PMC
Professional Medical Corporation

2425 S. Linden Road, Suite B • Flint, MI 48532

Dear Provider,

Thank you for your interest in becoming a member of Professional Medical Corporation (PMC), a network of over 460 independent primary care and specialist physicians who are dedicated to improvement and efficiency of patient care. Attached, please find a complete membership packet that will assist PMC in your enrollment process. Please fully complete the packet with the requested information. Failure to do so correctly may delay the processing of your information with the various health plans. **Only once the membership information is fully received with the $1,500 membership fee, will the agreements be submitted to the health plans.**

What you can expect – Once your signed application and attestations have been received along with the $1,500 membership fee, your information be submitted to the health plans for credentialing. Unfortunately, PMC staff cannot influence the length of time it takes for each health plan to process information for effective dates. Following receipt of the completed application and submission of information to the health plan, you will receive a welcome email from PMC Membership with additional information.

PMC has agreements with the following health plans, with attestations enclosed:

- Blue Cross Blue Shield of Michigan – Blueprint: Commercial and Medicare Advantage
- Blue Care Network: Commercial and Medicare Advantage
- Blue Cross Complete: Medicaid
- Health Alliance Plan: Commercial, Medicare Advantage, and Medicaid
- Humana: Medicare Advantage
- McLaren: Commercial, Medicare Advantage, and Medicaid
- Meridian: Commercial, Medicare Advantage, and Medicaid
- Molina: Medicaid and Medicare Advantage
- Priority Health: Commercial, Medicare Advantage, and Medicaid

PMC does not have agreements with the following health plans; therefore, you must contact them directly:

- Aetna
- Traditional Medicaid Fee-for-Service and Traditional Medicare Fee-for-Service
- United Healthcare

Important Notes

- PMC does not complete the CAQH process for physicians and it must be completed by your practice
- PMC does not credential but instead coordinates credentialing for the health plans. **All health plans indicated above take an average of 45-120 days to complete credentialing.** Physicians are advised against seeing patients until they are credentialed to avoid denied reimbursement. Your practice will be notified directly when the credentialing process is complete.

Please submit your materials or any questions to
PMCMembership@medicaladvantage.com

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2425 S. Linden Rd. Suite B, Flint, MI 48532 • Fax: (866) 396-9257

PROVIDER REQUEST FOR AFFILIATION

Printed Physician Name: _____

This form will be used to initiate enrollment with Professional Medical Corporation (PMC). Completing this form and submission of the documents below is the first step in the enrollment process. Please be advised as a PMC provider you must have a practice location within the Genesee/Lapeer County area and if you are a Primary Care Provider (PCP) you cannot belong to more than one PO/PHO. All documents are enclosed in the packet, unless otherwise noted.

Please indicate the hospital affiliations you currently have or are applying to. Please check all that apply:

- ☐ Currently have Hurley Medical Center Privileges
- ☐ Applying for Hurley Medical Center Privileges
- ☐ Currently have McLaren Regional Medical Center Privileges
- ☐ Applying for McLaren Regional Medical Center Privileges
- ☐ Currently have Genesys Regional Medical Center Privileges
- ☐ Applying for Genesys Regional Medical Center Privileges
- ☐ Other: _____

Please supply all documents listed:

- ☐ CAQH Summary (NOT full application) *Provided* by physician
- ☐ EFT Authorization form
- ☐ PGIP Agreement
- ☐ W-9
- ☐ Specialist Agreement – if applicable
- ☐ Current Copy of Malpractice Professional Liability Insurance face sheet
- ☐ Check for Stock Shares - $1500.00
- ☐ PMC Physician Information Form
- ☐ Stock Subscription agreement
- ☐ Network participation agreement
- ☐ PCP Expectation form – if applicable
- ☐ PMC Data Sharing, Access and Use Agreement
- ☐ PGIP Physician Acknowledgement form

Blue Care Network and Blue Cross Complete: BCN and BCNA pages 29-30, BCBSM 33-40, BCC pages 41-58

- ☐ BCN MCG Practitioner Affiliation Agreement
- ☐ BCN Medicaid Compliance Attestation
- ☐ BCN MCG Commercial Medicare Agreement
- ☐ BCC Enrollment Application

HAP: pages 59-72

- ☐ HAP Physician Information form
- ☐ HAP Mid West
- ☐ HAP Physician Acknowledgement and Consent form (HMO, Commercial & SR)

Humana: page 73

- ☐ Letter of Agreement

McLaren Health Plan: pages 74-78

- ☐ Physician Affiliation Acknowledgement

Meridian Health Plan: pages 79-82

- ☐ Physician Acknowledgement
- ☐ Provider Disclosure Information Request

Molina: pages 83-84

- ☐ Disclosure Form

Priority Health: pages 85-96

- ☐ Supplemental Credentialing Form
- ☐ Physician Acknowledgement

Please contact the membership department if you have any questions at PMCMembership@medicaladvantage.com.
Return these completed and signed forms to: PMC Membership via email: PMCMembership@medicaladvantage.com, fax: (866)396-9257, or by mail: 2425 S. Linden Rd. Ste B., Flint MI 48532

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In order to be considered for membership with Professional Medical Corporation, all interested physicians must meet the basic membership criteria, which include:

- A physician must be board-certified or show evidence of board-eligibility with intent to seek board certification.
- A physician must commit to participate in health plan contracts only through PMC **(THIS IS APPLICABLE TO PRIMARY CARE PHYSICIANS ONLY)**

  *Please check below the health plans you are currently contracted with. If you are **not** contracted, please circle those health plans you would like to contract with through PMC.*

- ☐ BCBSM PGIP
- ☐ Blue Care Network
- ☐ Blue Cross Complete
- ☐ Health Alliance Plan
- ☐ Humana
- ☐ Meridian Health Plan
- ☐ McLaren Health Plan
- ☐ Molina
- ☐ Priority Health

- A physician must pay a membership fee of $1,500. – Please make check payable to **Professional Medical Corporation**

By signing and dating below, the physician certifies that they have read the new physician criteria and that to the best of their knowledge; they meet all the above requirements.

Physician Name (PRINTED): _____

Date: _____

Physician Signature: _____

Practice Name: _____

This document must be returned with the **Physician Information Form and W-9 to PMC membership** at pmcmembership@medicaladvantage.com or fax to (866) 396-9257 to be considered for membership.

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Physician Information Form

Personal Information

Last Name:_____

First Name:_____

Middle Initial: _____

Provider Type (MD, DO, etc.): ____

PCP: (Yes/No) _____

Date of Birth: _____

Practice Information

Practice Name: _____

Address: _____

City: _____

State:_____

ZIP: _____

County: _____

Phone: _____

Alt. Phone: _____

Fax: _____

Email: _____

Tax ID#: _____
(PLEASE ATTACH W-9)

Pay to Information:

(if different than practice information)

Practice Name: _____ __ ____

Address: _____ ____

_____ ____

City/State/Zip: _____

Tax ID#: _____ _____ _____

Office Manager Information

Office Manager: _____

Office Manager Phone: _____

Office Manager Fax: _____

Office Manager E-Mail:_____

Additional Information

Practice Specialty: _____

Board Certified Specialty:_____

Board Eligible: (Yes/No) _____

State License #_____

DEA#_____

NPI Number: _____

Type 2 NPI#_____

CAQH ID: _____

Accepting New Patients: (Yes/No) _____

Hospital Affiliations: _____

_____

Medical Malpractice Carrier: _____

Office Technologies

Practice Management System: _____

EMR System: _____

E-Prescribing Vendor: _____

Patient Registry Vendor: _____

Patient Portal Vendor:_____

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STOCK SUBSCRIPTION AGREEMENT

I, **_____,** hereby subscribe to 150 shares of the Class A stock of Professional Medical Corporation, P.C. a Michigan professional services corporation ("Corporation"), at $10.00 ($1,500.00 total) per share and agree to the terms, conditions and restrictions stated below. I acknowledge that sale or transfer of the stock is restricted by the Corporation's Articles and Bylaws.

