PROVIDER RELATIONS PACKET CHECKLIST

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

- Plan Participating Checklist
- Aetna Addendum
- Aetna THR Narrow Network EPO Admitting Letter
- BCBS Behavioral Health AOE Form (if applicable)
- BCBS Coverage Letter
- BCBS Hospital Admitting Letter
- BCBS Medicaid Group/Solo Questionnaire (if applicable)
- Cigna Admitting Letter
- Cigna Election to Participate Addendum
- Cigna Medicare Advantage & Star Plus Admitting Letter
- Healthcare Highways Joinder Letter
- HFCA – must be signed
- Oscar Admitting Letter
- Scott & White Hospital Letter
- Superior Form 1600 Behavioral Health (if applicable)
- Transfer Agreement of Current IPA to TIOPA
- Tricare Opt In Letter
- W-9 (nothing earlier than the 2018 form accepted, completed, signed and dated)

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

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

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

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

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

INSTRUCTIONS
PLAN PARTICIPATION CHECKLIST
VERY IMPORTANT INFORMATION

Please take careful consideration before filling out the Plan Participation Checklist. Once you have made your selections and send the document to us, our Provider Relations team will submit the information to the payors. It generally takes 30 - 180 days to be loaded to the payors. We discourage providers from making changes to their selections for at least 6 months. We have found that making changes too soon after initial plan submission, not only causes problems for you, but slows the process for other providers who are waiting to be loaded by the payors.

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

If you are adding a provider to your group, PLEASE refer to the PPCL the established providers are on. We find that many times offices do not compare the plan PPCL of the established providers with the new provider being added, which causes inconsistencies in plan participation within the group. Subsequent PPCL corrections are often submitted too quickly after the initial PPCL has been processed, which causes issues and backlogs in the loading process. **It is important to wait a minimum of 6 months before making changes to plan participation by sending us another PPCL**. This can be avoided by taking the time to make careful selections on the initial PPCL, keeping a selection template at the practice level, and reading all checklist instructions, bylines, and participation criteria thoroughly.

We are limiting our members to a maximum of 2 plan changes per year per provider. If you need to change more than 2 times in a year's period, not counting new solicitations that are offered, there is a $350 charge to process the additional changes.

I have read and understand the information above.

Group Name _____

Provider Name _____

Group Admin or Provider Signature _____

Date _____

PLEASE NOTE CHANGES AS MARKED ☐

PLAN PARTICIPATION CHECKLIST

Provider Name: _____ Provider NPI: _____

Provider CAQH#:_____Provider Specialty: _____

Group Association: _____TIN:_____

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

COMMERCIAL PRODUCTS

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

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

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

- **Bright Health Management Inc.**
  (Must complete & return Bright Health Hospital Letter – Uses Medical City & Methodist Facilities)
  - ☐ Opt In – PPO Exchange (Effective 1/1/2022)
  - ☐ Opt Out

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

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

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

- **Family Healthcare (fka Texas Bluebonnet Health Plan)**
  - ☐ Opt In – PPO
  - ☐ Opt In – HMO
  - ☐ Opt In – EPO
  - ☐ Opt Out

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

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

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

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

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

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

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

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

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

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

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

- **Oscar --- All Products**
  Uses Medical City & Methodist Facilities
  - ☐ Opt In
  - ☐ Opt Out

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

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

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

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

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

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

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

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

- **TriWest (Humana Military)**
  (Must have BCBS Record ID number to participate)
  Provider BCBS Record ID # _____
  - ☐ Opt In
  - ☐ Opt Out

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

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

WORKERS' COMPENSATION PRODUCTS

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICARE ADVANTAGE PRODUCTS

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

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

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

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

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

- **Bright Health Management Inc.**
  (Must complete & return Bright Health Hospital Letter – Uses Medical City & Methodist Facilities)
  - ☐ Opt In – Medicare Advantage ***(Effective 1/1/2022)***
  - ☐ Opt Out

- **Care N Care Medicare Advantage – HMO and PPO**
  - ☐ Opt In
  - ☐ Opt Out

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

- **Cigna (fka HealthSprings) – Medicare Advantage**
  HMO Counties Currently – Collin, Dallas, Denton, Johnson, Parker, Hood, Wise, and Tarrant
  PPO Counties Currently – Collin, Dallas, Denton, Johnson, Tarrant
  - ☐ Opt In – Medicare Advantage PPO
  - ☐ Opt In – Medicare Advantage HMO
  - ☐ Opt In – Traditional Medicare PPO ***(No Gatekeeper)***
  - ☐ Opt Out

