fees

Recredentialing required by the insurance plans every 3 years.

All Providers	$350

Revised May 4th, 2022

CREDENTIALING PACKET CHECKLIST

PLEASE COMPLETE ALL FORMS AS THEY ARE REQUIRED BY THE NETWORKS FOR ENROLLMENT. BE PRECISE WHEN COMPLETING THESE FORMS AS THIS INFORMATION IS WHAT WILL BE POPULATED TO THE NETWORK DIRECTORIES.

- Application Fee (**MUST** be paid before credentialing can begin)
- DEA Form
- Malpractice Facesheet/COI
- Board Certification Copy
- PA/NP Protocol (if applicable)
- TIOPA Addendum
- TIOPA AHP/PPA Agreement
- TSCA Application

The following items are many times overlooked during completion of the application and are critical to the plans. Please review your credentialing application to assure these items have been addressed.

- Call coverage – The insurance networks, and the Board of Directors, **require** that every practitioner have call coverage. Be sure to list which provider will provide coverage for you.
- Do you have age or gender restrictions in your practice? (page 6 of TSCA & TIOPA Addendum)
- How do you want to be listed in the network directories? Be exact on primary office location, phone, fax and hours of operation and if you are accepting new patients. (page 6-7 of TSCA & TIOPA Addendum)
- Provide the address, phone, fax and email where you would like us to send any correspondence, credentialing or contracting information.
- Hospital privileges. Please list all hospitals that you are affiliated with. (pages 4 & 16 of TSCA)

IF THE APPLICATION IS INCOMPLETE, WE ARE UNABLE TO START THE CREDENTIALING PROCESS AND THIS WILL IN TURN DELAY YOUR SUBMISSION TO THE INSURANCE NETWORKS. PLEASE PROVIDE ACCURATE AND COMPLETE INFORMATION.

Laura Foster, CPMSM
Supervisor, Provider/Delegated Credentialing
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Phone 817-484-6274 FAX: 817-420-9656
lj.foster@tiopa.org

Pursuant to Texas Insurance Code § 1452.052, LHL234 Rev. 01/07 is promulgated by the Texas Department of Insurance. Please send this application to the carrier with whom you wish to become credentialed.

Texas Standardized Credentialing Application

(Please type or print)

Section I-Individual Information

TYPE OF PROFESSIONAL

LAST NAME	FIRST	MIDDLE	(JR., SR., ETC.)

MAIDEN NAME	YEARS ASSOCIATED (YYYY-YYYY)	OTHER NAME	YEARS ASSOCIATED (YYYY-YYYY)

HOME MAILING ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

HOME PHONE NUMBER	SOCIAL SECURITY NUMBER	☐ Female ☐ Male

CORRESPONDENCE ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP

IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS	ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? ☐ Yes ☐ No

U.S.MILITARY SERVICE/PUBLIC HEALTH ☐ Yes ☐ No	DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY)	LAST LOCATION

BRANCH OF SERVICE	ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? ☐ Yes ☐ No

Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)
Issuing Institution:

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)

☐ *Please check this box and complete and submit Attachment A if you received other professional degrees.*

POST-GRADUATE EDUCATION SPECIALTY
☑ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☑ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

Education - *continued*

POST-GRADUATE EDUCATION ☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

☐ Please *check this box and complete and submit Attachment B if you received additional postgraduate training.*

OTHER GRADUATE-LEVEL EDUCATION
Issuing Institution:

ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	

Licenses and Certificates - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.

LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
☐ DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
☐ DPS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
OTHER CDS (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No

UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☐ Yes ☐ No Medicare Provider Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ Yes ☐ No Medicare Provider Number:

EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ☐ N/A ☐ Yes ☐ No ECFMG Number:	ECFMG ISSUE DATE (MM/DD/YYYY)

Professional/Specialty Information

PRIMARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

SECONDARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

Professional/Specialty Information *-continued*

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

ADDITIONAL SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Work History *- Please provide a chronological work history. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.*

CURRENT PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.
Gap Dates: Explanation:

Gap Dates: Explanation:

Work History – *continued*

Gap Dates: Explanation:

Gap Dates: Explanation:

☐ *Please check this box and complete and submit Attachment C if you have additional work history*

Hospital Affiliations-*Please include all hospitals where you currently have or have previously had privileges.*

DO YOU HAVE HOSPITAL PRIVILEGES? ☐ Yes ☐ No	IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?	
PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?		
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

☐ *Please check this box and complete and submit Attachment D if you have additional current hospital affiliations.*

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		

☐ *Please check this box and complete and submit Attachment E if you have additional previous hospital affiliations.*

References-*Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.*

1 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY	STATE/COUNTRY POSTAL CODE

References- *continued*

2 NAME/TITLE		PHONE NUMBER
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
3 NAME/TITLE		PHONE NUMBER
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE

Professional Liability Insurance Coverage

SELF-INSURED? ☐ Yes ☐ No	NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY
ADDRESS	
CITY	STATE/COUNTRY POSTAL CODE

PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE ☐ Individual ☐ Shared	LENGTH OF TIME WITH CARRIER
NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS			
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE

PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE ☐ Individual ☐ Shared	LENGTH OF TIME WITH CARRIER

Call Coverage

☐ See attached list of hospital staff within my department I utilize for call coverage.

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE. ☐ CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

Practice Location Information - *Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.*

PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9

PRACTICE LOCATION ADDRESS
☐ **Primary**

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

		From	*To*		*From*	*To*		*From*	*To*
Monday	☐ No Office Hours	Morning:		Afternoon:			Evening:		
Tuesday	☐ No Office Hours	Morning:		Afternoon:			Evening:		
Wednesday	☐ No Office Hours	Morning:		Afternoon:			Evening:		
Thursday	☐ No Office Hours	Morning:		Afternoon:			Evening:		
Friday	☐ No Office Hours	Morning:		Afternoon:			Evening:		
Saturday	☐ No Office Hours	Morning:		Afternoon:			Evening:		
Sunday	☐ No Office Hours	Morning:		Afternoon:			Evening:		

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS	NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?	WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Yes ☐ No	☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?	DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No	☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No

☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No

☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?	WHO ADMINISTERS IT?
☐ Yes ☐ No Please specify the classes or categories:	

☐ Please *check this box and complete and submit Attachment F if you have other practice locations.*

Section II-Disclosure Questions - Please *provide* an explanation for any question answered yes-except 16-on page 10.

Licensure

1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?

☐ Yes ☐ No

2 Have you ever received a reprimand or been fined by any state licensing board?

☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☐ No

4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☐ No

5 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

☐ Yes ☐ No

Education, Training and Board Certification

6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

☐ Yes ☐ No

7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No

8 Have any of your board certifications or eligibility ever been revoked?

☐ Yes ☐ No

9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

☐ Yes ☐ No

DEA or DPS

10 Have your Federal IDEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?

☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

☐ Yes ☐ No

Other Sanctions or Investigations

12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, IDEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

☐ Yes ☐ No

Section II - Disclosure Questions - *continued*

Other Sanctions or Investigations

13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes ☐ No

14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

☐ Yes ☐ No

15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes ☐ No

Malpractice Claims History

16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?

☐ Yes ☐ No

☐ *If yes, please check this box and complete and submit Attachment G.*

Criminal

17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional

☐ Yes ☐ No

18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?

☐ Yes ☐ No

19 Have you been court-martialed for actions related to your duties as a medical professional?

☐ Yes ☐ No

Ability to Perform Job

20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes ☐ No

21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes ☐ No

Ability to Perform Job

22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes ☐ No

23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?

☐ Yes ☐ No

Please use the space on page 10 to explain yes answers to any question except #16.

Section II - Disclosure Questions-*continued*

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER	PLEASE EXPLAIN

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

TIOPA, Inc

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

APPLICANT'S INITIALS AND DATE (MM/DD/YYYY)

Section III – Standard Authorization, Attestation and Release – continued

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

DATE (MM/DD/YYYY)

Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following:

- ☐ Copy of DEA or state DPS Controlled Substances Registration Certificate
- ☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable

Reproduction of this form without any changes is allowed.

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	

OTHER POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☑ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

☐ Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION SPECIALTY
☑ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

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INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

☐ Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN)

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
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CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
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CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
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ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
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PHONE NUMBER	FAX	E-MAIL
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OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		
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ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
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ADDRESS		
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FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		

Practice Location Information - *Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.* | PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9

PRACTICE LOCATION ADDRESS
☐ **Primary**

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

		From	*To*		*From*	*To*		*From*	*To*
Monday	☐ No Office Hours	Morning:			Afternoon:			Evening:	
Tuesday	☐ No Office Hours	Morning:			Afternoon:			Evening:	
Wednesday	☐ No Office Hours	Morning:			Afternoon:			Evening:	
Thursday	☐ No Office Hours	Morning:			Afternoon:			Evening:	
Friday	☐ No Office Hours	Morning:			Afternoon:			Evening:	
Saturday	☐ No Office Hours	Morning:			Afternoon:			Evening:	
Sunday	☐ No Office Hours	Morning:			Afternoon:			Evening:	

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

Practice Location Information - continued

NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ Please *check this box and complete and submit Attachment F if you have other practice locations.*

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID **$** **$**
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID **$** **$**
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		

Application Addendum

First Name, Last Name, Credentials	Ethnicity:	Male/ Female	CAQH #
	_____	_____	_____

Personal Email	**Work Email**
Cell Phone Number	**Cell Phone Carrier** (ex: AT&T, Verizon)
Preferred way of Contact (please circle) ◯ Phone ◯ Email ◯ Text	**Accept Text Messages** (Please Circle) ◯ Yes ◯ No

Payer Plan Information

Do you accept the following?

New Patients ☐
Medicare ☐
Medicaid ☐
Work Comp ☐

Provider NPI: _____

Directory Information

Provider's Specialty

Primary: _____ Taxonomy Number: _____

Secondary: _____ Taxonomy Number: _____

Are you A PCP? Yes ◯ No ◯ (Note: If PCP, site visit is required every 5 years)
Are you a Specialist? Yes ◯ No ◯
Are you a Hospitalist? Yes ◯ No ◯

Received Cultural Training? Yes ◯ No ◯
Provide Tele-Med Services? Yes ◯ No ◯

Languages (Please check all that apply)

In office: _____ Speak: ☐ Write ☐ Read ☐

By Provider: _____ Speak: ☐ Write ☐ Read ☐

Patient Age and Gender Limits: Age: _____ Gender: Female: _____ Male: _____ Both: ____

Practice Location Information

Legal Business Name:	**DBA Business Name:** (if applicable)
Group Tax ID:	**Group NPI:**
Group PTAN: (Location Specific)	**Group TPI:**
Group Name/ Practice Name to appear in the Directory:	
Office Phone:	**Office Fax:**
Primary Office Contact Name:	**Phone:** **Email:**

Practice Address *(Please circle type of location)*

Primary Additional Address: _____
No/Street Suite City State/Zip Code

Pay to/Remittance Address: Address: _____
No/Street Suite City State/Zip Code

Credentialing Address: Address: _____
No/Street Suite City State/Zip Code

Correspondence Address: Address: _____
No/Street Suite City State/Zip Code

Do you want the practice location listed in the Directory? Yes _____ No_____

Does this location provide 24 hour 7 day a week phone coverage?

- ☐ Answering Service
- ☐ Voice Mail with Instructions to call answering service
- ☐ Voice mail with other instructions
- ☐ None

Does this practice location meet ADA Accessibility Standards? Yes_____ No_____

Which are the following facilities are handicapped accessible?

- ☐ Building
- ☐ Parking
- ☐ Restroom
- ☐ Other _____

Is this location accessible by public transportation?

- ☐ Bus
- ☐ Regional Train
- ☐ Other_____

For NP/PA's Only

First Name, Last Name, Credentials

Primary Practice Address

Address: _____
No/Street Suite City State/Zip Code

Primary Supervising Physician

Name of Supervising Physician _____
First Name Last Name Credentials

Supervising Physician NPI _____ Supervising Physician Specialty _____

Supervising Physician DEA _____ Supervising Physician TX License Number _____

On Supervising Physician TMB? Yes No On Physician Assistant License? Yes No

Secondary Supervising Physician *(If Applicable)*

Name of Supervising Physician _____
First Name Last Name Credentials

Supervising Physician NPI _____ Supervising Physician Specialty _____

Supervising Physician DEA _____ Supervising Physician TX License Number _____

On Supervising Physician TMB? Yes No On Physician Assistant License? Yes No

Credentialing Department
5608 Malvey Ave, Ste. 200
Fort Worth, TX 76107
Phone: (817)484-6274
FAX: (817)420-9656
Email: lj.foster@tiopa.org

TIOPA WORKERS' COMPENSATION SERVICES INFORMATION

Will you be accepting workers' compensation patients? ☐ **Yes** ☐ **No**

If **"Yes"** please complete sections **A, B & C**. If **"No"** please complete section **A** only.

A. General Information

Name: _____

Practice Name: _____

Sign: _____ Date: _____

B. Accepting Worker's Compensation:

If you will be participating with Workers' Compensation networks, please complete the following:

Will you accept NEW Workers' Compensation patients? ☐ Yes ☐ No

Will you act as a Primary Treating Physician (PTP)? ☐ Yes ☐ No

Your practice for Workers' Compensation can best be described as (initial one statement that best applies):

☐ Initial injury care for workers

☐ Initial visit for area of specialty care only. Specialty: _____

☐ Specialty and/or referral care only. Specialty: _____

Are you fully authorized and certified by the Division of Workers' Compensation (DWC) to certify Maximum Medical Improvement (MMI) and assign an impairment rating on an injured workers' claim? ☐ Yes ☐ No

(Enclose documentation supporting your Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and your current status on the Approved Doctors List (ADL).)

C: Backup Coverage:

Texas Insurance Code states that Networks must have availability and accessibility 24 hours per day, seven days per week. If you are not available, who will serve as your backup provider?