I further understand that all of my Class A stock in the Corporation will be redeemed by the Corporation for the lesser of $10.00 per share or the net book value of the stock at the time of redemption upon the occurrence of any one or more of the following:

(1) My death;

(2) My incapacity and/or inability to practice medicine for a continuous period of one year, at the discretion of the Board of Directors;

(3) The revocation or suspension of my professional license;

(4) Written notification to the President of the Corporation of my intent to withdraw from the Corporation;

(5) Failure to pay dues to the Corporation within 30 days following receipt of written notice that dues have not been paid;

(6) Termination of membership on the Medical Staff of a Hospital.

I further understand that ownership of this Class A stock entitles me to vote for the election of members of the Board of Directors of Professional Medical Corporation.

PROFESSIONAL MEDICAL CORPORATION, P.C.
By: Asif Ishaque, M.D.

_____
Its: President

Dated: _____

SUBSCRIBER
Physician Name: _____

_____
Physician Signature

Dated:_____

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2425 S. Linden Rd., Flint, MI 48532

PROFESSIONAL MEDICAL CORPORATION
PARTICIPATING PHYSICIAN NETWORK PROVIDER AGREEMENT

This Agreement, effective as of _____, 20__ (Effective Date) is by and between PROFESSIONAL MEDICAL CORPORATION, a Michigan nonprofit corporation ("PMC") and _____ , ("Physician") a licensed and fully qualified physician on the medical staff of a Flint area hospital.

R E C I T A L S

A. PMC contracts with third party payors, employers and others ("Health Plans") to provide comprehensive health care services including inpatient and outpatient hospital care, primary care and specialty care.

B. PMC has a network of high quality, cost effective physicians and other professionals and facilities to provide comprehensive health care services to Health Plan beneficiaries ("Beneficiaries") using a variety of reimbursement methodologies.

C. Physician is a licensed and fully-qualified physician (M.D. or D.O.) on the medical staff of a Flint area hospital and desires to become a PMC Participating Network Provider.

NOW THEREFORE, PMC and Physician agree to the following terms and conditions of participation.

1. Obligations of Physician

1.1 Physician shall provide health care services to Health Plan Beneficiaries in the same manner and equal in quality and access to the services provided to Physician's other patients. Services shall be rendered in accordance with generally accepted standards of medical care in the community, in accordance with State and Federal law, and within the training and competence of Physician. Physician shall maintain in good standing all licenses required by law, Medicare certification and such other accreditation or certification as may reasonably be required by PMC or a contracting Health Plan.

1.2 Physician agrees to provide quality, cost effective, covered services as defined by PMC or a contracting Health Plan ("Covered Services") in the discipline for which Physician is qualified and credentialed by PMC to Beneficiaries of all Health Plans with which PMC has entered into risk-sharing agreements without discrimination based on race, color, creed, health status, membership in a managed Health Plan, or any other unlawful discrimination. If a specialist, Physician agrees to accept referrals from PMC's Primary Care Provider ("PCP") gatekeepers for the treatment of Health Plan Beneficiaries. If a PCP, Physician agrees to accept all new patients assigned by PMC without discrimination unless Physician's practice is closed to new patients, in which case Physician shall notify PMC that the practice is closed. If and when the practice reopens to new patients, Physician shall immediately notify PMC. Physician agrees to refer only to another PMC Participating Network providers except when medical conditions require a referral outside of the Network.

1.3. Physician agrees to abide by utilization management and quality management programs developed or approved by PMC including, if applicable, a requirement that all specialty services be authorized by the PCP gatekeeper responsible for the patient requiring such services. PMC shall make every reasonable effort to minimize delay, inconvenience and paperwork in conjunction with this referral program. Physician shall advise Health Plan Beneficiaries of their payment responsibilities in the event that PMC or Health Plan determines that such services are not Covered Services. If Physician or the Health Plan Beneficiary has any questions whether a proposed procedure is a Covered Service under the Beneficiary's Health Plan, Physician shall refer those questions to PMC or the Health Plan Administrator prior to rendering such services.

1.4. Physician agrees to look only to the Health Plan or PMC for compensation for Covered Services provided to Health Plan Beneficiaries. Physician further agrees that in no event, including but not limited to the nonpayment by PMC or the contracting Health Plan, insolvency of PPO or the Health Plan or breach of this Agreement, shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Health Plan Beneficiary or person acting on behalf of a Health Plan Beneficiary for Covered Services provided except to the extent that co-payments are or may be required and as may be permitted under applicable coordination of benefits provisions. Physician agrees not to maintain any action at law or in equity against Health Plan Beneficiaries to collect sums that may be owed to Physician under the terms of this Agreement, even in the event that Health Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This subparagraph shall survive termination of this Agreement, regardless of the cause of such termination, and shall be construed to be for the benefit of Health Plan Beneficiaries. It shall not apply to services provided after termination of the Agreement or to non-covered services.

1.5. If PMC has been paid on a capitated basis for the delivery of health care services to Beneficiaries of a Health Plan, Physician agrees that under no circumstances, including but not limited to nonpayment by PMC, insolvency of PMC or the breach of this Agreement, will Physician bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against the Health Plan paying on such capitated basis or have recourse against the Beneficiaries of such Health Plan or persons acting on their behalf. This subparagraph shall survive termination of this Agreement, regardless of the cause of such termination, and shall be construed to be for the benefit of Health Plan Beneficiaries. It shall not apply to services provided after termination of the Agreement or to non-covered services. Notwithstanding the forgoing, Physician agrees that in the event of the insolvency of PMC or a contracting Health Plan or other cessation of operations, Physician will continue to provide Covered Services to Beneficiaries of any Health Plan through the last day of the month during which PMC received a capitation payment for Covered Services from that Health Plan or for thirty (30) days whichever is longer. These provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Physician and Beneficiaries or persons acting on their behalf insofar as such contrary agreements relate to liability for payment for or continuation of Covered Services provided under the terms and conditions of this continuation of Covered Services Provision.

1.6. Physician agrees to maintain professional liability insurance with minimum limits of at least $200,000 per incident and $600,000 annual aggregate. Physician will provide evidence of such insurance to PMC on request. Physician shall notify PMC at least 30 days prior to the effective date of termination of coverage or modification of any material term of the professional liability insurance required hereunder.

1.7. Physician agrees to keep and maintain medical records in accordance with the requirements of law and to allow reasonable access to such medical records by PMC as required by third party payors and as requested by other Network physicians providing services to a Health Plan Beneficiary receiving treatment by Physician. Participating Physicians shall allow appropriate representatives of PMC to have access to their offices and other practice locations for the purpose of inspections as permitted by law. Designees of PMC may include representatives of a Health Plan or an authorized government representative.

1.8 Physician agrees to cooperate fully with any peer review, utilization management, quality management, or other programs operated by PMC or a Health Plan including any procedures for corrective action or discipline where Physician fails to abide by the procedures and criteria developed or approved by PMC. Utilization management provisions may include recertification of elective admissions and procedures, referral processes and reporting of clinical encounter data. Physician shall maintain and make medical records available to PMC for the purpose of assessing quality of care, conducting medical care evaluations and audits, and determining, on a concurrent basis, the medical necessity and appropriateness of care provided to Beneficiaries, and shall make such records available to applicable State and federal authorities and their agents involved in assessing the quality of care or investigating member grievances or complaints, and to comply with applicable State laws and administrative rules and federal laws and regulations related to privacy and confidentiality of medical records.

1.9 Physician agrees to allow publication of name, address, specialty and other identifying information in provider directories published by PMC or Health Plan or by other health benefits programs with which PMC may

contract for the delivery of health care services. PMC will supply Physician with a list of Participating Network Providers.

1.10 Physician agrees to participate in and be bound by grievance procedures approved by PMC and in accordance with Michigan law.

1.11 Physician agrees to abide by the terms and conditions of the Agreements between PMC and a contracting Health Plan, copies of which will be made available to Physician on request.

1.12 Physician agrees to participate with the Stock Subscription Agreement as indicated on Exhibit 1, and if employed by a Flint area hospital and its successor or any of its affiliates, with the Stock Ownership Agreement as indicated on Exhibit II or Exhibit II-B.

