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
- 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 & 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.

Laura Foster, CPMSM
Supervisor, Provider/Delegated Credentialing
5608 Malvey Ave, Suite 200, Fort Worth, TX 76107
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

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 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

INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

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

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PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN)

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)

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		
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		
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
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
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
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
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		
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		
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		
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		
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		
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		

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

Billing Address: Address: _____
(Put N/A if same as Practice Address) No/Street Suite City State/Zip Code

Credentialing Address: Address: _____
(Put N/A if same as Practice Address) No/Street Suite City State/Zip Code

Correspondence Address: Address: _____
(Put N/A if same as Practice 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

This form must be completed by all practitioners. Please complete the sections that apply to you. Practitioners not accepting WC patients will need to complete sections A & B. Practitioners accepting WC patients will need to complete sections A & C. All practitioners will need to complete page 2.

A. General Information

Name _____

Address _____ Suite Number _____

City _____ State _____ Zip Code _____ County _____

Credentialing Contact _____

Telephone Number (_____) _____ Fax Number (_____) _____

B. Not Accepting Worker's Compensation

If you do not currently accept workers' compensation patients, if you plan to discontinue your workers' compensation practice (as of this date, _____, 20_____), or you are not certified/approved to provide workers' compensation services in accordance with Texas state laws, initial here _____ and return to TIOPA by fax to (817) 420-9656.

C. 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).)

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 _____

Address _____ Suite Number _____

City _____ State _____ Zip Code _____

Telephone Number ( ) _____ Fax Number ( ) _____

Do you have financial interests in other health care providers? _____Yes _____No
(Example: Are you a partial owner or investor in an imaging center or other service?)

Pursuant to Title 5, Workers' Compensation, Subtitle A. Texas Workers' Compensation Act, Chapter 413.041, Health Care Providers – Disclosure. Please disclose any financial interest you may have in other health care providers.

More information regarding financial disclosure: http://www.tdi.state.tx.us/pubs/fastfacts/fffinancialdisc.pdf

Name:

Business Address:

Tax ID Number(s):

Professional License Number: Phone:

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.

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 _____

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)

TABLE OF CONTENTS

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: Jim Paquette

Print Name: Tim Paquette – Board Secretary

Date: _____

"PROVIDER"

Signature: _____

Print Name: _____

Date: _____