Name: _____ Phone Number: _____

Credentialing Department
5608 Malvey Ave, Ste. 200
Fort Worth, TX 76107
Phone: (817)484-6274
FAX: (817)420-9656
Email: lj.foster@tiopa.org

FINANCIAL INTEREST DISCLOSURE

Financial Disclosure's purpose is: intended to reduce the likelihood of health care practitioners making unnecessary referrals to other health care providers in which health care practitioners have a financial interest. Any health care practitioner who wishes to participate in the Texas workers' compensation system in any capacity is required to disclose to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) the identity of any health care provider in which the health care practitioner has a financial interest in: a hospital, emergency clinic, outpatient clinic, imaging center, has an immediate family member who has a financial interest, or a health care provider that employs another health care provider who has a financial interest. Health Care providers can submit financial disclosure information online to the TDI-DWC via the TXCOMP Provider System at: https://appscenter.tdi.texas.gov/TXCOMPWeb/common/home.jsp. More information regarding financial disclosure: http://www.tdi.state.tx.us/pubs/fastfacts/fffinancialdisc.pdf.

Do you have financial interests in any health care providers? ◯ **Yes** ◯ **No**

Name: _____

Provider/Practice/Facility Name: _____

Tax ID Number(s): _____

Nature of Financial Interest: _____

Signature: _____ Date: _____

Credentialing Department
5608 Malvey Ave, Ste. 200
Fort Worth, TX 76107
Phone: (817)484-6274
FAX: (817)420-9656
Email: lj.foster@tiopa.org

NAME: _____

SPECIALTY: _____

COVERING PROVIDER(S) IN CASE OF AN EMERGENCY OR ON VACATION

COVERING PHYSICIAN(S): _____

COVERING PHYSICIAN(S): _____

(Cannot be a hospitalists group or ER)

NON-ADMITTING PHYSICIAN FORMALIZED INPATIENT COVERAGE

In lieu of your admitting inpatients. NCQA requires documentation indicating how your patients will be admitted.
If you have hospital admitting privileges, please leave blank.

ADMITTING PHYSICIAN(S): _____

ADMITTING PHYSICIAN(S): _____

SIGNATURE: _____DATE: _____

(Must be signed by physician- No signature stamps accepted)

Please complete and return this form to continue the credentialing process.

Credentialing Department
5608 Malvey Ave, Ste. 200
Fort Worth, TX 76107
Phone: (817)484-6274
FAX: (817)420-9656
Email: Lj.foster@tiopa.org

DEA PRESCRIBING PHYSICIAN FORM

NAME: _____

SPECIALTY: _____

I have a current Texas DEA: ☐ Yes ☐ No

I have applied for my Texas DEA, but have not received certificate: ☐ Yes ☐ No

I have not applied for my Texas DEA: ☐ Yes ☐ No

I have a current out of state DEA: ☐ Yes ☐ No

I will forward my Texas DEA as soon as I receive it. Until received I understand I cannot write prescriptions for Controlled Substances. ☐ Yes ☐ No

PHYSICIAN SIGNATURE: _____

(Must be signed by physician- No signature stamps accepted)

DATE: _____

PRESCRIBING PLAN FOR CONTROLLED SUBSTANCES

If the provider above does not have a current Texas DEA when starting practice, they must have an interim physician who will prescribe as needed. A Hospitalist Group or ER physician will **NOT** be accepted.Please list interim physician(s) below:

INTERIM PRESCRIBING PHYSICIAN(S): _____

DEA NUMBER: _____ EXPIRATION DATE: _____

INTERIM PRESCRIBING PHYSICIAN(S): _____

DEA NUMBER: _____ EXPIRATION DATE: _____

Please complete and return this form to continue the credentialing process.



PARTICIPATING ALLIED HEALTH PROFESSIONAL AGREEMENT

TIOPA, INC.

March 31, 1999
Rev. June 23, 2004
August 2008
August 2009
March 2013
November 2018

(LAST PAGE AGREEMENT WILL NEED TO BE SIGNED, DATED AND RETURNED)

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MEDICARE ADVANTAGE PROVISIONS ADDENDUM

This PARTICIPATING ALLIED HEALTH AGREEMENT (this "Agreement") is made and entered into as of the_____day of_____, 20_____between TIOPA, Inc., a Texas non-profit corporation ("Association") and_____("Allied Health Professional").

RECITALS

A. WHEREAS, TIOPA, Inc. is a Texas non-profit corporation organized for the purpose of facilitating the provision of professional medical services to Subscribers;

B. WHEREAS, TIOPA, Inc., a Texas business corporation, has developed a program, including a marketing program, to identify and solicit Payors and Managed Care Organizations that desire to contract with providers to provide health care services to Subscribers pursuant to Health Care Contracts;

C. W HEREAS, TIOPA, INC. intends to solicit, for Participating Providers consideration, offers from Payors regarding Health Care Contracts which would obligate the Participating Providers to provide Covered Services to Subscribers;

D. W HEREAS, TIOPA, Inc. will assist in arranging for physicians or allied health professionals to provide professional medical services to Subscribers;

E. WHEREAS, TIOPA, Inc. desires Allied Health Professional to be one of the Participating Providers to participate in providing Covered Services to Subscribers;

F. W HEREAS, Allied Health Professional is (i) a specially trained and duly licensed or accredited by the State of Texas (when necessary) health care professional engaged in the delivery of health care services within the scope of his specific license or accreditation, and desires to provide professional medical services within the scope of his license or accreditation to Subscribers in accordance with Health Care Contracts; and

G. WHEREAS, TIOPA, Inc. requires that Allied Health Professional comply with certain administrative policies and procedures in providing Covered Services to Subscribers.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual agreements and promises herein contained and on this date made and other consideration, the sufficiency of which is hereby acknowledged. TIOPA, Inc. and Allied Health Professional, each with the other, do hereby agree as follows:

1.0 DEFINITIONS The following terms shall have the meanings indicated below when used in this Agreement:

1.1 "Certificates" means, collectively, the United States Drug Enforcement Administration Controlled Substance Registration Certificate and the Texas Controlled Substance Registration Certificate.

1.2 "Covered Services" means those health care services Subscribers are eligible to receive pursuant to an applicable Health Care Contract or Plan Description.

1.3 "Credentialing" means the review and evaluation of a provider's background, training and experience and all other relevant factors to determine whether the provider is qualified to participate, or continue to participate, as the case may be, in the Provider Network.

1.4 "Health Care Contract" means a contract between a Payor and a Participating Provider obligating the Provider to provide Covered Services to Subscribers.

1.5 "Managed Care Organization" means a health maintenance organization or a preferred provider organization or any other comparable entity or organization that provides, or arranges for the provision of, health care services by specified or preferred health care providers.

1.6 "Participating Allied Health Professional" means a specially trained and duly licensed or accredited by the State of Texas (when necessary) health care professional engaged in the delivery of health care services with the scope of his specific license or accreditation. Participating Allied Health Professionals included, but are not limited to, Physician Assistants, Certified Registered Nurse Anesthesiologists, Certified Nurse Practitioners or Psychologists.

1.7 "Participating Physician" means a physician duly licensed by the State of Texas to practice medicine who has agreed, by contract, to provide Covered Services to Subscribers.

1.8 "Participating Provider" means a physician, allied health professional or other provider of health care services who has agreed, by contract, to provide Covered Services to Subscribers of Payors enrolled in the Provider Network.

1.9 "Payor" means an insurance carrier, non-profit hospital service plan, healthcare service plan, employer, employee welfare benefit plan, multiple employer welfare arrangement, a state or federal governmental agency, or any other entity which under contract or law has an obligation to provide, or arrange to pay for the provision of health care services to Subscribers.

1.10 "Plan or Plan Description" means an employee welfare benefits plan or a comparable health benefit of an employer, which provides benefits for health care services to subscribers in the plan.

1.11 "Privileges" means medical staff privileges or comparable privileges to treat and/or admit patients at a hospital or other comparable treatment facility.

1.12 "Professional Review Action" means professions review action as defined in the Health Care Quality Improvement Act of 1986.

1.13 "Provider Application" means the TIOPA, Inc. Allied Health Professional Provider Application.

1.14 "Provider Network" means the network of individual providers providing Covered Services to Subscribers.

1.15 "Services" means professional medical services.

1.16 " Subscriber" means an insured member or subscriber of a Payor or a Payors employee who, by contract with the Payor, is entitled to receive health care services.

1.17 " Third Party Administrator" means an entity or organization responsible for processing and paying, or arranging for the payment of, claims of Participating Providers for Covered Services provided to Subscribers.

1.18 " Utilization Management and Quality Management Plan" means a plan and related clinical criteria used for determining appropriate, cost-effective utilization of health resources and monitoring utilization and practice patterns of physicians. Such plans include procedures for certification of medical necessity, for the purpose of reimbursement for services provided, or to be provided, and review and appeal of determinations regarding medical necessity.

2.0 RESPONSIBILITIES OF TIOPA, INC.

2.1 Marketing and Contracting

2.1.1 Marketing Program. The parties understand and agree that TIOPA, Inc. is to implement a program, which includes a marketing program, to identify and solicit offers regarding Health Care Contracts from Payors who desire to contract with Managed Care Organizations and Managed Care Organizations that desire to contract with providers for health care services.

2.1.2 Publications. The parties understand and agree that TIOPA, Inc. may identify Allied Health Professional in any advertisement or director or any other publication in connection with marketing activities related to this Agreement. Allied Health Professional hereby agrees to, and consents to, TIOPA, Inc.'s using information regarding Allied Health Professional's professional status and activities, including, but not limited to, Allied Health Professional's name, licensure or accreditation, specialty if applicable, address and telephone number in any directory or marketing activities TIOPA, Inc. conducts in connection with the Provider Network or otherwise as provided in this Section 2.1.2.

2.1.3 Offers Regarding Health Care Contracts. The parties understand and agree that TIOPA, Inc. shall (a) solicit offers from Payors regarding Health Care Contracts which would obligate providers to provide Covered Services to Subscribers and (b) communicating any such offers to Allied Health Professional for his consideration.

2.2 Administrative Functions. TIOPA, Inc. shall perform, or arrange, through its designated representatives, for the performance of, such administrative and other related functions necessary to perform TIOPA, Inc.'s responsibilities pursuant to this Agreement.

2.3 Verification of Subscriber Eligibility and Benefits. The parties expressly understand and agree that TIOPA, Inc. does not verify, and is not responsible for verifying, the eligibility or benefits of any Subscriber.

2.4 Not an Insurer. The parties understand and agree that TIOPA, Inc. is not an insurer neither indemnitor nor an underwriter of any health care benefit or any type or form of employee benefit. The parties further understand and agree that TIOPA, Inc. is not a provider of, and is not responsible for providing, any health care service.

2.5 Communications Regarding Price Terms. Notwithstanding anything to the contrary in this Agreement, all price and price-related terms, if any, Allied Health Professional submits to TIOPA, Inc. shall be kept confidential and shall not be disclosed to any officer, director, member, contractor or any other person or entity who is in any way affiliated with other Participating Providers or any other than a Payor.

3.0 RESPONSIBILITIES OF ALLIED HEALTH PROFESSIONAL

3.1 Health Care Contracts

3.1.1 Generally. Allied Health Professional shall consider, in good faith, any and all offers from Payors regarding Health Care Contracts, which would obligate Allied Health Professional to provide Covered Services to Subscribers. The parties understand and agree that Allied Health Professional shall, as set forth more fully below in this Section 3.1, independently determine whether to enter into any such contracts. If Allied Health Professional enters into a Health Care Contract, the parties further understand and agree that Allied Health Professional shall provide Covered Services as needed to Subscribers consistent with accepted standards of practice, the applicable Health Care Contract or Plan Description and this Agreement. The parties further understand and agree that TIOPA, Inc. shall not control, direct, or otherwise supervise, or be responsible for, Allied Health Professional's facilities or personnel, if applicable, or those of the Participating Physician by whom Allied Health Professional is employed or otherwise contractually affiliated, in the performance of any medical services.

3.1.2 Appointment of Attorney-In-Fact. Allied Health Professional hereby appoints the President of TIOPA, Inc. as Allied Health Professional's attorney-in-fact with the authority to enter into any Health Care Contract on Allied Health Professional's behalf in accordance with section 3.1.3.

3.1.3 Execution of Contracts

A. Allied Health Professional understands and agrees TIOPA, Inc. shall have the ability to negotiate proposed Health Care Contracts with Payors. Allied Health Professional understands such discussions shall be conducted by the President of TIOPA, Inc. or his designee. However, Allied Health Professional shall be under no obligation to accept any proposed Health Care Contract.

B. Allied Health Professional hereby authorizes TIOPA, Inc., as his attorney-in-fact; to execute proposed Health Care Contracts on his behalf as evaluated by the TIOPA, Inc.'s Contracts Committee on his behalf, subject to paragraph c.

C. For each Health Care Contract TIOPA, Inc. negotiates on behalf of Allied Health Professional pursuant to this Agreement, TIOPA, Inc. shall forward to Allied Health Professional a copy of a summary of the Health Care Contract and a Notice of Health Care Contract Offer form for Allied Health Professional's review and approval. If Allied Health Professional approves the proposed Health Care Contract, he shall forward to TIOPA, Inc. a Participation Notice form (the "Participation Notice") authorizing TIOPA, Inc. to execute the proposed Health Care Contract on his behalf as his attorney-in-fact. Although Allied Health Professional may have rejected a proposal, Allied Health Professional understands TIOPA, Inc. may continue to negotiate the proposed Health Care Contract on behalf of any other participating provider.

3.2 Bylaws; Policies and Procedures. The parties understand and agree that Providers shall comply with (a) the Bylaws of the TIOPA, Inc. and (b) all policies and procedures and standards regarding the performance of Credentialing and utilization review and quality assessment in connection with any Health Care Contract the Provider enters into. Without limiting any other responsibility of Allied Health Professional hereunder, Allied Health Professional acknowledges and agrees that, pursuant to the policies and procedures of the TIOPA, Inc. concerning Credentialing, Allied Health Professional is required, without limitation, to notify the medical director of the TIOPA, Inc. in writing no later than ten (10) calendar days after any of the following: (i) any change in licensure, professional liability insurance coverage or membership or privileges at any hospital or any other health care facility; (ii) any impairment in mental or physical health which could affect Allied Health Professional's ability to provide Services to Subscribers or care and treatment to other patients; (iii) any settlement or jury verdict arising from Allied Health Professional's clinical and/or professional conduct and/or (iv) any alleged violation of law (other than minor traffic violations).