1.13 Physician agrees to support practice transformation consultant staff and PMC's verified and contracted third-party partners with success of the PMC programs and initiatives through provision of, at a minimum, view-only EHR access. Failure to do so could result in the reduction or elimination of said supportive services.

1.14 Physician agrees to provide written notification to the PMC in the event any of the following ever have been or becomes in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished:

- Medical license in any state
- DEA Registration
- Membership on any hospital staff
- Clinical privileges
- Professional society membership or fellowship
- Any type of professional sanction
- Any felony criminal charges

2. Obligations of PMC

2.1 Through its contracts with third party payors, employers and others, PMC agrees to pay or arrange for the payment of claims submitted by Physician for Covered Services that are medically necessary and appropriate based on compensation schedule(s) approved by the PMC. PMC will pay or arrange for payment at the rates set forth on the fee schedule(s) not withstanding any agreements between PMC and a Health Plan for capitation of physician fees or other programs for the assumption by PMC of risk.

2.2 PMC will collect data concerning the services provided by Physician and others participating in the PMC network of physicians. The data will be statistical in nature and will not relate to any specific patients seen by Physician or other physicians in the network. It is intended that PMC and Physician will use this data to assist in determining community standards for quality, cost efficient and appropriate health care services. Significant deviations from the norm will be discussed with Physician and may become grounds for disciplinary action including financial penalties and termination of participation in the Network if practice patterns continue outside of community standards.

2.3 PMC will act on behalf of Physician in negotiating contracts with Health Plans for the delivery of health care services to Beneficiaries. Physician agrees hereby to provide health care services for Health Plan Beneficiaries as required by the agreements negotiated by PMC. The rate of compensation for Physician's services shall not be changed without prior written notice to Physician advising of the change. PMC shall notify Physician of any newly negotiated fees, fee schedule or other compensation arrangement as they relate to Physician's practice for each contract in which Physician will participate under this agreement

2.4 PMC shall maintain a current Beneficiary eligibility data system (or require that contracting Health Plans maintain such a data system) and a means for telephonic or electronic access to such system to verify eligibility and reconcile errors.

2.5 PMC shall arrange for and encourage continuing education of Network Providers in the field of clinical medicine and related areas. PMC shall notify Physician of and provide initial and current information concerning changes in benefits, copayments and deductibles, and all operational policies and procedures with which Physician must comply as a condition of participation.

3. Term and Termination

3.1 This Agreement shall commence on the Effective Date stated above.

3.2 This Agreement shall be for an indefinite term and may be terminated by either party on 90-days prior written notice for any reason and without cause.

3.3 Either party may terminate this agreement for cause by giving the other party written notice at least 30 days in advance and specifying the reason for such termination. The other party shall have 20 days within which to cure any alleged breach or other cause to the satisfaction of the other party. If a satisfactory cure cannot be accomplished, this Agreement shall terminate in accordance with the 30-day notice. An unacceptable change in reimbursement rate shall be considered cause for termination.

3.4 Notwithstanding the foregoing, this Agreement shall terminate immediately upon the occurrence of any of the following:

(a) Suspension or revocation of Physician's license to practice medicine in the State of Michigan.
(b) Suspension or termination of Physician's privileges to practice medicine at a Flint area hospital.
(c) Physician's conviction of any felony.
(d) Physician's death.
(e) The closure of Physician's practice on account of illness, injury or other physical or mental condition rendering Physician incapable of providing professional services.

4. Miscellaneous

4.1 Physician represents and warrants to PMC that Physician has not been convicted of a felony nor had any professional license suspended or revoked in the last five years, nor has been suspended from participation as a provider for Medicare or Medicaid, nor been suspended or terminated from the medical staff of any hospital. Physician understands and acknowledges that any false information submitted as part of the credentialing process or otherwise may be grounds for termination for cause.

4.2 Physician acknowledges that they will not be eligible for any distribution of monies from PMC following their date of departure from PMC to join a competitor physician organization ("PO") even if earned prior to the effective date of termination from PMC. This also applies to a PMC member who leaves a PMC-offered health plan contract or program to participate through the same health plan or program through another PO. This is in effect regardless of the physician's duration of participation during the performance year. Physician must be a member of PMC at the time of PMC's receipt and distribution of monies in order to be eligible to receive such distributions.

4.3 Physician and PMC understand and acknowledge that the success of this plan for managing the delivery of care to Beneficiaries of Health Plans contracting with PMC depends to a significant degree on Physician's quality of care, efficiency and adherence to established referral protocols. PMC agrees to work actively to develop and implement a rational system for rewarding Physicians who demonstrate a pattern of delivering high quality, efficient services, and adherence to established utilization management criteria for referral to PMC's network or participating providers.

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2425 S. Linden Rd., Flint, MI 48532

IN WITNESS WHEREOF, the parties have executed this Agreement on the day and date first written above.

PHYSICIAN:

By: _____
<Physician Signature>

Its: _____

Date: _____

PROFESSIONAL MEDICAL CORP.

By: _____
Asif Ishaque M.D.

Its: President

PMC

Professional Medical Corporation

2425 S. Linden Rd., Suite B, Flint, MI 48532 • Fax: (866) 396-9257

Electronic Funds Transfer Form

Practice/Payee Name: _____

Practice Address: _____

TIN/EIN: _____

Contact Person: _____

Email Address: _____

Phone Number: _____

[ ] Yes, please sign me up for EFT. Please fill out the authorization below.

[ ] Continue my EFT, but please change the account information. Please fill out the authorization below.

If you need to add or change account information, please fill out the authorization below and ***attach a voided check to the form*** and return it to your practice coach.

EFT Authorization

I hereby authorize that PMC/MAG may deposit any payments to my account at _____.

(Name of your Financial Institution)

Complete the following:

[__] Account Routing Number#_____

[__] Account Number#_____

_____

Authorized Signature Date

_____

Print Name

Form **W-9**
(Rev. November 2017)
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.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

PMC
Professional Medical Corporation

2425 S. Linden Rd., Flint, MI 48532 Phone: (800) 594-6115 Fax: (866) 396-9257

BCBSM Physician Group Incentive Program
New Physician Acknowledgement Form

I hereby attest that I wish to participate in the BCBSM Physician Group Incentive Program (PGIP) through **Professional Medical Corporation (PMC)**, effective _____.

As part of PGIP participation requirements, I understand that:

- I can only participate in PGIP with one physician organization (PO).
- Any decision I make now or in the future about my PGIP participation will not affect my participation in other health plans or pay-for-performance programs.

Please select one:

☐ I understand that by signing this Acknowledgement I indicate my commitment to **PMC.**

☐ I do not wish to participate in PGIP through **PMC.**

☐ I am currently affiliated with another PO_____.

PO Name

but would like to participate in PGIP through **PMC.**

_____ _____
Physician Signature Date

_____
Physician Name (Please Print)

_____ _____
State License # NPI #

Please return by fax or email to:
PMC Membership
Email: pmcmembership@medicaladvantage.com
Fax: (866) 396-9257

Thank you in advance for your prompt response. We will communicate your decision to BCBSM and all involved POs (if applicable).

DATA SHARING, ACCESS, AND USE AGREEMENT

This Data Sharing Agreement (the "Agreement") is entered into and between _____ (the "Provider") and Professional Medical Corporation, P.C., a Michigan corporation (the "Recipient"). This Agreement will become effective upon the date of the last signature affixed below (the "Effective Date").

INTRODUCTION

WHEREAS, the Provider and Recipient desire to collaborate on several projects and contracts including:

- Michigan Department of Health and Human Services' State Innovation Model ("SIM") Patient Centered Medical Home ("PCMH") Initiative
- Blue Cross Blue Shield of Michigan Provider Group Incentive Program
- All executed Value-Based Reimbursement Payer contracts

WHEREAS, in performing activities of this collaboration, Provider will disclose to Recipient certain identifiable Protected Health Information;

WHEREAS Provider and Recipient wish to enter into this Data Sharing Access and Use Agreement for the purpose of addressing obligations arising from the disclosure of Protected Health Information; for the following identified purpose(s):

(1) To foster the transformation of participating practices to enable interventions that impact all persons served by the Practice in a cost-effective manner using evidence-based guidelines and practices;

(2) To improve health outcomes, improve patient experience of care, and reduce preventable healthcare costs; and

(3) To permit the sharing of payer, clinical, and demographic data with all SIM PCMH participants.