- **Family Healthcare (fka Texas Bluebonnet Health Plan)**
  - ☐ Opt In – Medicare Advantage
  - ☐ Opt Out

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

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

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

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

- **Superior Health Plan – Medicare Advantage HMO**
  - ☐ Opt In
  - ☐ Opt Out

- **TexanPlus / Wellcare – All Products**
  - ☐ Opt In
  - ☐ Opt Out

- **United Healthcare Medicare Advantage**
  Including, but not limited to - Dual Complete, Care Improvement Plus, AARP, WellMed.
  - ☐ Opt In
  - ☐ Opt Out

MEDICAID PRODUCTS

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

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

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

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

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

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

- **Cigna (fka Healthspring) Star Plus**
  - ☐ Opt In
  - ☐ Opt Out

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

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

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

Updated February 15, 2021

T.I.O.P.A., INC.
Effective Date: 12/15/2001

INDIVIDUAL PROVIDER ADDENDUM

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

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

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

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

PROVIDER: _____

PRINTED NAME: _____

Aetna THR Narrow Network EPO

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

Name of admitting physician/hospitalist group

Provider Signature

Provider printed name

Date

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

Cooke County
+ Muenster Memorial Hospital
+ North Texas Medical Center

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

Denton County
+ THR Denton
+ THR Flower Mound

Ellis County
+ Ennis Regional Medical Center

Erath County
+ Texas Health Harris Methodist Hospital Stephenville

Grayson County
+ Texoma Medical Center

Hood County
+ Lake Granbury Medical Center

Hunt County
+ Hunt Regional Medical Center

Johnson County
+ Texas Health Harris Methodist Hospital Cleburne

Kaufman County
+ THR Kaufman

Parker County
+ Texas Health Harris Methodist Hospital Azle

Rockwall County
+ THR Rockwall

Somervell County
+ Glen Rose Medical Center

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

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

BlueCross BlueShield of Texas

HOSPITAL COVERAGE LETTER

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

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

(Please print legibly)

Provider's Name: _____

Provider's Signature: _____

Provider's NPI #: _____

Date: _____

BCBSTX Provider Networks Include:

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

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

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

CIGNA

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

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

Provider Signature

Provider printed name

Date

PARTICIPATING HOSPITALS:

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

CIGNA ELECTION TO PARTICIPATE

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

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

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

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

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

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

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

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

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

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

Date: _____

Signature: _____

Printed Name: _____

Tax Identification Number: _____

Address: _____

_____

Email address: _____

CIGNA MEDICARE ADVANTAGE & CIGNA STAR PLUS

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

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

Provider Signature

Provider printed name

Date

PARTICIPATING HOSPITALS: *MEDICARE ADVANTAGE HMO/PPO*

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

PARTICIPATING HOSPITALS: *PPO ONLY*

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

PARTICIPATING HOSPITALS: *STAR PLUS*

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

OSCAR ADMITTING LETTER

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

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

_____

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

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

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

_____

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

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

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

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

LINKS TO OSCAR NETWORK HOSPITALS

https://medicalcityhealthcare.com/locations/

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

Hospital/Facility Privilege Form

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

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

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

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

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

Date: _____ Physician Name: (Signature): _____

NPI: _____ (Printed): _____

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

OPERATIONS — CENTRALIZED BACKGROUND CHECK UNIT

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

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

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

INDIVIDUAL'S IDENTIFYING INFORMATION

First Name	Middle Name	Last Name
	☐ No Middle Name	

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

Current Mailing Address	City	State	Zip Code

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

Email Address

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

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

PRIVACY STATEMENT

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

CENTRAL REGISTRY INFORMATION

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

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

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

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

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

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

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

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

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

SIGNATURES

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

Signature	Date Signed
X	

Printed Name

Humana
Government Business

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

Contracted Entity Name: ____TIOPA_____

Tax Identification Number (TIN) Name: _____

TIN to Add: _____NPI:_____

TIN to Remove: _____NPI:_____

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

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

Opt-Out (Termination):

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

Owner of Tax Identification Number (TIN): _____

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Phone: _____

FOR INTERNAL HUMANA MILITARY PURPOSES ONLY:

Impacted Contract ID(s): _____ _____

_____

_____

Revised July 2018

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

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

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

☐ Other (see instructions) ►

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

Cat. No. 10231X

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

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

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

5608 Malvey Avenue, Suite 200
Fort Worth, Texas 76107
Phone 817-484-6274 • Fax 817-420-9661

Status of Network Participation and Agreement Transfer

Dear TIOPA Member,

You were recently submitted by TIOPA for participation with the networks offered under our IPA agreement. We have discovered that you are currently loaded and tied to another IPA agreement. In order to effectively and accurately administer your participation in the network and to prevent claim payment errors from occurring, we request you select the contractual arrangement in which you would like to participate. By signing this page, you understand that you are transferring your network affiliation from your current IPA to TIOPA. Please note that changes may cause you to be removed from networks not available through TIOPA and added to networks not available under your present IPA affiliation.