3.3 Eligibility and Benefit Verification. Allied Health Professional shall be solely responsible to verify the eligibility of each Subscriber for benefits and the benefits available to the Subscriber.

3.3.1 Charges for Covered Services. The parties understand and agree that (a) Allied Health Professional or the Physician by whom Allied Health Professional is employed or otherwise contractually affiliated shall be responsible for billing and collecting fees for Covered Services, and (b) TIOPA, Inc. shall have no responsibility for billing or collection or paying Allied Health Professional's fees for Covered Services, unless the applicable Health Care Contract provides that TIOPA, Inc. shall have claims management or claims processing responsibilities. If TIOPA, Inc. has such claims management or claims processing responsibilities, the parties understand and agree that TIOPA, Inc.'s responsibilities regarding billing, collecting and disbursing Allied Health Professional's fees for Covered Services shall be described in the applicable Health Care Contract.

3.4 Compliance with Regulatory and Accreditation Standards. Allied Health Professional shall comply with all applicable federal, state and local laws, rules and regulations and any applicable Health Care Contract and any applicable Plan in connection with the performance of Covered Services and maintain all licenses, certifications and accreditation necessary for Allied Health Professional to provide health care services.

3.5 Hold Harmless for Covered Services. Allied Health Professional agrees notwithstanding any other provision of this Agreement, that for any Covered Services furnished to subscribers pursuant to any Health Care Contract or Plan, Allied Health Professional shall in no event with respect to such Subscribers (including, but not limited to, non-payment by the Payor or Managed Care Organization, insolvency of the Payor or Managed Care Organization, or the Payors or Managed Care Organization's breach of the applicable Health Care Contract or Plan) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against, such Subscribers or any other person other than the Payor or Managed Care Organization for such Covered Services; provided, however, that the preceding sentence shall not prohibit Allied Health Professional from billing and collecting supplemental charges, co- payments, or fees for uncovered services provided on a fee-for-service basis to Subscribers. Allied Health Professional agrees that this Section 3.5 shall (i) survive the termination of this Agreement regardless of the cause therefor and shall be construed to be for the benefit of the Subscribers, and (ii) supersede any oral or written contrary agreement now existing or hereafter entered into between Physician and TIOPA, Inc., or between Allied Health Professional and any Payor, Managed Care Organization or Subscriber.

4.0 ACCESS TO BOOKS AND RECORDS

4.1 Other Party's Representatives. Subject to the provisions of law relating to confidentiality of patient records, Allied Health Professional agrees to permit TIOPA, Inc.'s accountants and other representatives to have reasonable access during normal business hours to records regarding Covered Services for the purpose of confirming compliance with the requirements of the Agreement.

4.2 Governmental Entities. To the extent required by applicable law and regulations, each party shall make this Agreement and its books, documents and records available to the Secretary of the Department of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives.

4.3 Notice to TIOPA, Inc. If Allied Health Professional is requested to disclose any books, documents or records relevant to this Agreement or any services it has provided to a Subscriber for the purpose of an audit or investigation. Allied Health Professional shall notify TIOPA, Inc. of the nature and scope of such request and shall make available to TIOPA, Inc., upon request by TIOPA, Inc., all such books, documents or records.

5.0 CONFIDENTIALITY OF RECORDS

5.1 Records. Allied Health Professional shall maintain the usual and customary records, in accordance with all applicable federal and state statutory and regulatory requirements, for each Subscriber in the same manner as for the other patients of Allied Health Professional.

5.2 Confidentiality. Except as otherwise required by applicable law or this Agreement, the parties agree to keep confidential, and to take reasonable precautions to prevent the unauthorized disclosure of, any and all records required by this Agreement to be prepared or maintained by the parties.

5.3 Duplicating. Any and all Subscriber records and charts prepared by Allied Health Professional as a result of Services provided to Subscribers shall be, and remain, the property of Allied Health Professional. During and after the term of the Agreement, Allied Health Professional shall permit TIOPA, Inc. or the representative of any Payor to inspect and duplicate, at its expense, any individual chart or record to the extent necessary for the performance of utilization review, quality assessment, credentialing or any other like function required or necessary in connection with Health Care Contracts; provided, however, such inspection, duplication or review of confidential Subscriber medical records shall be done in compliance with all statutes and regulations regarding privilege and confidentiality and shall be subject to appropriate patient consent.

6.0 INSURANCE AND INDEMNIFICATION

6.1 Insurance. Allied Health Professional shall obtain and maintain, at its own expense, during the term of the Agreement, professional and general liability insurance coverage as required by (a) any Health Care Contract Allied Health Professional enters into and (b) the Bylaws or rules and regulations of TIOPA, Inc. and (c) the Medical Staff Bylaws of any hospital or other health care facility where Allied Health Professional has Privileges and shall provide evidence of such coverage to TIOPA, Inc. upon TIOPA, Inc.'s request. Allied Health Professional shall notify TIOPA, Inc. no later than five (5) days prior to the effective date of the termination or lapse, or any material change in the terms, of such coverage.

6.2 Indemnification. Allied Health Professional shall defend, indemnify and hold TIOPA, Inc. and its affiliates and their successors and assigns and their officers, directors, employees, agents and independent contractors harmless from and against any and all claims, actions, causes of actions, demands, suits, debts, liens, contracts, agreements, promises, liabilities, damages, losses, costs or expenses (including attorneys' fees, court costs and costs of settlement) whatsoever in connection with injury to, or death of, any person or damage to property of third party arising out of, resulting from, attributable to, or proximately caused by any negligent or intentional act or violation of any law or regulation by Allied Health Professional, or his agents, employees, servants or independent contractors arising out of the performance of any of his duties under this Agreement or any Health Care Contracts or the provision of any services or claims for reimbursement for services provided to Subscribers.

7.0 TERM OF AGREEMENT This Agreement shall become effective as of the date TIOPA, Inc. approves Allied Health Professional's Provider Application (the "Effective Date") and continue for a term of one (1) year, unless earlier terminated pursuant to the provisions of this Agreement (the "Primary Term"). The term of this Agreement shall be extended for an additional one (1) year period (each an "Extended Term"), whether one or more, commencing on the expiration of the Primary Term and on the expiration of each succeeding Extended Term unless (i) no later than sixty (60) days before the expiration of the Primary Term or the Extended Term, as applicable, either party delivers to the other written notice of its election not to renew this Agreement or (ii) either party is in material default of its obligations hereunder. For the purposes of this Section 7.0, material default by either party shall not be deemed to exit unless, and until, the notice requirements described in Section 9.11 are satisfied and the time to cure the default has elapsed without either TIOPA, Inc. or Physician as applicable, taking the action necessary to cure such default. The provisions of this Section 7.0 relating to extension of the term of this Agreement shall not in any way negate the right of either party to terminate this Agreement pursuant to Section 8.0.

8.0 TERMINATION

8.1 Automatic Termination. This Agreement shall automatically terminate upon (i) the loss or suspension of Allied Health Professional's license or accreditation to practice his allied health profession in the State of Texas or the loss or suspension of a Certificate, if applicable; (ii) Allied Health Professional's professional liability coverage as required under Section 6.1 of this Agreement is no longer in effect; or (iii) TIOPA, Inc. determines that Allied Health Professional is not in compliance with an applicable Utilization Management and Quality Management Plan, provided that Allied Health Professional has had the opportunity, if, and to the extent, applicable, to participate in any review and appeals procedures.

8.2 Termination for Cause. Either party may terminate this Agreement if the other party materially breaches any provision of this Agreement effective thirty (30) days after the date of written notice to the other party; provided, however, that the party which desires to terminate this Agreement has given the other party written notice of such material breach and intention to terminate this Agreement, and such breach has not been cured within thirty (30) days after the date of such notice. The notice of breach provided pursuant to this Section 8.2 shall specify with reasonable particularity the nature and extent of the complained of material breach. In the case of termination by TIOPA, Inc., Allied Health Professional shall also have the opportunity to participate in any applicable appeals and review procedures.

8.3 Termination for Insolvency. A party may terminate this Agreement immediately if any other party is (i) adjudicated bankrupt or becomes insolvent or (ii) institutes or consents to any voluntary bankruptcy or other similar arrangement or a receiver or trustee is appointed for any similar reason.

8.4 Termination by TIOPA, Inc. Provided that Allied Health Professional has had the opportunity, if, and to the extent, applicable, to participate in any applicable review and appeals procedures, TIOPA, Inc. may terminate this Agreement immediately in the event of any of the following:

1. The termination or suspension by TIOPA, Inc. of the Participating Physician by whom the Allied Health Professional is employed or otherwise contractually affiliated;

2. The termination or other similar change in the employment or other contractual affiliation of Allied Health Professional with the Participating Physician by whom the Allied Health Professional is employed or otherwise contractually affiliated on the date hereof;

3. Failure or inability of Allied Health Professional or Allied Health Professional's personnel, if applicable, for any reason, to devote appropriate and sufficient time to fulfill Allied Health Professional's duties and responsibilities pursuant to a Health Care Contract;

4. Failure of Allied Health Professional to diligently or effectively perform his duties pursuant to a Health Care Contract;

5. Any of this information provided by Allied Health Professional in the Provider Application is not true, correct or complete;

6. Commission by Allied Health Professional of any act involving moral turpitude or the commission of any act or the suffering by Allied Health Professional of any occurrence or condition which could reasonably be expected to adversely affect TIOPA, Inc.'s reputation or standing in the community;

7. Any Professional Review Action, including, but not limited to, summary suspension of Allied Health Professional's privileges, if applicable, is taken against Allied Health Professional who adversely affects Allied Health Professional's Privileges;

8. Allied Health Professional commits negligence or gross negligence in the performance of his duties pursuant to a Health Care Contract;

9. Failure of negligence to provide any information TIOPA, Inc. requires in order for TIOPA, Inc. to perform its responsibilities pursuant to this Agreement; or

10. Allied Health Professional or his personnel, if applicable, fail to maintain a cooperative attitude or cooperate with TIOPA, Inc. or its representatives.

8.5 Optional Termination. Either party may terminate this Agreement, with or without cause or penalty, effective sixty (60) days after the date of providing written notice to the other party.

8.6 Termination by Mutual Consent. The parties may terminate this Agreement by mutual written agreement.

9.0 MISCELLANEOUS

9.1 Independent Contractors. In the performance of the work, duties, and obligations set forth in this Agreement, and in regard to any services rendered or performed on behalf of Subscribers by Allied Health Professional, each party, its agents, servants and employees are at all times acting and performing as independent contractors. Subject to the terms of this Agreement, neither party shall have nor exercise any control or discretion over the method by which the other party shall perform such work or render or perform such services and functions.

9.2 Non-exclusivity of Relationship. Nothing in this Agreement shall be construed to restrict Allied Health Professional from providing, or entering into other contracts or agreements to provide, health care services to persons other than Subscribers, provided that such activities do not materially hinder or conflict with the Allied Health Professional's ability to perform his duties and obligations under this Agreement.

9.3 Remedies. The remedies provided to the parties by this Agreement are not exclusive or exhaustive, but are cumulative of each other and in addition to any other remedies the parties may have.

9.4 Waiver. Waiver by any party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any prior, concurrent or subsequent breach. None of the provisions of this Agreement shall be considered waived by a party except when such waiver is given in writing.

9.5 Force Majeure. If any party fails to perform its obligations hereunder (except for the obligation to pay money) because of strikes, accidents, acts of God, weather conditions, or action or inaction of any government body or other proper authority or other causes beyond its control, then such failure to perform shall not be deemed a default hereunder and shall be excused without penalty until such time as said party is capable of performing.

9.6 Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties their successors and assigns, and nothing in this agreement is intended, nor shall be deemed to confer any benefits on any third party other than an affiliate of TIOPA, Inc.

9.7 Governing Law and Venue. This Agreement shall be construed and enforced pursuant to the laws of the State of Texas, and the obligations contained herein are performable in Tarrant County, Texas. Venue of any judicial proceeding or other proceeding brought to enforce this Agreement shall be in Tarrant County, Texas.

9.8 Attorneys' Fees. If any party brings an action against any other party to enforce any condition or covenant of this Agreement, the prevailing part shall be entitled to recover its court costs and reasonable attorneys' fees incurred in such action from the other parties.

9.9 Assignability

9.9.1 Allied Health Professional. The rights, duties and obligations of Allied Health Professional may not be assigned or delegated to any other person, group or corporation without the prior written consent of the TIOPA, Inc.

9.9.2 TIOPA, Inc. Upon notice to Allied Health Professional, TIOPA, Inc. shall have the right to assign this Agreement to its successor in the event of a merger, consolidation, or corporation reorganization involving IPA provided such successor agrees to assume TIOPA, Inc.'s obligations under this Agreement.

9.10 Amendments. This Agreement can be amended only by an instrument in writing signed by each of the parties. Amendments to this Agreement shall be effective as of the date provided therein.

9.11 Notices. Whenever, under the terms of this Agreement, written notice is required or permitted to be given by a party to the other parties, such notice shall be deemed delivered when personally delivered or one (1) day following receipt by a commercial delivery service or two (2) days following the date of deposit in the United State mail in a properly stamped envelope, certified mail, return receipt requested, addressed to the party to whom it is to be given at the address following the party's signature to this Agreement.

9.12 Counterparts. This document shall be executed in multiple counterparts, each of which when taken together shall constitute but on and the same instrument.

9.13 Section Headings. The headings preceding the text of the several sections of this Agreement are inserted solely for convenience of reference and shall not constitute a part of this Agreement, nor shall they affect the meaning, construction, or effect of any section hereof.

9.14 Severability. The sections and individual provisions contained in this Agreement shall be considered severable from the remainder of this Agreement and in the event that any section or other provision is determined to be unenforceable as written for any reason, such determination shall not adversely affect the remainder of the sections or other provisions of this Agreement. It is agreed further, that in the event any section or other provision is determined to be unenforceable, the parties shall use their best efforts to agree on an amendment to the Agreement to supersede the severed section or provision.