THEREFORE, in consideration of the foregoing, the parties agree as follows:

DEFINITIONS

The following terms are defined for purposes of this Agreement. Terms used, but not otherwise defined in this Agreement shall have the same meaning as those terms in the Privacy Rule.

a) *HIPAA* means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

b) *Covered Entity*: Per 45 CFR 160.103 ("Definitions"), is a health plan, health care clearinghouse, or health care provider that is subject to the standards, requirements, and implementation specifications of the HIPAA Privacy Rule. Covered Entity in this Agreement shall mean the Provider.

c) *De-identified Data:* Per 45 CFR 164.514(a), is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

d) *Individual:* Per 45 CFR 160.103 ("Definitions"), is the person who is the subject of protected health information and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

e) *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

f) *Protected Health Information or PHI:* Per 45 CFR 160.103 ("Definitions"), means information, maintained or transmitted in any form or medium, that: (i) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual, and (ii) identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

g) *Required by Law:* Per 45 CFR 164.103 ("Definitions"), means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law.

h) *Secretary* shall mean the Secretary of the Department of Health and Human Services or his designee.

OBLIGATIONS OF THE RECIPIENT

a) To not use or disclose Provider's Protected Health Information in any manner other than as permitted by this Agreement or as required by applicable law.

b) To not contact or attempt to contact individuals whose data is contained in Provider's Protected Health Information for any purpose not authorized by this Agreement.

c) To use appropriate administrative, technical, and physical safeguards, including compliance with security provisions at 45 CFR §§ 164.308, 310, 312, and 316 pursuant to Section 3401(a) of the HITECH Act to prevent any use or disclosure of Provider's Protected Health Information not authorized under this Agreement.

d) To ensure that any agent, including subcontractors, to whom Recipient authorizes to use or disclose Provider's Protected Health Information are held to the same HIPAA privacy and HITECH security standards that apply to Recipient.

e) To report to the Provider, through its Health Systems Privacy Officer (Privacy Officer), any use or disclosure of Provider's Protected Health Information not authorized by this Agreement that Recipient or its agents become aware of within ten (10) days of discovery.

f) To mitigate any harmful effect caused by Recipient's wrongful use or disclosure of Provider's Protected Health Information in violation of this Agreement.

g) To make available, at the Provider's request, any internal practices, books, and recordings, including policies and procedures, relating to the use, disclosure, and security of the Protected Health Information for purposes of determining Recipient's compliance with this Agreement and to the HIPAA privacy standards.

h) To the extent permissible by law, to provide written notification to Provider if it receives a subpoena, court or administrative order or other discovery request or mandate pertaining to the release of any part of Provider's Protected Health Information within five (5) days of the receipt of such a request. Written notification must occur before the Recipient responds to the request so to enable Provider time to object.

USES OF DATA

a. Recipient shall share Provider's aggregated De-identified Data with other participants for purposes including population health analysis, quality improvement, and utilization measures.

b. Provider may also access or receive from Recipient its own raw PHI or as it has been combined with relevant payer and demographic data.

c. Access to data and systems of Provider may be supplied to Recipient to support clinical analysis and care management support of the PMC and/or SIM population.

TERM AND TERMINATION

a. *Term*. The Term of this Agreement shall commence as of the Effective Date and will terminate when all of Provider's Protected Health Information is destroyed and certified as destroyed, in writing, to the Provider through its Privacy Officer.

b. *Termination*. In the event that the Provider becomes aware of any use of Provider's Protected Health Information that is not authorized under this Agreement or required by applicable law, the Provider may (i) terminate this Agreement upon notice, (ii) disqualify (in whole or in part) the Recipient or Recipient's authorized agents from receiving Provider's Protected Health Information in the future, and (iii) report the inappropriate use or disclosure to the Secretary of the Department of Health and Human Services, as appropriate.

c. *Effect of Termination*. Recipient will destroy all of Provider's Protected Health Information and provide written certification to the Provider through its Privacy Officer that it was destroyed, including all of Provider's Protected Health Information that is in the possession of Recipient's agents. No copies of Provider's Protected Health Information may be retained.

MISCELLANEOUS

a. *Breach or Violation*. Provider is not responsible for Recipient's violations of the HIPAA Privacy Rule unless Provider knows of a pattern of activity or practice that constitutes a material breach or violation of the HIPAA Privacy Rule. HIPAA defined violations, including those rising to the level of a breach, will be reported to the Secretary of the Department of Health and Human Services ("DHHS").

b. *Amendment*. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Provider to comply with the requirements of the Privacy Rule and HIPAA.

c. *Survival*. The respective rights and obligations of Recipient shall survive the termination of this Agreement.

d. *Interpretation*. Any ambiguity in this Agreement shall be interpreted in a manner consistent with the HIPAA Privacy Rule.

e. *Indemnity*. Recipient shall indemnify and hold harmless Provider and its officers, trustees, employees, and agents from any and all claims, penalties, fines, costs, liabilities or damages, including but not limited to reasonable attorney fees, incurred by Provider arising from a violation of Recipient's obligations under this Agreement.

f. *Injunctive Relief*. Recipient stipulates that its unauthorized use or disclosure of the Protected Health Information would cause irreparable harm to the Provider, and in such an event, Provider shall be entitled to institute proceedings in any court of competent jurisdiction to obtain damages and injunctive relief.

g. *Assignment*. This Agreement may not be assigned.

h. *Authorized Signers.* As applicable, Provider warrants and represents that it is authorized to sign this Agreement on behalf of all Practices participating with the Provider.

IN WITNESS WHEREOF, the parties have caused this Data Sharing Agreement to be executed by their respective duly authorized representatives effective as of the day and year set forth below.

PROFESSIONAL MEDICAL CORPORATION

By: _____ (Signature)

Name: Asif Ishaque, MD (Please Print)

Title: President Date: _____

PROVIDER

By: _____ (Signature)

Name: _____ (Please Print)

Title: _____ Date: _____

PMC
Professional Medical Corporation

2425 S. Linden Rd., Flint, MI 48532 Phone: (800) 594-6115 Fax: (866) 396-9257

PCP-Specialist Agreement

Organized System of Care Vision

An Organized System of Care (OSC) is comprised of a community of caregivers dedicated to the Patient-Centered Medical Home (PCMH) Neighbor (N) model, who share a commitment to effective and efficient co-management of a population of patients across settings of care and over time. The OSC's patient population is comprised of patients attributed to the OSC's Primary Care Physicians (PCPs).
Specialty and sub-specialty practices affiliated with the PMC OSC agree to collaborate with provider partners in the context of the OSC in the development of information systems and care processes which support coordination and management of patients' care across settings and over time. In addition, they agree to engage in processes consistent with the principles of the PCMH-N model, which include:

- Ensure effective communication, coordination, and integration with PCMH practices.
- Provide appropriate and timely consultations and referrals that complement and advance the PCMH-N model for practices.
- Confirm appropriate flow of necessary patient and care information.
- Establish shared responsibility for relevant types of clinical interactions, in accordance with principles listed below.
- Support patient-centered care and enhanced access and high-quality, safe care.
- Recognize the PCMH practice as the source of the patient's primary care.
- Understand that the PCMH practice has the overall responsibility for coordination and integration of care provided to that patient.

Expectations:

• Specialists are expected to be in communication with PCPs about their patients and to provide timely written reports on consultations within 7 business days of consultation with a patient.

• Care should always be directed back to the PCP as soon as it is appropriate to do so and the specialist will reinforce the PMC OSC's primary care philosophy.

• The specialist will not refer the patients to other specialists without first consulting with the PCP.

• When the PCP is uncertain of appropriate laboratory or imaging diagnostics, the specialist will assist the PCP prior to the appointment regarding appropriate pre-referral work-up.