Please indicate below the IPA you are discontinuing your affiliation with. We will process changes as indicated and will stop the previous elections under your current IPA agreement.

Current IPA: _____

Provider Signature: _____

Printed Name: _____

Tax ID: _____ Date: _____

Meet our Value-Based Partners…

As more and more payers move focus and dollars from Fee for service contracts into Value based Care agreements, it's more important than ever that Primary Care Providers and Specialists consider adding value based contracts into their contracting portfolios. TIOPA is pleased to partner with Physicians Integrated Network (PIN) as its preferred value based partner. For practices oriented to value based care arrangements, these contracts represent additional care coordination dollars as well as equity opportunity on top of existing fee for service contracts.

Please note: given the population health focus of these agreements, strong physician and clinical engagement is required. Participation is subject to completion of an interview and onboarding process.

North Texas Clinically Integrated Network (TXCIN) is a network of over 1000 primary and specialty care physicians working together to improve patient outcomes, improve quality of care and reduce the overall cost of care in North Texas. With TXCIN, physicians have the opportunity to participate in one or more commercial and direct-employer value-based agreements with carriers such as UHC, Cigna, Aetna, BCBS, Medicare and more. These contracts pay additional dollars for care-coordination activities as well as gainshare dollars when the network achieves savings. These contracts are open to independent PCP's and ideal for practices that are using EHR technology and engaging in preventive care activities (e.g. wellness exams, preventive screenings, etc.)
To find out more, check the box(es) below or email bgazaway@txcin.org

Interested in finding out more about TXCIN?
❑ Yes, I'm interested in finding out more
❑ No, I am not interested
❑ Already participating with TXCIN

APEX High-Performance Collaborative is designed to meet the challenges and opportunities of the next-generation of value-based care. With a contracting emphasis on Episodes of Care and data centralization, Apex is a great fit for Specialist and PCP practices that want to leverage the power of their data and downstream supplier relationships to improve quality and outcomes while reducing the overall cost of care for their patients. Participating physicians earn bonus dollars on data-centralization effort as well as episode performance.
To find out more, check the box(es) below or email jmartin@revelationmd.org

Interested in finding out more about APEX HPC?
❑ Yes, I'm interested in finding out more
❑ No, I am not interested
❑ Already participating with APEX

TXCIN/ APEX FAQ

Who can participate in these value-based contracts?
TXCIN value-based contracts are available to independent Primary Care Providers including: Family Practice, Internal Medicine and Geriatric Medicine. Participation for Mid-levels, Pediatrics and OB/GYN is limited and contract-specific.
Apex participation is available to surgical and non-surgical specialties.

At this time, Chiropractic, Physical Therapy and Optometry are not considered eligible specialties for value-based contracts.

What's required of participants?
Participants will be required to sign a TIOPA's TXCIN/APEX Opt-in Form and Data-Usage Agreement and complete an onboarding process. For more information, visit www.txcin.org/FAQ

Practice Name: _____

Physician Name: _____

Physician direct email: _____ Physician Direct Phone: _____

Practice Champion Name: _____

Practice Champion email: _____ Practice Champion Phone: _____

Are you currently participating in value-based contracts? If so, which one(s)?
❑ No
❑ Yes: _____

Please tell us your specialty(ies)

TXCIN Participation:
- ☐ General Practice
- ☐ Family Practice
- ☐ Internal Medicine
- ☐ Geriatric Medicine
- ☐ Pediatric Medicine
- ☐ Other:

_____

APEX Participation:
- ☐ Allergy/ Immunology
- ☐ Anesthesiology
- ☐ Cardiology
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Surgery
- ☐ Infectious Diseases
- ☐ Nephrology
- ☐ Neurology
- ☐ OB/GYN
- ☐ Oncology/ Hematology
- ☐ Ophthalmology
- ☐ Orthopedics
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Physical Medicine & Rehab
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Psychiatry
- ☐ Pulmonology
- ☐ Rheumatology
- ☐ Sports Medicine
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Wound Care
- ☐ Other

_____