9.15 Entire Agreement. This Agreement and any and all attachments, including, but not limited to, the Provider Application, set forth the entire understanding and agreement between the parties and shall be binding upon the parties, their subsidiaries, affiliates, successors, and permitted assigns. All prior negotiations, agreements and understandings are superseded hereby.

9.16 Further Acts. Each party agrees to cooperate fully with the other parties to take such further actions and execute such other documents or instruments as necessary or appropriate to implement this Agreement.

MEDICARE ADVANTAGE PROVISIONS ADDENDUM

References to "**Provider**" in this Medicare Advantage Provisions Addendum ("**Addendum**") are to the provider of health care services contracted with TIOPA under a participation agreement ("**Agreement**"). TIOPA has entered into an agreement ("**MAO Agreement**") with one or more health care entities ("**MAO**") that have an agreement with the Centers for Medicare and Medicaid Services ("**CMS**") for the provision of medical and related health care services Medicare Advantage plan ("MA Plan"), a Medicare Advantage – Prescription Drug plan ("MA-PD Plan"), and/or a Capitated Financial Alignment Demonstration plan ("Medicare-Medicaid Plan") (each such MA Plan, MA-PD Plan and CFAD Plan to be alternatively referred to herein as a "Medicare Plan," and collectively as the "Medicare Plans"). The provisions in this Addendum relate specifically to services provided by Provider to an MAO and its Covered Persons. In the event of a conflict between the terms of this Addendum and the Agreement with respect to Medicare Plan, the terms of this Addendum control.

1. DEFINITIONS. The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Addendum. Capitalized terms not otherwise defined in this Addendum shall be defined as set forth in the Agreement.

1.1 Capitated Financial Alignment Demonstration Program means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 Clean Claim means a claim that has no defect, impropriety, lack of any required substantiating documentation including the substantiating documentation needed to meet the requirements for encounter data or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 CMS Contract means the contract between a Payor and CMS, or among Payor, CMS and the State, that governs the terms of the Payors participation in a Medicare Plan.

1.4 Covered Persons means those individuals who are enrolled in a Medicare Plan.

1.5 Covered Services means those services which are covered under a Medicare Plan.

1.6 HHS means the United States Department of Health and Human Services.

1.7 Medicare Advantage Program means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.8 Payor means the health maintenance organization or managed care organization that has a CMS Contract to participate in a Medicare Plan.

1.9 State means one or more applicable state governmental agencies of the State of Texas.

2. COVERED SERVICES. Provider shall furnish Covered Services to Covered Persons as set forth herein.

3. SUBCONTRACTOR OBLIGATIONS. To the extent that Provider executes a contract with any other person or entity that in any way relates to Provider's obligations under the Agreement or this Addendum, including any downstream entity, subcontractor or related entity, Provider shall require that such other person or entity assume the same obligations that Provider assumes under this Addendum.

4. GOVERNMENT RIGHT TO INSPECT. Provider agrees that 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, computer or other systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Addendum or from the date of completion of any audit, whichever is later. *42 C.F.R. § 422.504 (i)(2)(i) and (ii)*

Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, records, including medical records and documentation of the Provider, that pertain to any aspect of service s performed, reconciliation of benefit liabilities, and determination of amounts payable under this Addendum, or as the Secretary of HHS may deem necessary to enforce the CMS Contract.

Provider shall cooperate with and shall assist and provide such information and documentation to such entities as requested. Provider shall retain, and agrees that this right to inspect, evaluate and audit shall extend for a period of ten (10) years following the termination date of this Addendum or completion of audit, whichever is later, unless (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the Payor at least 30 days before the normal disposition date; at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by the Payor, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit at any time. This provision shall survive termination of this Addendum. To the extent that Provider executes a contract with any other person or entity that in any way relates to Provider's obligations under this A ddendum, Provider shall require that such other person or entity assume the same obligations that Provider assumes under this Article IV. *42 C.F.R. § 422.504 (e)(2).*

5. CONFIDENTIALITY AND ENROLLEE RECORD REQUIREMENTS. Provider shall comply with all confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal and State laws regarding the 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 subpoena; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §422.504(a)(13) and 422.118*

6. HOLD HARMLESS.

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of the Payor. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(i)*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost- sharing as part of the integrated package of benefits. 42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance. With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with the Payor. Provider shall accept payment from the Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. COMPLIANCE WITH CMS CONTRACT. Provider shall perform its obligations under this Addendum in a manner consistent with and in compliance with TIOPA, Inc.'s and Payors contractual obligations under the CMS Contract. *42 C.F.R.§422.504(i)(3)(iii)*

8. PROMPT PAYMENT. The Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance this Addendum. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Payor at such address as may be designated by Payor. *42 C.F.R. §422.520(b)(1) and (2)*

9. COMPLIANCE WITH FEDERAL AND STATE LAWS. TIOPA, Inc., Provider, Payor, and any related party or other contractor or subcontractor shall comply with all applicable laws, regulations and CMS and/or State instructions. *42 C.F.R.§422.505(i)(4)(v)*

10. DELEGATION OF DUTIES. In the event that Payor delegates to TIOPA, Inc. any function or responsibility imposed pursuant to the State Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by TIOPA, Inc. or Provider of functions or responsibilities imposed pursuant to this Addendum shall be subject to the prior written approval of Payor and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

10.1 TIOPA, Inc.'s delegated activities and reporting responsibilities, if any, are specified in the Delegated Credentialing Agreement or Delegated Services Agreement attached to this Agreement.

10.2 CMS and the Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the Payor determine that such parties have not performed satisfactorily.

10.3 The Payor will monitor the performance of the parties on an ongoing basis.

10.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Payor, or the credentialing process will be reviewed and approved by TIOPA, Inc. and Payor must audit the credentialing process on an ongoing basis.

10.5 If TIOPA, Inc. or Payor delegates the selection of providers, contractors, or subcontractors, TIOPA, Inc. and the Payor retain the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. 422.504(i)(4) and (5)*

11. SAFEGUARDING OF PRIVACY. Provider shall comply with all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Provider shall comply with TIOPA, Inc.'s and the Payors policies and procedures with respect to the safeguarding of privacy of individually identifiable information relating to a Covered Person. *42 C.F.R. §§422.504(a)((13); 422.118*

12. NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS. Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42C.F.R. §422.110(a*)

13. SERVICE AVAILABILITY. Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

14. CULTURAL COMPETENCE. Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R.§422.112(a)(8).*

15. FOLLOW-UP CARE. Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42C.F.R. §422.112(b)(5).*

16. ADVANCE DIRECTIVES. Provider shall comply with the Payors policies and procedures concerning advance directives. *42 C.F.R. §422. 128(b)(1)(ii)(E).*

17. PROFESSIONALLY RECOGNIZED STANDARDS OF CARE. Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R.§422.504(a)(3)(iii).*

18. CONTINUATION OF BENEFITS. Provider shall provide Covered Services as provided in the Agreement and this Addendum: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Addendum. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

19. PHYSICIAN INCENTIVE ARRANGEMENT. If Provider is a physician or physician group the Payor shall not make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. If the physician incentive plan places Provider at substantial financial risk (as determined under § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with § 422.208(f) of this section. Payor must provide to CMS the information specified in §422.210 for all physician incentive plans (if any). *42 C.F.R. §422.208.*

20. INFORMATION DISCLOSURES TO CMS. Provider shall cooperate with TIOPA, Inc. and the Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

21. NOTICE OF PROVIDER TERMINATIONS. TIOPA, Inc. shall make a good faith effort to provide written notice to Payor of a termination of a contracted provider so that Payor will have at least 30 calendar days before the termination effective date to notify all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

22. RISK ADJUSTMENT DATA. Provider shall provide to Payor complete and accurate risk adjustment data as required by CMS. *42 C.F.R. §422.310(d)(3), (4).* Upon Payors or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. *42 C.F.R. §422.310(e)*.

23. COMPLIANCE WITH PAYOR POLICIES. If Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Payors request, consult with Payor regarding Payors medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b).* Provider shall comply with Payors quality assurance and performance improvement programs. *§42 C.F.R. 422.504(a)(5).*

24. WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION. In the event Payor suspends or terminates this Addendum with respect to Provider or any physicians employed or contracted with Provider, Payor shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Payor, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1*)

25. NOTICE OF WITHOUT CAUSE TERMINATION. Each party must provide at least sixty (60) days written notice to each other before terminating this Addendum without cause. *42 C.F.R. §422.202(d)(4).*

26. COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS. Payor, and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R.§422.504(h)(1).*

27. EXCLUDED PRACTITIONERS. Provider warrants to TIOPA, Inc. and each Payor (a) that Provider and each of its owners, employees and contractors who provide health care, utilization review, medical, social work, or any administrative services under or in connection with the Agreement (collectively "Personnel") (i) are not listed on the General Services Administration's Excluded Parties List System ("GSA List"), and (ii) are not suspended or excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b(f), or any form of state Medicaid program (collectively, "Government Payor Programs"), and (b) that, to Provider's knowledge, there are no pending or threatened govern mental investigations that m ay lead to suspension or exclusion of Provider or Personnel from Government Payor Programs or may cause for listing on the GSA List. *42 C.F.R. §422.752(a)(8).*

28. COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS. Provider shall cooperate and comply with all applicable State, federal and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

29. OFFSHORE SUBCONTRACTORS. Provider shall disclose to Payor in writing, within 30 days of signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *Health Plan Management System memos 7/23/2007, 9/20/2007, and 8/26/2008.*

30. SCOPE AND CONFLICTS. Nothing in this Addendum shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, except as stated in this Addendum. In the event of any inconsistences between this Addendum and any provision of the Agreement in connection with Provider's provision of Covered Services to Covered Persons, the provisions of this Addendum shall govern. In the event that any provision of this Addendum conflicts with the provisions of any statute or regulation applicable to Payor, the provisions of the statute or regulation shall have full force and effect.

31. TERMINATION. This Addendum shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. The Addendum may be further terminated by Payor immediately upon written notice to the Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or is suspended or excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b(f), or any form of state Medicaid program.

In Witness Whereof, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the date first written above.

"TIOPA, INC."

Name: Tim Paquette

Print Name: Tim Paquette – Board Secretary

Date: _____

"PROVIDER"

Signature: _____

Print Name: _____

Date: _____

PROVIDER RELATIONS PACKET CHECKLIST

PLEASE COMPLETE ALL FORMS AS THEY ARE REQUIRED BY THE NETWORKS FOR ENROLLMENT. BE PRECISE WHEN COMPLETING THESE FORMS AS THIS INFORMATION IS WHAT WILL BE POPULATED TO THE NETWORK DIRECTORIES.

- Plan Participating Checklist
- Aetna Addendum
- Aetna THR Narrow Network EPO Admitting Letter
- BCBS Coverage Letter
- Bright HealthCare Coverage Letter
- Cigna Admitting Letter
- Cigna Election to Participate Addendum
- Cigna Medicare Advantage Admitting Letter
- Oscar Admitting Letter
- Scott & White Hospital Letter
- Tricare Opt In Letter
- W-9 (nothing earlier than the 2018 form accepted, completed, signed and dated)

The following items are many times overlooked during completion of the application and are critical to the plans. Please review your credentialing application to assure these items have been addressed.

- Call coverage – The insurance networks, and the Board of Directors, **require** that every practitioner have call coverage. Be sure to list which provider will provide coverage for you.
- Do you have age or gender restrictions in your practice? (page 6 of TSCA & TIOPA Addendum)
- How do you want to be listed in the network directories? Be exact on primary office location, phone, fax and hours of operation and if you are accepting new patients. (page 6-7 of TSCA & TIOPA Addendum)
- Provide the address, phone, fax and email where you would like us to send any correspondence, credentialing or contracting information.
- Hospital privileges. Please list all hospitals that you are affiliated with. (pages 4 & 16 of TSCA & TIOPA Addendum)

IF THE APPLICATION IS INCOMPLETE, WE ARE UNABLE TO START THE CREDENTIALING PROCESS AND THIS WILL IN TURN DELAY YOUR SUBMISSION TO THE INSURANCE NETWORKS. PLEASE PROVIDE ACCURATE AND COMPLETE INFORMATION.

5608 Malvey Ave
Ste 200
Fort Worth, TX 76107
Ph: (817)484-6274 Fax: (817)420-9661

INSTRUCTIONS
PLAN PARTICIPATION CHECKLIST
VERY IMPORTANT INFORMATION

Please take careful consideration before filling out the Plan Participation Checklist. Once you have made your selections, and sent the document to us, our Provider Relations team will submit the information to the payors. It generally takes 30 - 180 days to be loaded to the payors. If you are adding a provider to your group, PLEASE refer to the PPCL the established providers use. Please utilize the PPCL of the established providers as a guide for the new provider's PPCL. If not, it can cause inconsistencies in plan participation within the group. Subsequently, PPCL corrections are often submitted too quickly after the initial PPCL has been processed, which causes issues and backlogs in the loading process. **It is important to wait a minimum of 6 months before making changes to plan participation by sending us another PPCL**. To avoid this, take the time to make careful selections on the initial PPCL, keeping a selection template at the practice level, and reading all checklist instructions, bylines, and participation criteria thoroughly.

If you are pending a Medicare PTAN and/or Medicaid TPI but plan to accept Medicare Advantage and Medicaid managed care plans in the future**, please make your selections for these plans on your initial checklist**. Once we receive your Medicare PTAN and/or Medicaid TPI we will automatically enroll you in the plans you selected.

To establish valuable organization with the networks, and maintain your revenue cycle we recommend you make minimal changes. For this reason, we are limiting our members to a maximum of 2 plan changes per fiscal year October 1 – September 30. If you need to change your plan participation more than 2 times in a fiscal year, there is a $350 charge to process each additional change. Please note this does not include new plan offerings when we send out opt-in forms with solicitations.

I have read, and I understand the information above.

Group Name _____

Provider Name _____

Group Admin or Provider Signature _____

Date _____

PLEASE NOTE CHANGES AS MARKED ☐

PLAN PARTICIPATION CHECKLIST

Provider Name: _____ Provider NPI: _____

Provider CAQH#: _____ Provider Specialty: _____

Group Association: _____TIN: _____

Please select Opt-in or Opt-out on all options listed below and return with your application.
If a plan does not have an Opt-in/Opt-out box checked it defaults to Opt-out and will not be sent for enrollment.