• Specialists will follow evidence-based care guidelines (dependent on specialty).

• Specialists should provide the PMC OSC with any information needed to maintain an online directory at www.pmcpo.com

PMC
Professional Medical Corporation

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Primary Care — Specialty Care

Referral Guidelines

I commit to:	I commit to:
• Develop a mutually agreed upon referral that defines the need for a referral, consult or co-management of a patient's care. • PCP will provide completed diagnostic testing and labs that may assist with patient care. • PCP will provide patient demographics, med list, known allergies, problem list and any other pertinent patient information. • Provide and receive respectful feedback to/ from specialist to promote the objectives of these guidelines, including periodic evaluation of processes. • Explain specialist results and treatment plan to patient/caregiver. • Engage patient/caregiver in PCMH concept.	• Develop a mutually agreed upon referral that defines the need for a referral, consult or co-management of a patient's care. • Schedule all referred patients promptly and redirects patients as appropriate. • Notify PCP of patient no shows and cancellations. • Provide written reports within 7 business days of referral/consult and will include all tests, procedures and treatment provided along with findings, interpretations, diagnosis and prognosis. • Provide a list of medications prescribed and/or discontinued to the PCP. • Provide PCP dates of future scheduled appointments and treatment plan. • Notify the PCP of referrals needed for other specialists. • Provide and receive respectful feedback to/ from the PCP to promote the objectives of these guidelines, including periodic evaluation of processes. • Inform patient/caregiver of diagnosis, prognosis and follow-up.

Transitions of Care

I commit to:	I commit to:
• Maintain complete and up-to-date clinical records. • Inform the patient/caregiver of the need, purpose, expectations and goals of the specialty visit. • Provide the patient/caregiver with specialist contact information and expected timeframe for appointments or make the appointment on behalf of the patient. • See high risk patients discharged from hospital within 7 days of discharge.	• Determine and/or confirm insurance eligibility. • Provide a single source referral contact person. • Notify the PCP of In-Patient admissions. • Assist the PCP prior to the appointment regarding appropriate pre-referral work-up, when needed.

PMC
Professional Medical Corporation

2425 S. Linden Rd., Flint, MI 48532 Phone: (800) 594-6115 Fax: (866) 396-9257

Access

I commit to:	I commit to:
• Communicate with a patient who no-shows to a specialist. • Determine a reasonable time frame for a specialist appointment. • Provide accessible contact via pager, phone or email. • Provide information on Urgent Cares in the area. • Arrange for coverage when I am unavailable.	• Notify the PCP of no-shows, cancellations and other actions that may place the patient in jeopardy. • Provide visit availability according to patient need. • Be available to the patient/caregiver for questions. • Be available for PCP consultation. • Provide accessible contact via pager, phone, or email. • Arrange for coverage when i am unavailable.

Care Coordination and Management

I commit to:	I commit to:
• Follow the principles of PCMH • Manage the medical problem to the extent of my scope of practice, abilities and skills. • Follow standard practice and evidence-based guidelines. • Review and act on the care plans developed by the specialist. • Resume care of the patient when the patient returns from the specialist. • Explain and clarify the results of consultation, engage patient/caregiver with a treatment plan and follow-up.	• Review patient care information sent by the PCP. • Address the referring provider's and patient/ caregiver's concerns. • Shared Management -Share with PCP long-term management for patient condition and provide advice and periodic follow up with patient. • Principal Care – Assume responsibility for long-term, comprehensive management of patient's condition, PCP receives consult reports, input on secondary referrals and end of life decisions. • Co-Management- Specialist becomes the first contact for care until crisis or treatment has stabilized. PCP remains active in, and provides input on, secondary referrals. • Send timely reports to the PCP to include the care plan, follow-up and results of diagnostic studies or interventions. • Prescribe pharmaceutical therapies in line with *generic options* when available and if appropriate for patient needs. • E-Prescribe all eligible scripts. • Provide useful and necessary education/ guidelines/protocols to the PCP, as needed.

PMC
Professional Medical Corporation

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_____
Practice/Physician Representative - Print Name

_____ _____
Practice/Physician Representative Signature Date
**

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

MEDICAL SERVICE AGREEMENT

MCG PRACTITIONER AFFILIATION ACKNOWLEDGEMENT

FOR BCN COMMERCIAL AND BCN ADVANTAGE

This Acknowledgement is effective _____ (to be completed by Health Plan), by and among **Blue Care Network of Michigan, Blue Care of Michigan, Inc. and BCN Service Company** (hereinafter collectively referred to as **Health Plan**), Professional Medical Corporation, a Medical Care Group or MCG (**Provider**) and _____ **(Practitioner)**, who is a member of Medical Care Group.

For the purpose of providing health care services to Health Plan Members enrolled under Health Plan's BCN Commercial and/or Medicare Advantage Program, as applicable, and in consideration of the mutual promises of the parties to the Medical Service Agreement (**Agreement**) and as amended for Medicare Advantage (**Amendment**), as applicable, Practitioner agrees as follows:

1. **Provider Contracting Authority**- For the purposes of providing health care services to Members and in consideration of the mutual promises of the parties to the Agreement and/or Amendment, as applicable, Provider and Practitioner represent that the Practitioner is contracted with Provider and that Provider is duly authorized and empowered to contract on Practitioner's behalf for the purpose of binding Practitioner to the terms and conditions of the Agreement and/or the Amendment, as applicable.

2. **Agreement**- Practitioner warrants that he/she has received and read the Health Plan Medical Service Agreement and/or Amendment, as applicable between Health Plan and Provider, which is incorporated herein by reference, and agrees to be bound by the terms and conditions contained in the Agreement and/or the Amendment, as applicable. The Agreement and/or the Amendment, as applicable, this Acknowledgement, and the Health Plan Provider Manual constitute the entire agreement between Health Plan, Provider, and Practitioner. Practitioner is fully aware of the responsibilities and requirements pertinent to his/her designated role as Specialist Practitioner or Primary Care Practitioner under the Agreement and/or Amendment, as applicable. Provider and Practitioner agree to abide by the terms and conditions set forth in the Agreement and/or the Amendment, as applicable, this Acknowledgement, and all amendments or modifications thereto.

3. **Identifying Information**- Upon execution of this Acknowledgement, Provider shall provide to Health Plan on at least an annual basis the required identifying information for Practitioner. Such information shall be provided and periodically updated by Provider in such detail and format as necessary for Health Plan to maintain accurate provider enrollment records.

4. The terms of this Acknowledgement supersede the terms of any previous MCG Practitioner Affiliation Acknowledgement between Health Plan and Practitioner.

Professional Medical Corporation

MCG Name (Print or Type)

Signature

Farhan Khan, MD

Name (Print or Type)

Medical Director

Title

Date

HEALTH PLAN

Signature

Name (Print or Type)

Title

Date

PRACTITIONER

Signature

Name (Print or Type)

Date

NPI Number

Tax ID Number

BCN Commercial and BCN Advantage

PRACTITIONER AFFILIATION ATTESTATION: NON-EMPLOYEE PRACTITIONERS

This Attestation is effective **January 1, 2021**, by and among **Blue Cross Blue Shield of Michigan Mutual Insurance Company ("BCBSM")**, Professional Medical Corporation, PC **("Risk Bearing Contracting Entity or RBCE")** and _____ **("Practitioner")**, who, through this Attestation is confirming his or her affiliation with RBCE and agrees to the following:

1. **Practitioner Representations** - Practitioner represents and warrants that he or she has received, read, and understands the Provider Incentive and Risk Agreement and its attachments, addenda (including any Service Level Addendum ("SLA")), schedules, and exhibits (including Product Exhibits)(collectively the "Agreement") between BCBSM and RBCE, which is incorporated herein by reference.