COMMERCIAL PRODUCTS

- **Aetna Commercial Plans (*All or nothing)***
  Includes, but not limited to – Choice POS, Elect, HMO, Open Choice PPO, Meritain Health, & Walmart.
  (Must sign & return enclosed Individual Provider Addendum)
  ☐ Opt In
  ☐ Opt Out

- **Aetna THR Joint Venture EPO (Narrow Performance Network)**
  Requires specific hospital privileges or return covering letter for NP/PA.
  (Must be enrolled under the commercial plans with TIOPA to qualify)
  ☐ Opt In
  ☐ Opt Out

- **Blue Cross and Blue Shield of Texas**
  (Must have BCBS Record ID associated with the current TIN to participate)
  Provider BCBS Record ID # _____
  ☐ Opt In – Blue Choice PPO *(Includes EPO, Federal Employees Benefit Plan, POS, and TRS ActiveCare)*
  ☐ Opt In – Blue Essentials HMO *(Includes Blue Essential Access, Health Select, and TRS ActiveCare)*
  ☐ Opt In – Blue Advantage HMO *(Exchange product)*
  ☐ Opt In – Blue Premier
  ☐ Opt Out

- **Bright Health Management Inc.**
  (Must complete & return Bright Health Hospital Letter – Uses Medical City & Methodist Facilities)
  ☐ Opt In –Texas Standard Plan
  ☐ Opt Out

- **ChoiceCare PPO Humana**
  ☐ Opt In
  ☐ Opt Out

- **Cigna Healthcare of Texas, Inc (All or nothing)**
  Includes, but not limited to – HMO/OAS/Network, PPO, Open Access Plus. Providers cannot just enroll in Local Plus.
  (Must complete & return CIGNA Election to Participate addendum & Cigna Hospital Letter).
  ☐ Opt In
  ☐ Opt In – Local Plus – (Narrow network at discretion of Cigna for enrollment, no guarantee.)
  ☐ Opt Out

- **Cigna Healthcare North Texas Provider Select Plan**
  ☐ Opt In – Tier I – Network participation at discretion of Cigna for enrollment, no guarantee.
  ☐ Opt In – Tier II – Rolled into the OAP product, if opted into.
  ☐ Opt Out

- **Coventry/First Health – PPO**
  ☐ Opt In
  ☐ Opt Out

- **Evry PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Friday Health Plan – Exchange PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Galaxy Health Network (All or nothing)**
  Includes – PPO, & Medical Savings Card
  - ☐ Opt In
  - ☐ Opt Out

- **Healthcare Highways Healthplan PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Health EZ – The City of Crowley Employee Benefit Plan**
  For Johnson & Tarrant Counties
  - ☐ Opt In
  - ☐ Opt Out

- **Healthscope Benefits, Inc - DART- (All Commercial)**
  - ☐ Opt In
  - ☐ Opt Out

- **Healthsmart Preferred Care**
  - ☐ Opt In – ACCEL
  - ☐ Opt In – GEPO
  - ☐ Opt In – HPO (Health Payors)
  - ☐ Opt In – PPO
  - ☐ Opt Out

- **Imagine Health – PPO**
  Requires privileges at a Baylor facility
  - ☐ Opt In
  - ☐ Opt Out

- **Independent Medical Systems (IMS) – PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Molina Healthcare – Exchange Network**
  - ☐ Opt In
  - ☐ Opt Out

- **Multiplan Network**
  - ☐ Opt In
  - ☐ Opt Out

- **National Preferred Provider Network (NPPN) – PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Nexcaliber PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Oscar --- All Products**
  Oscar will only except ODs if you are Therapeutic Optometrists
  Uses Medical City & Methodist Facilities
  - ☐ Opt In
  - ☐ Opt Out

- **Prime Health Services, Inc.**
  - ☐ Opt In – Group Health
  - ☐ Opt Out

- **Private Healthcare Systems, Inc. (PHCS)**
  - ☐ Opt In – PPO
  - ☐ Opt Out

- **Provider Select, Inc. – PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Scott & White Health Plan -- BSWQA NOT INCLUDED**
  Includes – HMO, PPO, POS, ASO, Medicare Advantage, & TRS.
  (Must have privileges at a BSW facility OR complete & return the attached BSW admitting letter..
  - ☐ Opt In
  - ☐ Opt Out

- **Stone Mountain Risk PPO**
  Must complete & return Stone Mountain Hospital letter
  Uses Dallas Medical Center & Dallas Regional Medical Center
  - ☐ Opt In – Hospital Narrow Network PPO
  - ☐ Opt Out

- **Superior Ambetter Exchange**
  - ☐ Opt In
  - ☐ Opt Out

- **Three Rivers Provider Network – PPO**
  - ☐ Opt In
  - ☐ Opt Out

- **Tricare (Humana Military)**
  Includes – Champ VA, Life, Prime, & Select
  (Must be Tricare Certified, and complete & return the Opt In/Out form)
  - ☐ Opt In
  - ☐ Opt Out

- **TriWest**
  (Must have BCBS Record ID associated with the current TIN to participate)
  Provider BCBS Record ID # _____
  - ☐ Opt In
  - ☐ Opt Out

- **United Healthcare Commercial**
  Including, but not limited to – Charter, Choice, Core, Navigate, Nexus, Select, UMR & GEHA
  - ☐ Opt In
  - ☐ Opt Out

- **USA Managed Care Organization**
  - ☐ Opt In – PPO
  - ☐ Opt In – LoneStar Athletic Injury Network PPO
  - ☐ Opt Out

WORKERS' COMPENSATION PRODUCTS

☐ **I WISH TO OPT OUT OF ALL WORKERS COMPENSATION PLANS**

- **CareWorks (fka Rockport Healthcare Group)**
  - ☐ Opt In – Workers' Compensation
  - ☐ Opt In – NWI
  - ☐ Opt Out

- **Corvel Healthcare (All or nothing)**
  Includes – Auto, Non-Subscriber Work Injury, & Workers' Comp
  - ☐ Opt In
  - ☐ Opt Out

- **Coventry/First Health**
  With the enrollment in Coventry you will automatically be enrolled in the following networks: Caramor Network (DBA: Avidel Medical Management); Conduent Care Solutions TX HCN; First Health TX HCN; Genex/American Airlines Group Network; Genex Health Care Network; Hartford Workers Compensation Health Care Network.

  ALL OTHER SUB-NETWORKS REQUIRE ADDITIONAL STEPS TO JOIN THE NETWORK AS DETAILED ON THEIR SEPARATE WEBSITES, INCLUDING BUT NOT LIMITED TO: AIG TX HCN, AIG Productivity Edge TX HCN-CHCWC, Broadspire, Coventry Workers' Comp Network, Employers Managed Provider Network, Gallagher Bassett, Liberty Health Care Network, Sedwick, Texas Star Network, Travelers, United Airlines TX HCN-CHCWC, Zenith Health Care Network, & Zurich Services.
  - ☐ Opt In – Auto
  - ☐ Opt In – Workers' Compensation
  - ☐ Opt Out

- **Galaxy Health Network – Non-Subscriber Work Injury**
  - ☐ Opt In
  - ☐ Opt Out

- **Healthsmart Preferred Care – Workers' Compensation**
  - ☐ Opt In
  - ☐ Opt Out

- **MultiPlan – Workers' Compensation**
  - ☐ Opt In – Auto
  - ☐ Opt In – Workers' Compensation
  - ☐ Opt Out

- **Prime Health Services, Inc.**
  - ☐ Opt In – Auto
  - ☐ Opt In – IME
  - ☐ Opt In – Workers' Compensation
  - ☐ Opt Out

- **The Reny Company – Non-Subscriber Work Injury**
  - ☐ Opt In
  - ☐ Opt Out

- **Texas Healthcare Foundation – Non-Subscriber Work Injury**
  - ☐ Opt In
  - ☐ Opt Out

- **Three Rivers Provider Network – Workers' Compensation**
  - ☐ Opt In
  - ☐ Opt Out

- **USA Managed Care Organization – Workers' Compensation**
  - ☐ Opt In
  - ☐ Opt Out

MEDICARE ADVANTAGE PRODUCTS

MUST submit a Medicare/PTAN enrollment letter to TIOPA before being submitted to any Medicare plan. Providers must apply for and maintain PTAN initial enrollments and revalidations. Unless you opt to have TIOPA obtain and maintain the PTAN for you at an additional fee.

Individual PTAN(s) associated with TIN _____ ☐ **I WISH TO OPT OUT OF ALL MEDICARE PLANS**

- **Aetna – Medicare Advantage – HMO and PPO**
  (Must sign and return enclosed Individual Provider Addendum)
  - ☐ Opt In – Medicare Advantage
  - ☐ Opt In – Prime Medicare Advantage
  - ☐ Opt Out

- **Amerigroup Medicare Advantage (Amerivantage)**
  (Includes, but not limited to – Amerivantage HCOP—Texas Medicare Advantage Dual Coordination Plus, HMO – Traditional HMO, HMO SNP – Chronic Care Medicine, ISNP – Care To You, PPO – Choice PPO Medicare Network, SNP – Special Needs Plan)
  - ☐ Opt In
  - ☐ Opt Out

- **Blue Cross Medicare Advantage**
  (Must have/keep CAQH updated before enrollment approval)
  Provider BCBS Record ID # _____
  - ☐ Opt In – Medicare Advantage HMO
  - ☐ Opt In – Medicare Advantage PPO
  - ☐ Opt Out

- **Bright Health Management Inc.**
  (Must complete & return Bright Health Hospital Letter – Uses Medical City & Methodist Facilities)
  - ☐ Opt In – Medicare Advantage
  - ☐ Opt Out

- **Care N Care Medicare Advantage – HMO and PPO**
  HMO include Southwestern Select HMO for Tarrant and Johnson Counties
  - ☐ Opt In
  - ☐ Opt Out

- **Choice Care Network by Humana – Medicare Advantage**
  - ☐ Opt In – Medicare Advantage HMO ***(For Specialists only NO PCPs)***
  - ☐ Opt In – Medicare Advantage PFFS
  - ☐ Opt In – Medicare Advantage PPO
  - ☐ Opt Out

- **Cigna Medicare Advantage (fka HealthSprings)**
  Pediatrics not eligible for CHS MA
  HMO Counties Currently – Collin, Dallas, Denton, Johnson, Parker, Hood, Wise, and Tarrant
  PPO Counties Currently – Collin, Dallas, Denton, Johnson, Tarrant
  - ☐ Opt In – Medicare Advantage PPO
  - ☐ Opt In – Medicare Advantage HMO
  - ☐ Opt In – Traditional Medicare PPO ***(No Gatekeeper)***
  - ☐ Opt Out

- **Global Health HMO Medicare Advantage**
  - ☐ Opt In
  - ☐ Opt Out

- **Imperial Insurance Company of TX – Medicare Advantage**
  - ☐ Opt In
  - ☐ Opt Out

- **Molina – Medicare Advantage Options**
  - ☐ Opt In
  - ☐ Opt Out

- **Scott & White Medicare Advantage HMO**
  (Must have privileges at a BSW facility OR complete & return the attached BSW admitting letter.
  ☐ Opt In
  ☐ Opt Out

- **WellCare by Allwell**
  ☐ Opt In
  ☐ Opt Out

- **United Healthcare Medicare Advantage**
  **** At this time, UHC is not enrolling PCPs in the Medicare Advantage products. We are not sure when this will change. Please to continue to opt-in if this is a product you are interested in because geographical regions are also considered.** ***Including, but not limited to - Dual Complete, Care Improvement Plus, AARP, WellMed.***
  ☐ Opt In
  ☐ Opt Out

MEDICAID PRODUCTS

MUST submit a Medicaid/TPI enrollment letter to TIOPA before being submitted to any Medicaid plan. Providers must apply for and maintain TPI initial enrollments and revalidations. Unless you opt in to have TIOPA obtain and maintain your TPI for you at an additional cost.

Individual TPI(s) associated with TIN _____ ☐ **I WISH TO OPT OUT OF ALL MEDICAID & CHIP PLANS**

- **Aetna Better Health Medicaid**
  (Must sign & return enclosed Individual Provider Addendum)
  - ☐ Opt In – CHIP
  - ☐ Opt In – Star
  - ☐ Opt In – Star Kids
  - ☐ Opt Out

- **Amerigroup Texas, Inc.**
  - ☐ Opt In – CHIP
  - ☐ Opt In – Star
  - ☐ Opt In – Star Plus
  - ☐ Opt In – Star Kids
  - ☐ Opt In – Star Plus + MMP ***(Medicare/Medicaid Dual)***
  - ☐ Opt Out

- **Blue Cross & Blue Shield of Texas Medicaid**
  - ☐ Opt In – CHIP
  - ☐ Opt In – Star
  - ☐ Opt In – Star Plus
  - ☐ Opt In – Star Kids
  - ☐ Opt Out

- **Cook Children's Health Plan**
  Open to Existing Groups ONLY, and limited to the following counties: Denton, Hood, Johnson, Parker, Tarrant, & Wise. Any enrollments in other counties are at the discretion of Cook Children's Health Plan. (Must have/keep CAQH updated before enrollment approval)
  - ☐ Opt In – CHIP
  - ☐ Opt In – Star
  - ☐ Opt In – Star Kids
  - ☐ Opt Out

- **Cigna Star Plus (fka Healthspring)**
  This plan has transitioned to Molina Star Plus, and Molina Star Plus MMP as of 1/1/2022
  You will need to opt into Molina to continue seeing these patients.

- **Molina Healthcare**
  - ☐ Opt In – CHIP
  - ☐ Opt In – Star
  - ☐ Opt In – Star Plus
  - ☐ Opt In – Star Plus + MMP ***(Medicare/Medicaid Dual)***
  - ☐ Opt Out

- **Superior Health Plan**
  - ☐ Opt In – CHIP
  - ☐ Opt In – Foster Care
  - ☐ Opt In – Star HMO
  - ☐ Opt In – Star Plus
  - ☐ Opt In – Star Plus + MMP ***(Medicare/Medicaid Dual)***
  - ☐ Opt Out

- **United Healthcare Medicaid**
  At this time UHC Medicaid is closed, enrollment is solely at the discretion of UHC
  - ☐ Opt In
  - ☐ Opt Out

PLAN CHECKLIST ADDENDUM
NEW SOLICIATIONS FOR FISCAL YEAR 21-22

These plans have been recently added to our available options for opt in and were sent as a solicitation after finalization of the application packets. We need an indication on these plans if you wish to opt in or out of the new plans.