2. **Agreement to be Bound** – Practitioner agrees to be bound by the terms and conditions of the Agreement as an Affiliated Practitioner. Practitioner agrees that he or she is fully aware of his or her responsibilities and requirements under the Agreement and understands the financial terms and his or her rights and obligations thereunder, including the proposed distribution methodology and the potential for certain amounts to be withheld by BCBSM from payments pursuant to the Agreement. Practitioner understands that he or she may receive a share of any Gains RBCE earns under the Agreement or he or she may be required to pay a share of any Losses RBCE suffers under the Agreement. Practitioner further understands that any dispute arising under the Agreement between RBCE and Practitioner are to be handled solely between RBCE and Practitioner.

3. **RBCE Contracting Authority**- Practitioner grants authority to the RBCE to amend or modify the Agreement, and all rights and obligations thereunder, as RBCE deems necessary. RBCE agrees to provide appropriate notice of such amendments to Practitioner.

4. **Identifying Information**- The Parties understand and agree that BCBSM will rely upon this Attestation for purposes of effectuating and operationalizing the Program and Agreement. Further, RBCE and Practitioner agree to promptly notify BCBSM should Practitioner's affiliation status change, as set forth in the Agreement.

Signatures follow on next page.

This Attestation is agreed to by these Parties, as witnessed by their respective signatures below. By signing this Attestation, each signatory certifies and warrants that he or she has the actual authority to bind his or her respective Party to this Attestation.

RBCE

Signature

Asif Ishaque, MD
Name (Print or Type)

PMC President
Title

Date

BCBSM

Signature

Name (Print or Type)

Title

Date

RBCE AFFILIATED PRACTITIONER

Signature

Name (Print or Type)

Date

NPI Number

Tax ID Number

Instructions for fax cover sheet

We cannot accept handwritten forms. Do not hand write anywhere on the forms, otherwise processing will be delayed.

To ensure forms are processed timely, please adhere to the following instructions:

Enter all information online; press the tab key  after each entry to move from field to field.

- **For individual practitioners**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 1 NPI (National Provider Identifier)
  - State license number
  - When adding an individual to an existing group, be sure to fax a group change form

- **For allied providers**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

- **For professional group practices and facilities**
  - From (Insert name of contact person)
  - Date (mm/dd/yyyy)
  - Type 2 NPI (National Provider Identifier)
  - Tax identification number

Instructions for document submission

1. Fax cover sheet must be the first page of your form submission.

2. Fax the registration form and attachments (i.e., signature documents) to **1-866-900-0250**. Be sure to fax the registration information separately for each provider. (For example: If you register two or more providers, you must send a fax for each provider. They cannot be bundled into one fax transmission.)

Questions? Call 1-800-822-2761

FAX COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your document to avoid processing delays.

Fax To: 866-900-0250 Provider Enrollment

From:

Date:

Form Number: 10576

Type 1 NPI:

Type 2 NPI:

State License Number:

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Please complete this form if you are an MD, DO, DC, DPM, DMD/DDS (board certified oral surgeon only), independent physical therapist, independent occupational therapist or independent speech language pathologist applying to Blue Cross Blue Shield of Michigan/Blue Care Network for the first time.

Note: You are required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® at http://proview.caqh.org/pr. In order for your managed care affiliation request to be processed you must **complete your CAQH application within 14 calendar days**. If you have already completed a CAQH application, your attestation must be up to date. If your CAQH application is not complete or if your attestation is expired after 14 calendar days, your request will be closed, and you will need to reapply using the Practitioner Change form.

Section 1: Demographic Data

*denotes a required field

*First name	
Middle name	
*Last name	
Suffix	☐II ☐III ☐IV ☐Jr. ☐Sr.
*What type of provider are you?	☐MD ☐DO ☐DC ☐DPM ☐DMD ☐DDS ☐IPT ☐IOT ☐ISLP
*County where your primary address is located	
*Degree	
*Date of birth	
Gender	☐Male ☐Female
Preferred salutation	☐ Dr. ☐Ms. ☐Mrs. ☐Mr. ☐Miss

Race/Ethnicity

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Chinese/Chinese-American
- ☐ Filipino
- ☐ Japanese/Japanese-American
- ☐ Korean
- ☐ Vietnamese
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Mexican/Mexican-American
- ☐ Hispanic/Latin American
- ☐ Arab
- ☐ Other Race
- ☐ Assyrian/Chaldean
- ☐ Other Asian
- ☐ Multiracial
- ☐ Not Disclosed

If registered with CAQH, CAQH ID number	

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 2: Change EIN/Tax information

Note: You must include IRS Form 147c or IRS Tax Coupon as an attachment.

*Social Security number	
*Is your EIN/Tax ID number the same as your SSN?	☐ Yes ☐ No (If no, enter Tax ID number below
EIN/Tax number	
EIN/Tax Name as indicated on IRS document	
*Tax exempt	☐ Yes ☐ No
Medicare/PTAN number:	

If you would like to bill with your Type 2 NPI (National Provider Identifier) representing your incorporated individual business, you must **also** complete a New Group Enrollment form to register this entity as a group.

Section 3: Primary specialty

*denotes a required field

*Specialty	
If your specialty is Adolescent Medicine, Family Medicine, Geriatric Medicine - Family Practice, Geriatric Medicine, General Practice, Internal Medicine, Pediatrics, Public Health / General Preventive Medicine, or Preventive Medicine; are you functioning as a: ☐ Primary Care Physician (PCP) or a ☐ Specialty Care Physician (SCP)	
*Board certified (MD, DO, DMD, DPM DDS only)	☐ Yes ☐ No
*Board eligible (MD, DO, DMD, DPM, DDS only)	☐ Yes ☐ No
*Do you practice exclusively in a hospital setting? If ***yes***, Section 1 of CAQH must be updated to reflect hospital based status	☐ Yes ☐ No
*Residency Completed?	☐ Yes ☐ No
*Residency Completion date?	

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 4: Requested networks

You will be notified of your status and the effective dates of affiliation in BCBSM and BCN managed care networks after credentialing for the networks is completed and BCBSM and BCN has countersigned your affiliation agreements. **Important: Along with this application, it is necessary to complete and submit the signature document appropriate for your provider type. For each network you wish to participate in, be sure to place a check mark by the appropriate affiliation agreement, sign the signature document, and submit it along with this form.**

BCBSM and BCN do not permit retroactive effective dates in managed care networks.

If you are a specialist billing with a Type 2 NPI, BCN contracts with the Group Practice. Please follow the instructions on the website for Professional Group Enrollment.

Select networks you are applying to:

Provider Type	Eligible Networks for Provider Type	
Doctor of Medicine Doctor of Osteopathy	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Advantage℠ PPO	☐ TRUST PPO ☐ Blue Preferred Plus ☐ Vision/Hearing (if applicable)
Chiropractor Podiatrist Oral Surgeon	☐ Traditional-Participating ☐ Traditional-Nonparticipating	☐ Medicare Advantage℠ PPO ☐ Blue Preferred Plus ☐ TRUST PPO
Independent Physical Therapist Independent Occupational Therapist	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Advantage℠ PPO	☐ BCN Commercial ☐ Blue Preferred Plus ☐ TRUST PPO ☐ BCN Advantage℠ HMO
Independent Speech Language Pathologist	☐ Traditional-Participating ☐ Traditional-Nonparticipating ☐ Medicare Advantage℠ PPO	☐ BCN Commercial ☐ Blue Preferred Plus ☐ TRUST PPO ☐ BCN Advantage℠ HMO

BCN Primary Care Physicians

Select the Network(s) to which you are applying	☐ BCN Advantage℠ HMO	☐ BCN Commercial
Please provide the name of the medical care group and number you wish to joining	Medical care group name:	
	Medical care group number:	

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 5: Address data

Primary office address (Must be an address where health care services are rendered and may be published in BCBSM and BCN provider directories)		
*Street address		
*City	*State	ZIP code
Primary telephone number must be a phone number patients can call to make an appointment		
*Primary telephone number	Fax number	

Payment/Remit address		
Street Address		
City	State	Zip Code

Mailing address		
Street Address		
City	State	Zip Code

Medical Records Request (MRR)		
Street Address		
City	State	Zip Code
Contact Name - First	Middle	Last
Telephone	Fax	Email

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 5: Address data *(continued)*

Contact information
Please provide the name and contact information of a person who can answer questions about information in this application.

*First name			*Last name
*Telephone number	extension		Fax number
Work email address			Preferred method of contact? ☐ Email ☐ US Mail

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

***Primary address - Accessibility**

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

Section 6: Services

All provider services:

☐ In-home visits

If you provide in-home visits, please indicate below if you practice exclusively in the home setting or if you also provide care in an office setting:

- ☐ Acupuncture
- ☐ In-home only
- ☐ In-home and office

☐ Lactation counseling

Occupation Therapist, Physical Therapist, Speech Language Pathologist Services:

Autism service	☐ Add ☐ Remove

Telehealth Services

☐ Telehealth - Audio/Visual ☐ Telehealth - Telephone Only

Blue Cross Blue Shield Blue Care Network of Michigan

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NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 7: Additional solo practice locations (Must be an address where health care services are rendered and may be published in BCBSM and BCN provider directories)

#1 Street Address		
City	State	Zip Code
Telephone Number	Fax Number	

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

#2 Street Address		
City	State	Zip Code
Telephone Number	Fax Number	

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

#3 Street Address		
City	State	Zip Code
Telephone Number	Fax Number	

Additional address - Accessibility

*Handicap accessibility: ☐ Yes ☐ No	*Accessible by bus: ☐ Yes ☐ No

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open Time							
Close Time							

If you have additional locations, please list and attach separately.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

NEW PRACTITIONER ENROLLMENT FORM

State license number	Type 1 National provider identifier	Type 2 National provider identifier

Section 8: Application signature

Have you ever been convicted of, pled guilty to, or nolo contendere to any felony?

☐ No ☐ Yes (Insert nature of offenses)

In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, function, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

☐ No ☐ Yes (Insert nature of offenses)

In the past ten years, has any professional corporation, partnership, limited liability company or any other such entity in which you own an equity interest (directly or indirectly) and/or serve any management or leadership function (including, but not limited to, acting as a manager, board member, director, or executive) been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor or been found liable or responsible for any civil or criminal offense?

☐ No ☐ Yes (Insert nature of offenses)

I certify that the information contained in this application is true and complete. I will notify Blue Cross and Blue Shield of Michigan and Blue Care Network immediately in writing of changes affecting this data. If I am a practitioner in training, I will not report services that are related to my training program and rendered at the address from which I am training. Should I re-enter training,I will notify BCBSM and BCN.

For providers applying to be Traditional non-participating providers, the authorized signer agrees on behalf of itself and the provider on whose behalf the authorized signer is acting, to adhere to BCBSM's Billing Guidelines for Non-Participating Providers. These Guidelines include, without limitation, the requirement to permit BCBSM or its designee physical access to the provider's premises to review and/or copy for any permissible purpose any and all medical and billing records submitted by the provider or its billing agent, and the requirement that the provider accept BCBSM's payment as payment in full for services rendered to a BCBSM member when the provider has indicated that it will accept assignment of payment on the member's behalf, will participate with BCBSM on a particular claim, or has otherwise indicated that he/she wishes to receive payment directly from BCBSM and, with the exception of any applicable deductibles, co-payments, or co-insurance amount, not balance bill the member for the difference between BCBSM's payment and the provider's charged amount.

*Print or Type Name	*Authorizing Signature/Title	*Date

Explanation of Medicaid Compliance Attestation

The Michigan Department of Health and Human Services (MDHHS) requires Medicaid managed care health plans to do the following on an annual basis:

1) Collect the name, address, Social Security Number and date of birth of contracted provider's managing employees for purposes of verifying eligibility to participate in Federal and State health care programs. The term "managing employee" means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity. Please provide a supplemental file should the afforded space not allow for you to report all of the managing employees.

2) For facility/ancillary provider types, identify the name and address of all individuals/entities with an ownership interest of 5% or more.

We are addressing both requirements via the enclosed Medicaid Compliance Attestation. If you are an individual practitioner or group of practitioners, fill in sections A and B. If you are any other provider type (other than an individual practitioner or group of practitioners), fill in the information requested in sections A, B and C and sign and return the Attestation along with the agreement in the enclosed envelope within 30 days.

Practitioner Enrollment Form

Suite 1300
4000 Town Center
Southfield, MI 48075

mibluecrosscomplete.com

1. **Complete the application in its entirety.**
2. **No handwritten forms; please type.**
3. **This cover sheet must be the first page of your form submission.**
4. **Fax the enrollment form and attachments (i.e. supporting documents) to 1-855-306-9762 or email to bccproviderdata@mibluecrosscomplete.com. Be sure to submit the enrollment form separately for each provider. (For example: If you register two or more providers, you must send a fax/email for each provider. They cannot be bundled into one transmission.)**
5. **You can also mail the completed forms and documentation to: Blue Cross Complete of Michigan, Provider Network Management, 4000 Town Center; Suite 1300, Southfield, MI 48075**
6. **Supporting documents checklist is located at the end of the enrollment form. Please review and ensure all required documents are submitted along with this enrollment form.**

Note: You are required to complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® at https://upd.caqh.org/oas/.* In order for your Blue Cross Complete affiliation request to be processed, you **must complete your CAQH application** within 14 calendar days. If you have already completed the CAQH application, your attestation must be up to date. If your CAQH application is not complete or if your attestation is expired after 14 calendar days, your request will be closed and you will need to reapply once updated.

To avoid processing delays, please ensure all fields below are completed	
Fax to:	**1-855-306-9762** Attn: Provider Network Management
Email to:	**BCCproviderdata@mibluecrosscomplete.com**
From:	
Date:	
Type 1 NPI:	
Type 2 NPI:	
State License Number:	
Is the provider enrolled in CHAMPS?**	**Yes** ☐ **No** ☐ **If yes, Effective date:** **End date:**
Is the provider already enrolled with Blue Cross Blue Shield of Michigan or Blue Care Network?	**Yes** ☐ **No** ☐
If "No", to either question, please be advised your application will be closed with no further action taken.	

*Blue Cross Complete does not control this website and is not responsible for its content

** Michigan Department of Health and Human Services enrollment system

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 1: Demographic information

* denotes required field

1. *First name		2. *Last name	
3. Middle name		4. *Degree or title	
5. Gender	Select One	6. CAQH ID number	
7. *Date of birth (MM/DD/YYYY)		8. Ethnicity	
9. Social Security Number		10. Race	
11. Other names you may have used (Maiden, a.k.a., etc.)		12. Languages spoken other than English	
13. *Medicaid number		14. *Medicare number	

Section 2: Practice specialty for which you are seeking affiliation

1. *Provider type	Primary Care Practitioner ☐	Specialist ☐
2. *Specialty		
3. *Board certified (M.D., D.O., D.M.D., D.P.M., D.D.S. only)	Yes ☐	No ☐
4. *Board eligible (M.D., D.O., D.M.D., D.P.M., D.D.S. only)	Yes ☐	No ☐
5. Do you practice exclusively in a hospital setting? (if "Yes", Section 1 of the CAQH must be updated to reflect hospital based status)	Yes ☐	No ☐
6. Are you enrolling under a FQHC/RHC/THC/LHD group?	Yes ☐	No ☐

Section 3: Practice training information

1. **Provider Training** – Check all completed trainings					
Deafness or hard of hearing ☐	Serious Mental illness ☐	Child welfare ☐	Substance abuse ☐	Blindness or visual impairment ☐	Co-occurring disorders ☐
Chronic Illness ☐	HIV/AIDS ☐	Physical disabilities ☐	Trauma ☐	Homelessness ☐	Cognitive disabled ☐

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 4: Advanced Practice Provider and Allied Health Practitioner supervising physicians

* denotes required field

1. Supervising physician name	
2. Supervising physician specialty	
3. Supervising physician NPI	

Section 5: Medical Care Group or Independent Physician Association Affiliation

* denotes required field

1. Please provide the name of the medical care group or independent physician association and number you wish to join (required for PCPs)	
a. Medical Care Group name	
b. Medical Care Group number (begins with an "IH")	