- **Superior Ambetter Value**
  Solication window: 04/01/2022-04/22/2022
  Contract effective date: 05/01/2022

  ☐ Opt In
  ☐ Opt Out

- **Provider Partners Health Plan – ISNP**
  Solication window: 05/24/2022-06/15/2022
  Contract effective date: 01/01/2022

  ☐ Opt In
  ☐ Opt Out

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

INDIVIDUAL PROVIDER ADDENDUM

The undersigned health care provider ("Provider"), a member of T.I.O.P.A., Inc. ("Entity"), has and does hereby designate Entity as his/her attorney-in-fact for the purposes of negotiating, consenting to and executing the IPA Agreement (the "Agreement"), between Aetna U.S. Healthcare of North Texas Inc. ("Company") and Entity and any documents related to amendments to the Agreement. Terms capitalized herein but not otherwise defined shall have the meanings ascribed to them in the Agreement.

Provider hereby acknowledges that Provider has reviewed the Agreement (a copy of which has been made available to Provider by Entity), under which Entity, on behalf of Provider, agrees to provide Covered Services to Members enrolled in the Plans. Plans include any health benefit product or plan issued, administered, or serviced by Company or one of its Affiliates, including, but not limited to, HMO, preferred provider organization, indemnity, Medicaid, Medicare and Worker's Compensation. Such Agreement must comply with all applicable provisions of the Assurance of Voluntary Compliance between Company and the Texas Attorney General ("AVC"). Provider hereby agrees to be bound by the terms and conditions of the Agreement, including, without limitation, compliance with the Participation Criteria applicable to Provider, the applicable provisions of the AVC, and all applicable Company rules, policies and procedures.

Provider hereby agrees that in the event: (i) Provider ceases to be a member of Entity; (ii) the Agreement expires or is terminated for any reason; (iii) the Entity is dissolved; (iv) a voluntary or involuntary bankruptcy or a proposed settlement of outstanding debts under applicable reorganization or insolvency laws is filed by or against Entity, a receiver is appointed or Entity makes an assignment for the benefit of creditors; or (v) the Entity otherwise ceases to exist, either voluntarily or involuntarily (each, a "Triggering Event"), the terms of the Agreement shall, at Company's option, survive with respect to Provider for the first six (6) months after such Triggering Event, in which case Provider shall continue to provide services to Members in accordance with the terms of the Agreement during said nine (6) month period. Provider agrees to take any and all actions necessary to effectuate the intent of this paragraph, including executing an individual agreement for participation in Company's provider network if so requested by Company.

IN WITNESS WHEREOF, the undersigned has executed this Individual Provider Addendum as of this ___ day of _____, 20 __, intending to be legally bound hereby.

PROVIDER: _____

PRINTED NAME: _____

Aetna THR Narrow Network EPO

I do not currently have privileges at an Aetna EPO Network facility. Should hospitalization of an Aetna EPO Network patient become necessary, I will refer the member to an Aetna EPO network physician or hospitalist for admission to an Aetna EPO network facility (listed below). Specialist are required to have privileges with at least one Aetna EPO network facility (listed below).

Name of admitting physician/hospitalist group

Provider Signature

Provider printed name

Date

Collin County
+ Children's Medical Center Plano
+ Methodist McKinney Hospital
+ Methodist Richardson Medical Center
+ Texas Health Center for Diagnostics & Surgery Plano
+ THR Allen
+ THR Plano

Cooke County
+ Muenster Memorial Hospital
+ North Texas Medical Center

Dallas County
+ Children's Medical Center of Dallas
+ Methodist Charlton Medical Center
+ Methodist Dallas Medical Center
+ Methodist Hospital for Surgery
+ Methodist Rehabilitation Hospital
+ THR Dallas
+ Texas Institute for Surgery
+ Texas Scottish Rite Hospital for Children
+ UT Southwestern University Hospital
+ UT Southwestern University Hospital Zale Lipshy

Denton County
+ THR Denton
+ THR Flower Mound

Ellis County
+ Ennis Regional Medical Center

Erath County
+ Texas Health Harris Methodist Hospital Stephenville

Grayson County
+ Texoma Medical Center

Hood County
+ Lake Granbury Medical Center

Hunt County
+ Hunt Regional Medical Center

Johnson County
+ Texas Health Harris Methodist Hospital Cleburne

Kaufman County
+ THR Kaufman

Parker County
+ Texas Health Harris Methodist Hospital Azle

Rockwall County
+ THR Rockwall

Somervell County
+ Glen Rose Medical Center

Tarrant County
+ Children's Southlake Specialty Care
+ Cook Children's Medical Center
+ Methodist Southlake Hospital
+ Methodist Mansfield Medical Center
+ Texas Health Arlington Memorial Hospital
+ Texas Health Harris Methodist Hospital Alliance
+ Texas Health Harris Methodist Hospital Fort Worth
+ Texas Health Harris Methodist Hospital (HEB)
+ Texas Health Harris Methodist Hospital Southlake
+ Texas Health Harris Methodist Hospital Southwest Fort Worth
+ Texas Health Heart & Vascular Hospital Arlington
+ Texas Health Huguley Hospital Fort Worth South
+ Texas Health Specialty Hospital Fort Worth
+ USMD Hospital at Arlington

Wise County
+ Wise Regional Health System
+ Wise Regional Hospital Bridgeport

BlueCross BlueShield of Texas

HOSPITAL COVERAGE LETTER

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a participating network hospital (in the applicable BCBSTX provider network(s) in which I participate), with the exception of medical emergencies, my practice will be confined to outpatient care.

I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer BCBSTX subscriber/member care to a participating physician or hospitalist (in the applicable BCBSTX provider network) who has active admitting privileges at a participating network hospital (in the applicable BCBSTX provider network).

(Please print legibly)

Provider's Name: _____

Provider's Signature: _____

Provider's NPI #: _____

Date: _____

BCBSTX Provider Networks Include:

1) BlueChoice® PPO
2) Blue Medicare Advantage (PPO)
3) HMO Blue® Texas
4) Blue Advantage HMO℠
5) Blue Community HMO
6) Medicaid (STAR) and CHIP

Note: *If you are unsure of the participation status in a specific BCBSTX provider network, for yourself, another physician, hospitalist, or hospital, please contact your local BCBSTX Provider Relations office by fax, phone, or you may use our online provider finder at https://public.hcsc.net/providerfinder/search.do?corpEntCd=TX1&nextPage=.*

Provider Relations Office	FAX Number	Telephone Number
Austin	512-349-4853	512-349-4847
Corpus Christi	361-852-0624	361-878-1623
Dallas	972-766-2231	972-766-8900 / 800-749-0966
El Paso	915-496-6614	915-496-6600
Houston, Beaumont, East Texas	713-663-1227	713-663-1149 / 800-637-0171
Lubbock, Amarillo	806-783-4666	806-783-4610
Midland, Abilene, San Angelo	432-620-1428	432-620-1406
San Antonio	361-852-0624	361-878-1623

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Bright HealthCare™

Facility Privilege Attestation Form

Bright HealthCare requires members to receive services at Bright Health-contracted facilities in non-emergent situations.

If you do not provide your services in or do not have hospital privileges at a facility in the Bright HealthCare network, it is required that you refer Bright HealthCare Members to an in-network physician who will admit the Member to a contracted facility. For outpatient services, you are also required to utilize in-network facilities. Specialist physicians that perform services in a hospital must perform these services at an in-network facility.

All contracted facilities, laboratories, radiology and imaging centers, and ambulatory surgical centers are listed on our website at BrightHealthCare.com. Click “Find a Provider”, select the appropriate plan type based on your contract with Bright HealthCare, then enter your location to find a list of in-network facilities.

I agree to ensure that Bright HealthCare Members will be referred to in-network facilities for outpatient services hospital inpatient admissions, if required.

_____

Name of Bright HealthCare Network Participating Provider(s) who will admit Members

Provider Signature: _____

Provider Printed Name:_____ Date: _____

CIGNA

I do not currently have privileges at a Cigna participating hospital. Should hospitalization of a Cigna patient become necessary, I will refer the member to a Cigna in-network physician for admission to a network hospital.

Name of physician/hospitalist group who admits for you, or list the hospital you admit to from the list below.

Provider Signature

Provider printed name

Date

PARTICIPATING HOSPITALS:

Baylor Scott & White Health System Hospitals
Children's Medical Health System Hospitals
Christus Trinity Mother Frances Hospitals
Cook Children's Medical Center
Corpus Christi Medical Center
Covenant Medical Centers
East Texas Medical Center
Good Shepherd Health Network
HealthSouth Rehabilitation Hospitals
Kindred Hospitals
LifeCare Hospitals
Longview Regional Medical Center
Medical City Hospitals & Clinics
Methodist Health System Hospitals
Midland Memorial Hospital
Odessa Regional Medical Center
Palo Pinto General Hospital
Parkland Memorial Hospital
Paris Regional Medical Center
Star Medical Center
St. David's Facilities & Clinics
Texas Health Resources Hospitals
Texas Scottish Rite Hospitals
Texoma Medical Center
UMC Health System Hospitals
USMD Hospitals
UT Southwestern Medical Center

CIGNA ELECTION TO PARTICIPATE

This Election to Participate ("Election") confirms the undersigned health care provider's (who is referred to as "You") agreement to provide Covered Services to Participants under the Provider Group Services Agreement between Cigna Healthcare of Texas Inc ("Cigna") and TIOPA, Inc. ("Group") ("Group Agreement") You acknowledge that You wish to be a "Represented Provider" under the Group Agreement for so long as that Group Agreement is in effect You understand that your participation under this Election will become effective upon notice from Cigna or Group and shall continue until termination of this Election. You understand that your participation under this Election may continue beyond termination of the Group Agreement as specified below

1. **Covered Services.** You will provide Covered Services to Participants within the scope of your health care practice and in accordance with the applicable terms and conditions of the Group Agreement, the Administrative Guidelines and this Election.

2. **Payment.** You will accept as full payment due from Payor for rendering Covered Services the amounts specified and payable by Group or Payor, as applicable, under Your agreement with Group. You may not seek reimbursement from Cigna or any other Payor for such Covered Services and will look solely to Group for payment of Covered Services if payments for Covered Services under the Group Agreement are directed to the Group.

3. **Participant Hold Harmless for Covered Services.** Under no circumstances, including, without limitation, the termination of the Group Agreement or this Election, the non-payment by Payor or Group or Payor's or Group's insolvency will You seek payment for covered Services provided pursuant to this agreement from any Participant or persons acting on their behalf. This provision shall not prohibit collection of applicable Copayments, Coinsurance or Deductibles in accordance with the terms of the applicable Benefit Plan. You agree that this provision survives the termination of this Election for Covered Services rendered prior to the termination of the Election, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Participant. You agree that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between You and a Participant or persons acting on their behalf.

4. **Compliance with Applicable Law/Regulatory Addenda.** You will provide Covered Services in accordance with applicable law. One or more regulatory Addenda may be attached to the Group Agreement setting out provisions that are required by law with respect to Covered Services rendered to certain Participants (i.e. Participants under an insured plan). Those provisions are incorporated by reference into this Election and shall apply to the extent required by law and as specified in such Addenda.

5. **Termination of Group Agreement.** In the event that the Group Agreement terminates, this Election will also terminate unless Cigna chooses to continue this Election. If Cigna chooses to continue this Election, You will continue to provide Covered Services in accordance with the terms of the Group Agreement, the Administrative Guidelines and this Election until this Election is terminated under the Termination of Election provision below, and You will be reimbursed directly for Covered Services in accordance with the terms of the Group Agreement.

6. **Termination of Election.** Cigna may terminate this Election at any time upon prior written notice if You no longer maintain the licenses required to perform Your duties under the Election, You are disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over You or You no longer satisfy Cigna's credentialing requirements. In addition, Cigna or You may terminate this Election at any time upon 60 days' prior written notice.

7. **Limited Superseding Effect.** For so long as it is in effect, this Election supersedes any and all other agreements between You and Cigna (or any of its affiliates) regarding provision of Covered Services to Participants with respect to those Benefit Plans covered by the Group Agreement.

8. **Notices.** During the term of the Group Agreement, any notices to You under this Election will be effective if provided to the Group as specified in the Group Agreement. After termination of the Group Agreement, Cigna will notify You in accordance with the terms of the Group Agreement but at Your address set forth below.

9. **Defined Terms.** Capitalized terms used in this Election that are not specifically defined herein shall have the meaning provided in the Group Agreement.

Date: _____

Signature: _____

Printed Name: _____

Tax Identification Number: _____

Address: _____

_____

Email address: _____

CIGNA MEDICARE ADVANTAGE

I do not currently have privileges at a Cigna Medicare Advantage, or Cigna Star Plus participating hospital. Should hospitalization of a Cigna Medicare Advantage, or Cigna Star Plus patient become necessary, I will refer the member to a Cigna Medicare Advantage, or Cigna Star Plus in-network physician for admission to a network hospital.

Name of physician/hospitalist group who admits for you, or list the hospital you admit to from the list below.

Provider Signature

Provider printed name

Date

PARTICIPATING HOSPITALS: *MEDICARE ADVANTAGE HMO/PPO*

Cherokee –	East Texas Medical Center & Christus Mother Francis Hospital Jacksonville
Collin –	Baylor Scott & White Centennial, Medical City McKinney, Medical City Plano
Dallas –	Dallas Medical Center, Dallas Regional Medical Center, City Hospital at White Rock, Parkland Hospital, Pine Creek Medical Center, Crescent Medical Center, Baylor Scott & White Sunnyvale, Medical City Las Colinas, Medical City Dallas
Denton –	Medical City Denton, Medical City Lewisville
Henderson –	UT Health – Athens
Hood –	Lake Granbury Medical Center
Lubbock –	Covenant Medical Centers
Parker –	Medical City Weatherford
Rusk –	UT Health – Henderson
Tarrant –	Medical City Arlington, Medical City North Hills, Medical City Fort Worth
Upshur –	UT Health – Gilmer
Wise –	Wise Regional Health System
Wood –	UT Health -Quitman, Christus Mother Francis Hospital Winnsboro

PARTICIPATING HOSPITALS: *PPO ONLY*

Collin –	THR Allen, THR Plano, Texas Health Center for Diagnostic & Surgery
Dallas –	THR Dallas, Texas Institute for Surgery
Denton –	THR Denton and THR Flower Mound
Johnson –	THR Harris Methodist Cleburne
Tarrant –	THR Arlington, THR Harris Methodist Azle, Fort Worth, HEB, Southlake, Southwest Fort Worth THR Heart & Vascular Hospital Arlington, THR Huguley, USMD Arlington and Fort Worth

PARTICIPATING HOSPITALS: *STAR PLUS*

Cameron –	Harlingen Medical Center, Valley Baptist
Collin –	THR Allen, THR Plano, Texas Health Center for Diagnostic & Surgery
Dallas –	Dallas Medical Center, THR Dallas, Texas Institute for Surgery
Denton –	THR Denton and THR Flower Mound
Erath –	THR Stephenville
Hidalgo –	Cornerstone Regional Hospital, Doctors Hospital Renaissance, Edinburg Children's Hospital, Knapp Medical Center, McAllen Heart Hospital, McAllen Medical Center, Mission Regional Medical Center
Hood –	Lake Granbury Medical Center
Johnson –	THR Harris Methodist Cleburne
Kaufman –	THR Kaufman
Maverick –	Fort Duncan Regional Medical Center
Parker –	Medical City Weatherford
Rockwall –	THR Rockwall
Tarrant –	THR Arlington, THR Harris Methodist Azle, THR Harris Methodist Fort Worth THR Harris Methodist HEB, THR Harris Methodist Southlake, THR Harris Methodist Southwest Fort Worth, THR Heart & Vascular Hospital Arlington, THR Huguley, USMD Arlington, USMD Fort Worth
Star –	Starr County Memorial Hospital
Webb –	Doctors Hospital Laredo, Laredo Medical Center
Wise –	Wise Regional Medical Center

OSCAR ADMITTING LETTER

As of January 1, 2020 Oscar has changed their in-network facilities to Medical City and Methodist facilities. You may use the links at the bottom to find facilities near you.

- ☐ I have current privileges at a Medical City or Methodist participating hospital. Should hospitalization of an Oscar patient become necessary, I will admit the patient to an in-network network hospital.

_____

Name of OSCAR in-network hospital where I have admitting privileges.

***Hospital has been verified by Credentialing Staff _____(initial)*

- ☐ I do not currently have privileges at a Medical City or Methodist participating hospital. Should hospitalization of an Oscar patient become necessary, I will refer the member to a Medical City or Methodist in-network physician for admission to a network hospital.

_____

Name of physician/hospitalist group with admitting privileges at an OSCAR in-network hospital.

***Provider has been verified to be in-network by Credentialing Staff _____(initial)*

- ☐ I do not want to opt-in on any Oscar product.

- Provider Signature _____
- Provider Printed Name: _____ Date: _____

LINKS TO OSCAR NETWORK HOSPITALS

https://medicalcityhealthcare.com/locations/

https://www.methodisthealthsystem.org/locations/

Hospital/Facility Privilege Form

Scott & White Health Plan (SWHP) requires members to receive services at SWHP contracted facilities in non-emergent situations.

If you do not provide your services in or do not have hospital privileges at a facility contracted with the SWHP, it is required that you refer SWHP members to a SWHP physician who will admit your SWHP members to a contracted facility. For outpatient services, you are also required to utilize SWHP facilities. Specialist physicians that perform services in a hospital must perform these at a SWHP contracted facility.

Hospitals, lab, radiology/imaging facilities, and ambulatory surgical centers contracted with SWHP are listed on our website at www.swhp.org. Select "Find a Provider" at the bottom of the page or under the "Menu" section. Then select appropriate Plan type, enter doctor or facility name and/or city or zip, then select a specialty from the drop down box.

I have reviewed the SWHP contracted facilities on the website referenced above and agree to refer SWHP members to a SWHP contracted facility in all non-emergent situations.

Physician who will admit patient on your behalf (if known): _____

Date: _____ Physician Name: (Signature): _____

NPI: _____ (Printed): _____

Humana
Government Business

Opt-In / Opt-Out Letter
Multi-TIN Agreement

Contracted Entity Name: ____TIOPA_____

Tax Identification Number (TIN) Name: _____

TIN to Add: _____NPI:_____

TIN to Remove: _____NPI:_____

Please indicate your response in one of the boxes below:
Opt-In (Add):

☐ As signature authority for the TIN listed above, I have reviewed the TRICARE Contract, Fee Schedule, Provider Manuals and TRICARE requirements and have decided to 'ACCEPT' the TIOPA contracted rates and be bound to the terms of said agreement. My signature below represents my "Acceptance" and willingness to participate and terminates any prior agreement. I acknowledge all physicians under the above tax identification number are included and will be notified of their new effective date, with the understanding that leaving this TIN may prompt a new agreement.

Opt-Out (Termination):

☐ As signature authority for the TIN listed above, the TIN will no longer be participating under the Multi-TIN agreement known as TIOPA.

Owner of Tax Identification Number (TIN): _____

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Phone: _____

FOR INTERNAL HUMANA MILITARY PURPOSES ONLY:

Impacted Contract ID(s): _____ _____

_____

_____

Revised July 2018

Last Edit: 07.05.22

Physician Assistant

FY 2021-2022



Delegation Protocol for Physician Assistants

A. PURPOSE:

The purpose of this Delegation Protocol is to describe the scope of practice of the Physician Assistant ("PA") and to authorize the PA who signs this Delegation Protocol to initiate certain medical aspects of patient care including the carrying out or signing of prescription drug orders pursuant to the Texas Medical Practice Act and the Texas Medical Board ("TMB") rules.

Name of PA _____
Address: _____
License Number: _____ DEA Number: _____

Name of Supervising Physician _____
Address: _____
Medical License Number: _____ DEA Number: _____

B. PRACTICE LOCATION:

The PA will provide care under this Agreement to patients treated in the facility or facilities in which the PA legally practices listed below:

Site 1: _____

Site 2: _____

Site 3: _____

Site 4: _____

C. SCOPE OF PRACTICE/RESPONSIBILITIES:

The PA shall provide, within his/her education, training and experience, medical services that are delegated by the supervising physician. Both the PA and the supervising physician are responsible for identifying the PA's scope of practice, the relationship of and access to each other, appropriateness of delegated tasks, process for evaluating the PA's performance and for confirming that the PA's annual registration permit is current. A PA may have more than one supervising physician. Medical services provided by the PA may include, but are not limited to the following:

1) Obtaining patient histories and performing physical examinations;
2) Ordering and/or performing diagnostic and therapeutic procedures;
3) Formulating a working diagnosis;
4) Developing and implementing a treatment plan;
5) Monitoring the effectiveness of therapeutic interventions;
6) Assisting at surgery;
7) Offering counseling and education to meet patient needs;
8) Requesting, receiving, and signing for the receipt of pharmaceutical sample prescription medications and distributing the samples to patients in a specific practice setting in which the PA is authorized to prescribe pharmaceutical medications and sign prescription drug orders as authorized by law;
9) Signing or completing a prescription as allowed by this Delegation Protocol;

10) Making appropriate referrals;
11) All procedures delineated and approved in the Clinical Privileges form of UNT Health: and
12) Other: _____

_____

D. CARRYING OUT OR SIGNING PRESCRIPTION DRUG ORDERS:

The PA must have valid prescription authorization numbers and must comply with all federal, state and local laws and regulations relating to the prescribing of dangerous drugs and controlled substances, including but not limited to requirements set forth by the Texas Department of Public Safety and the Drug Enforcement Administration. After delegated prescriptive authority has been registered with the Texas Medical Board by the PA and the supervising physician, and in accordance with all applicable laws, the PA may prescribe medications in the categories as checked below:

1.) Dangerous drugs, defined as all drugs, excluding controlled substances, that can only be dispensed with a prescription from a licensed practitioner, such as antibiotic, antiviral, antiparasitic, topical and other agents, and that are consistent with the PA's scope of practice and experience.

Describe any limitations, such as restricting the prescribing of certain drugs, as applicable:

_____

_____

2.) Controlled Substances, limited to those controlled substances listed under Schedules III-V and consistent with the PA's scope of practice and experience. In addition, the PA cannot issue prescriptions, including refills, for a period to exceed 90 days and cannot authorize a refill beyond the initial 90 days prior to consulting with the delegating physician and noting the consultation in the patient's medical record. The PA cannot authorize the prescription of a controlled substance for a child less than 2 years of age prior to consulting with the delegating physician and noting the consultation in the patient's medical record.

Describe any limitations, such as restricting the prescribing of certain drugs, as applicable:

_____

_____

If prescribing at the physician's primary practice site, the PA may only prescribe to patients with whom the delegating physician has established or will establish a physician-patient relationship.

The PA may authorize a generic substitution. Except for Schedule III-V drugs, as specified under TMB rules, there are no limitations the number of dosage units and refills permitted beyond that which would be considered appropriate and reasonable for the drug and the patient's medical condition.

The PA shall provide appropriate instructions to the patient on the use of any medication prescribed, including appropriate warnings, and will monitor applicable lab values or other medical tests.

The supervising physician is responsible for complying with all other physician requirements related to delegation of prescriptive authority. The supervising physician will not delegate prescriptive authority to a combined number of more than four (7) FTEs of APNs and/or PAs practicing at the physician's primary and alternate practice sites, including the practice location identified above, unless a waiver is granted by the TMB.

E. PHYSICIAN'S ADDITIONAL RESPONSIBILITIES

For all delegated medical aspects of care, the supervising physician will provide continuous supervision (constant physical presence of the physician is not required) of the PA under this Delegation Protocol and in accordance with state law including, but not limited to, the Texas Medical Practice Act and the TMB rules. The supervising physician will be available for consultation in person or by phone on a daily basis on an as needed basis in order to collaborate with the PA to establish a diagnosis, plan of care or referral. The physician will be available for and accept referrals from the PA or make alternate arrangements for such referrals. Telecommunication is acceptable.

A PA may be supervised by an alternate supervising physician in the absence of the supervising physician consistent with the Texas Medical Practice Act and the TMB rules.

The supervising physician retains the professional and legal responsibility for the care rendered by the PA.

F. QUALITY OF CARE

It is the professional responsibility of the supervising physician and PA that dialogue be continuous and ongoing as required. The collaborative relationship is also built on trust and a mutual acknowledgment of the abilities of the PA and the supervising physician. The PA and the supervising physician should be reasonable and prudent when formulating the Delegation Protocol. The Delegation Protocol must be jointly developed, reviewed and signed on an annual basis, maintained in the practice setting and made available as necessary to verify authority to provide medical aspects of care.

G. CALL COVERAGE

PA must have call coverage for admitting patients into a health facility. Their supervising physician or alternate physician will admit their patients unless they have no admitting privileges. The PA must make other arrangements with another physician who can admit patients. Please list physician (s) below:

Supervising Physician Name: _____

Supervising Physician Name: _____

Alternate Physician: _____

Alternate Physician: _____

H. SIGNATURES

The following signatures denote the PA's and the supervising physician's understanding of the above Delegation Protocol. In each instance this document is amended, both parties must re-acknowledge by signature their concurrence and understanding of the change. This document will be maintained in the Credentialing file of the PA.

Physician Assistant Name: _____ Date: _____

Signature: _____

Supervising Physician Name: _____ Date: _____

Signature: _____

Alternate supervising physician _____

Alternate supervising physician _____

APRN

FY 2021-2022



Collaborative Practice and Prescriptive Authority Agreement for
Advanced Practice Registered Nurses

A. PURPOSE:

The purpose of this Collaborative Practice and Prescriptive Authority Agreement is to describe the scope of practice of the Advanced Practice Nurse ("APRN") and to authorize the APRN who signs this Collaborative Practice and Prescriptive Authority Agreement to initiate certain medical aspects of patient care including the carrying out or signing of prescription drug orders pursuant to the Texas Medical Practice Act, the Texas Medical Board ("TMB") rules and the Texas Nursing Practice Act and the Texas Board of Nursing ("TBON") rules.

Name of Advanced Practice Registered Nurse _____
Address: _____
Nurse License Number: _____ DEA Number: _____

Name of Supervising Physician _____
Address: _____
Medical License Number: _____ DEA Number: _____

B. SETTING:

The APRN will provide care under this Collaborative Practice and Prescriptive Authority Agreement to patients treated in the facility or facilities in which the APRN legally practices listed below:

Site 1: _____

Site 2: _____

Site 3: _____

Site 4: _____

C. SCOPE OF PRACTICE/RESPONSIBILITIES:

The advanced practice nurse provides a broad range of health services to a variety of patients, the scope of which shall be based upon educational preparation, continued advanced practice experience and the accepted scope of professional practice of the particular specialty area and shall know and conform to the Texas Nursing Practice Act, current TBON rules, regulations, and standards of professional nursing, and all federal, state, and local laws, rules, and regulations affecting the advanced role and specialty area. In addition, (1) the scope of practice of particular specialty areas shall be defined by national professional specialty organizations or advanced practice nursing organizations recognized by the Board. (2) the advanced practice nurse's scope of practice shall be in addition to the scope of practice permitted a registered nurse and does not prohibit the advanced practice nurse from practicing in those areas deemed to be within the scope of practice of a registered nurse, (3) the advanced practice nurse acts independently and/or in collaboration with the health team in the observation, assessment, diagnosis, intervention, evaluation, documentation, rehabilitation, care and counsel, and health teachings of persons who are ill, injured or infirm or experiencing changes in normal health processes; and in the promotion and maintenance of health or prevention of illness, and (4) when providing medical aspects of care, advanced practice nurses shall comply with this Collaborative Practice and Prescriptive Authority Agreement and all applicable laws, ruled and regulations including those promulgated by the TMB and the TBON.

D. CARRYING OUT OR SIGNING PRESCRIPTION DRUG ORDERS:

The APRN must have valid prescription authorization numbers and must comply with all federal, state and local laws and regulations relating to the prescribing of dangerous drugs and controlled substances, including but not limited to requirements set forth by the TBON, the Texas Department of Public Safety and the Drug Enforcement Administration. The APRN may only prescribe those medications that are FDA approved except at otherwise permitted by the TBON. After filing an application for prescriptive authority with the TBON by the APRN and after delegated prescriptive authority has been registered with the TMB by the APRN and the supervising physician, and in accordance with all applicable laws, the APRN may prescribe medications in the categories as checked below:

1.) Dangerous drugs, defined as all drugs, excluding controlled substances, that can only be dispensed with a prescription from a licensed practitioner, such as antibiotic, antiviral, antiphrastic, topical and other agents, and that are consistent with the APRN's scope of practice and experience.

Describe any limitations, such as restricting the prescribing of certain drugs, as applicable:

2.) Controlled Substances, limited to those controlled substances listed under Schedules III-V and consistent with the APRN's scope of practice and experience. In addition, the APRN cannot issue prescriptions, including refills, for a period to exceed 90 days and cannot authorize a refill beyond the initial 90 days prior to consulting with the delegating physician and noting the consultation in the patient's medical record. The APRN cannot authorize the prescription of a controlled substance for a child less than 2 years of age prior to consulting with the delegating physician and noting the consultation in the patient's medical record.

Describe any limitations, such as restricting the prescribing of certain drugs, as applicable:

3.) The APRN may direct the hospital pharmacy to dispense Controlled Substances, Schedule II for administration to in-patients or for patients being treated in the emergency room within the following parameters: Pain, sedation, seizures, anesthesia/analgesic for emergency procedures unless restricted or limited here.

Describe any limitations, such as restricting the prescribing of certain drugs, as applicable:

If prescribing at the physician's primary practice site, the APRN may only prescribe to patients with whom the delegating physician has established or will establish a physician-patient relationship.

The APRN may obtain and distribute drug samples in compliance with the TBON rules and regulations. The APRN must maintain a record of distribution that includes the date of distribution, the patient's name, the name and strength of the drug and directions for use.

The APRN may authorize a generic substitution. Except for Schedule III-V drugs, as specified under TMB rules, there are no limitations the number of dosage units and refills permitted beyond that which would be considered appropriate and reasonable for the drug and the patient's medical condition.

The APRN shall provide appropriate instructions to the patient on the use of any medication prescribed, including appropriate warnings, and will monitor applicable lab values or other medical tests.

The supervising physician is responsible for complying with all other physician requirements related to delegation of prescriptive authority. The supervising physician will not delegate prescriptive authority to a combined number of more than four (7) FTEs of PAs and/or APRNs practicing at the physician's primary and alternate practice sites, including the practice location identified above, unless a waiver is granted by the TMB.

E. PHYSICIAN'S ADDITIONAL RESPONSIBILITIES

For all delegated medical aspects of care, the supervising physician will provide continuous supervision (constant physical presence of the physician is not required) of the APRN under this Collaborative Practice and Prescriptive Authority Agreement and in accordance with state law including, but not limited to, the Texas Medical Practice Act and the TMB rules. The supervising physician will be available for consultation in person or by phone on a daily basis on an as needed basis in order to collaborate with the APRN to establish a diagnosis, plan of care or referral. The physician will be available for and accept referrals from the APRN or make alternate arrangements for such referrals. Telecommunication is acceptable.

An APRN may be supervised by an alternate supervising physician in the absence of the supervising physician consistent with the Texas Medical Practice Act and the TMB rules.

The supervising physician retains the professional and legal responsibility for the delegated medical care rendered by the APRN. The APRN shall retain the professional and legal responsibility for care rendered under the scope of advanced nursing practice.

F. CALL COVERAGE

APRN must have call coverage for admitting patients into a health facility. Their supervising physician or alternate physician will admit their patients unless they have no admitting privileges. The APRN must make other arrangements with another physician who can admit patients. Please list physician (s) below:

Supervising Physician Name: _____

Alternate Physician: _____

Supervising Physician Name: _____

Alternate Physician: _____

G. QUALITY OF CARE

It is the professional responsibility of the supervising physician and APRN that dialogue be continuous and ongoing as required. The collaborative relationship is also built on trust and a mutual acknowledgment of the abilities of the APRN and the supervising physician. The APRN and the supervising physician should be reasonable and prudent when formulating the Collaborative Practice and Prescriptive Authority Agreement. The Collaborative Practice and Prescriptive Authority Agreement must be jointly developed, reviewed and signed on an annual basis, maintained in the practice setting and made available as necessary to verify authority to provide medical aspects of care.

The APRN must be monitored and evaluated on an ongoing basis. The following evaluation of clinical care will be adhered to:

QA Activity for Site 1	Frequency:	Person Conducting Activity:
Ex: Chart review	1x monthly	Delegating physician or attending

H. SIGNATURES

The following signatures denote the APRN's and the supervising physician's understanding of the above Collaborative Practice and Prescriptive Authority. In each instance this document is amended, both parties must re-acknowledge by signature their concurrence and understanding of the change. This document will be maintained in the Credentialing file of the APRN.

Advanced Practice Nurse Name: _____ Date: _____

Signature: _____

Supervising Physician Name: _____ Date: _____

Signature: _____

Alternate Physician: _____

Alternate Physician: _____

BEHAVIOR HEALTH ADDENDUM

ONLY COMPLETE THE FOLLOWING IF YOU ARE A BEHAVIORAL HEALTH PROVIDER

IF YOU ARE A BEHAVIOR HEALTH PROVIDER THE FOLLOWING DOCUMENTS ARE ALSO REQUIRED ALONG WITH THE PROVIDER REALTIONS PACKET AND THE CREDENTIALING PACKET

- BCBS Behavioral Health AOE Form (if applicable)
- Superior Form 1600 Behavioral Health (if applicable)

The following items are many times overlooked during completion of the application and are critical to the plans. Please review your credentialing application to assure these items have been addressed.

- Call coverage – The insurance networks, and the Board of Directors, **require** that every practitioner have call coverage. Be sure to list which provider will provide coverage for you.
- Do you have age or gender restrictions in your practice? (page 6 of TSCA & TIOPA Addendum)
- How do you want to be listed in the network directories? Be exact on primary office location, phone, fax and hours of operation and if you are accepting new patients. (page 6-7 of TSCA & TIOPA Addendum)
- Provide the address, phone, fax and email where you would like us to send any correspondence, credentialing or contracting information.
- Hospital privileges. Please list all hospitals that you are affiliated with. (pages 4 & 16 of TSCA & TIOPA Addendum)

IF THE APPLICATION IS INCOMPLETE, WE ARE UNABLE TO START THE CREDENTIALING PROCESS AND THIS WILL IN TURN DELAY YOUR SUBMISSION TO THE INSURANCE NETWORKS. PLEASE PROVIDE ACCURATE AND COMPLETE INFORMATION.

Request for Child Abuse / Neglect Central Registry Check — Superior Health Plan

OPERATIONS — CENTRALIZED BACKGROUND CHECK UNIT

Purpose: Use this form to grant authorized representatives of Superior Health Plan permission to request a Department of Family and Protective Services (DFPS) Central Registry check on your behalf.

Directions: Complete each section of the form. Do not leave any section blank. Write "not applicable" or "N/A" if a section does not apply to you. **Incomplete or illegible forms will not be accepted.** Send the completed and signed form to Credentialing@superiorhealthplan.com. A copy of this form will be submitted to DFPS on your behalf.

If you have questions about this form, email shpbgc@dfps.state.tx.us.

INDIVIDUAL'S IDENTIFYING INFORMATION

First Name	Middle Name	Last Name
	☐ No Middle Name	

Other names or spellings used (married, maiden, alias, etc.) (continue on a separate page as needed)
First:
Middle:
Last:

Current Mailing Address	City	State	Zip Code

Social Security Number	Date of Birth	Sex	Telephone Number
		☐ Female ☐ Male	

Email Address

Ethnicity	Race	
☐ Hispanic	☐ White	☐ Asian
☐ Non-Hispanic	☐ Black	☐ American Indian/Alaskan Native
	☐ Unable to Determine	☐ Native Hawaiian/Pacific Islander

List any other addresses or cities in Texas where you have resided (continue on a separate page as needed):

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our Privacy and Security Policy.

CENTRAL REGISTRY INFORMATION

As required by Texas Family Code § 261.002, DFPS maintains a central registry of the names of persons found by DFPS to have abused or neglected a child. The DFPS Central Registry consists of only information gathered during child abuse and neglect investigations:

- conducted by Child Protective Services, Child Care Licensing, and Adult Protective Services Provider Investigations; and
- resulting in a disposition of "reason to believe" and a designated perpetrator or sustained perpetrator.

Please Note: Cases involving adult victims are not included in the DFPS Central Registry.

In addition, the person will not clear the Central Registry check if the person is an alleged perpetrator in an open DFPS child abuse or neglect investigation. A new Central Registry check may be requested at the conclusion of the investigation to determine if the person has been listed as a designated perpetrator on the Central Registry.

As the subject of the request, you have the right to review the results of this check. If Central Registry history is found that identifies you as a designated perpetrator who was determined by DFPS to have abused or neglected a child, DFPS will **only** send the results directly to you via mail or email. You have the option to share these findings with the Superior Health Plan representative who submitted the request on your behalf. As the subject of the request, you may have the right to contest/challenge the findings if you have not previously exhausted all opportunities. If Central Registry history is found that identifies you as a sustained perpetrator, DFPS will provide the results to you as well as to Superior Health Plan.

The following types of Central Registry history will bar you from working with DFPS clients:

- Physical Abuse (PHAB)
- Sexual Abuse (SXAB)
- Labor Trafficking (LBTR)
- Sex Trafficking (SXTR)
- Sexual Exploitation (SXAB) (APS Provider Investigations only)
- Exploitation (EXPL) (APS Provider Investigations only)
- Exploitation for Licensing (EXPC)

The following types of Central Registry history will require DFPS to conduct a review. A determination to either clear or bar you from contact with DFPS clients will be provided to Superior Health Plan:

- Neglectful Supervision (NSUP)
- Abandonment (ABAN)
- Refusal to Accept Parental Responsibility (RAPR)
- Emotional Abuse (EMAB)
- Physical Neglect (PHNG)
- Medical Neglect (MDNG)
- Mental Health Neglect (MHNG) (APS Provider Investigations only)
- Suicidal Threat (SUTH) (APS Provider Investigations only)
- Neglect (NEGL) (APS Provider Investigations only)

SIGNATURES

- I am the person listed above. The information in this document is correct. I understand that providing false information is a violation of Texas Penal Code Section 37.10.
- I grant Superior Health Plan (and its representatives) permission to request a Central Registry check on my behalf.
- I understand that DFPS will send the results of my background check to Superior Health Plan (and its representatives) if Central Registry history identifies me as a sustained perpetrator.
- I acknowledge that DFPS cannot guarantee that information transmitted electronically is secure and accessible only to approved parties.

Signature	Date Signed
X	

Printed Name

BlueCross BlueShield of Texas

Provider Name:	Provider Type:

NPI:

Language(s) Spoken (other than English):

Behavioral Health - Areas of Expertise					
Practice Description	**Ages 0-5**	**Ages 6-12**	**Ages 13-17**	**Ages 18-64**	**Ages 65+**
Abuse, Assault and Trauma (PTSD)					
Adoption Issues					
Affective Mood Disorders					
Anger Management					
Anxiety and Panic Disorders					
Applied Behavior Analysis (ABA)					
Attention Deficit Disorders					
Autism Spectrum Disorders					
Bariatric Assessment					
Behavior Modification					
Bipolar Disorders/Manic Depressive Illness					
Brief Solution Focused					
Chemical Dependency/Chemical Dependency Assessment					
Cognitive Behavior Therapy					
Compulsive Gambling					
Couples/Marriage Therapy					
Critical Incident Stress Debrief (CISD)					
Cultural/Ethnic Issues					
Depression					
Developmental Disorders					
Dialectical Behavior Therapy					
Divorce/Blended Family Issues					
Domestic Violence					
EAP General					
Eating Disorders (if yes, respond to the 4 questions below):					
Are you a CEDS (Certified Eating Disorder Specialist)?	O Yes			O No	
Do you have 3 years' experience in this area?	O Yes			O No	
Do you work closely with a dietician/nutritionist?	O Yes			O No	
Can you schedule an Urgent Appointment within 48 hrs.?	O Yes			O No	
An Area of Expertise in Eating Disorders designation is available only to Providers who answer "Yes" to all 4 of the above questions.					

Behavioral Health - Areas of Expertise					
Practice Description	**Ages 0-5**	**Ages 6-12**	**Ages 13-17**	**Ages 18-64**	**Ages 65+**
Electroconvulsive Therapy - Inpatient					
Electroconvulsive Therapy - Outpatient					
Eye Movement Desensitization & Reprocessing (EMDR)					
End of Life Issues					
Family Therapy					
Forensic					
Gay/Lesbian/Bisexual Issues					
Grief/Bereavement					
Group Therapy					
Hearing Impaired					
HIV/AIDS/ARC Related Issues					
Infertility					
Medical Illness/Disease Management					
Medication Management					
Men's Issues	X	X			
Multi-Systemic Therapy (MST)					
Neuropsychological Testing					
Pain Management					
Pastoral Counseling					
Personality Disorders					
Phobias					
Police/Fire Fighter Issues	X	X	X		
Postpartum Issues	X	X			
Prenatal Issues	X	X			
Psychological Testing					
Schizophrenia and other Psychotic Disorders					
Sexual Dysfunction					
Sexual Offender Treatment					
Somatoform Disorders					
Suboxone Treatment					
Transgender Issues					
Women's Issues	X	X			

Public Transportation Access O Yes O No

TDD Capacity O Yes O No

Wheelchair Accessibility O Yes O No

Accepting New Patients O Yes O No

Completed by: _____ Date: _____