Section 6: Primary office practice information

* denotes required field

1. Primary office address (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory, Primary Care Practitioners must practice a minimum of 20 hours per week, per location)	
a. *Group practice name (as it appears on W-9 /SS4 form)	
b. *Federal tax ID	
c. *Tax exempt	Yes ☐ No ☐
d. *Street address	
e. *City	
f. *State	
g. *Zip code	
h. *County	
i. *Primary telephone number	
j. *Fax number	

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 6: Primary office practice information (continued)

* denotes required field

2. Payment or remit Address (if different from your primary address)	
a. Street address	
b. City	
c. State	
d. Zip code	
3. Mailing address (if different from your primary address)	
a. Street address	
b. City	
c. State	
d. Zip code	
4. Medical Records Request (MMR) (if different from your primary address)	
1. Street address	
2. City	
3. State	
4. Zip Code	

5. *Office hours

	From	**To**
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 6: Primary office practice information (continued) * denotes required field

6. Waiting times (in days)	
a. Routine visits	
b. Well exams	
c. Urgent problems	
7. Panel information	
a. Do you place an age limit on your patients?	Minimum age:_____ Maximum age:_____
b. Accepting new patients into the practice?	☐ Yes ☐ No
c. Accepting existing patients only?	☐ Yes ☐ No
d. Place limitation on patient gender?	☐ Male ☐ Female

8. *ADA accessibility – Check all categories that indicate where your office is barrier free

Service Location ☐	Restrooms ☐	Exam rooms ☐	Medical Equip ☐	Blind ☐	Cognitively disabled ☐	Hard of hearing ☐

9. Contact information – please provide the name and contact information of a person who can answer questions about information in this enrollment form	
a. *Contact name	
b. *Telephone number	
c. *Email address	
d. *Provider website (URL address)	

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 7: Secondary office practice information

* denotes required field

1. Secondary office address (must be an address where health care services are rendered and may be published in the Blue Cross Complete provider directory)			
a. *Group practice name (as it appears on W-9 /SS4 form)			
b. *Federal tax ID		c. Type 2 NPI (if different)	
d. *Tax exempt	Yes ☐	No ☐	
e. *Street address			
f. *City			
g. *State			
h. *Zip code			
i. County			
j. *Primary telephone number			
k. Fax number			
2. Payment or remit address (if different from your secondary address)			
a. Street address			
b. City			
c. State			
d. Zip code			
3. Mailing address (if different from your secondary address)			
a. Street address			
b. City			
c. State			
d. Zip code			
4. Medical Records Request (MMR) (if different from your secondary address)			
a. Street address			
b. City			
c. State			
d. Zip code			

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 7: Secondary office practice information - continued

* denotes required field

5. *Office hours		
	From	**To**
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		

6. Waiting times (in days)	
a. Routine visits	
b. Well exams	
c. Urgent problems	

7. Panel information		
a. Do you place an age limit on your patients?	Minimum age: Profes	Maximum age:
b. Accepting new patients into the practice?	Yes ☐	No ☐
c. Accepting existing patients only?	Yes ☐	No ☐
d. Place limitation on patient gender?	Male ☐	Female ☐

8. *ADA accessibility – Check all categories that indicate where your office is barrier free

Service Location ☐	Restrooms ☐	Exam rooms ☐	Medical Equip ☐	Blind ☐	Cognitively disabled ☐	Hard of hearing ☐

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 8: Telehealth services

* denotes required field

1. Telehealth services	
a. Do you offer telehealth services?	Yes ☐ No ☐
b. If yes, though what technology do you offer these services? ***Please check all that apply***	☐ Video ☐ Phone ☐ Provider mobile app ☐ Internet (website)
c. Is this technology HIPAA compliant?	Yes ☐ No ☐
d. What type of services are you providing by telehealth? ***Please check all that apply***	☐ Well visit ☐ Sick visit ☐ Behavioral health ☐ Health risk assessment ☐ Therapies ☐ Other: _____

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Practitioner Enrollment Form

State license number	Type 1 NPI	Type 2 NPI

Section 9: Enrollment signature

* denotes required field

I certify that the information contained in this application is true and complete and the accompanying documents are correct and complete to the best of my knowledge and belief. If this enrollment form contains any material omission or false or misleading information, I understand that participation with Blue Cross Complete may be rejected or terminated. I further understand that a copy of these statements shall be as binding as the original.

I will notify Blue Cross Complete of Michigan immediately in writing of changes affecting this data. If I am a practitioner in training, I will not report services that are related to my training program and rendered at the address from which I am training. Should I re-enter training, I will notify Blue Cross Complete of Michigan.

I hereby authorize Blue Cross Complete to verify the information provided on this application and accompanying documentation through contracting, credentialing, recredentialing or reappointment activity of Blue Cross Complete.

Credentialing – Healthcare professional and provider rights

I understand that healthcare professional and providers have the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information
- Be notified if any credential information is received that varies substantially from application information submitted by the health care professional or provider: (actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of reference, recommendations or other peer-review protected information. The health care professional or provider will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his or her application
- Upon request, be informed of the status of their application – if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the Credentialing Committee for approval.

*Print or type Name	*Practitioner signature and title	*Date

Provider enrollment required document checklist

Provider classification	To avoid processing delays, please ensure all items are submitted
Anesthesia assistant	• Type 1 National Provider Identifier • W9 form • Supervising physician
Audiologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Certified nurse midwife	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available) • For CNMs performing deliveries, the following are also required: ▪ Written confirmation of established privileges with hospitals or has hospital-affiliated birthing centers • Written confirmation of an established, interdependent relationship for medical consultation or collaboration or referral to an OB/GYN
Certified nurse practitioner	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Certified registered nurse anesthetist	• State of Michigan professional license • Type 1 National Provider Identifier • W9 form • Council for Affordable Quality Healthcare number

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Practitioner Enrollment Form

Provider classification	To avoid processing delays, please ensure all items are submitted
Chiropractor	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Certified nurse specialist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Doctor of medicine	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Hearing aid dealer	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Independent occupational or physical therapist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Independent speech language pathologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)

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Practitioner Enrollment Form

Provider classification	To avoid processing delays, please ensure all items are submitted
Licensed Master of social worker	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Licensed professional counselor	• Type 1 National Provider Identifier • State of Michigan professional license • W9 form • Council for Affordable Quality Healthcare number (if available)
Ophthalmologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Optician or optical Supplier	• Type 2 National Provider Identifier • W9 form
Optometrist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)
Oral surgeon	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)

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Practitioner Enrollment Form

Provider classification	To avoid processing delays, please ensure all items are submitted
Physician assistant	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available) • Supervising physician name and NPI
Podiatrist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Psychiatrist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number
Psychologist	• Type 1 National Provider Identifier • W9 form • State of Michigan professional license number • Council for Affordable Quality Healthcare number (if available)

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MEDICAL SERVICE AGREEMENT

MCG PRACTITIONER AFFILIATION ACKNOWLEDGEMENT

This Acknowledgement is effective _____ (Date to be entered only by Health Plan), by and between **Blue Cross Complete of Michigan** (hereinafter "**Health Plan**"), **PROFESSIONAL MEDICAL CORPORATION**, a Medical Care Group or MCG (hereinafter "**Provider**") and _____ (hereinafter **"Practitioner")**.

1. **Provider Contracting Authority**- For the purposes of providing health care services to Members and in consideration of the mutual promises of the parties to the Medical Service Agreement ("**Agreement**"), Provider and Practitioner represent that Practitioner is contracted with Provider and that Provider is duly authorized and empowered to contract on Practitioner's behalf for the purpose of binding Practitioner to the terms and conditions of the Agreement.

2. **Agreement**- Practitioner warrants that he/she has received and read the Health Plan Medical Service Agreement between Health Plan and Provider, which is incorporated herein by reference, and agrees to be bound by the terms and conditions contained in the Agreement. The Agreement, this Acknowledgement, and the Health Plan Provider Manual constitute the entire Agreement between Health Plan, Provider, and Practitioner. Practitioner is fully aware of the responsibilities and requirements pertinent to his/her designated role as Specialist Practitioner or Primary Care Practitioner under the Agreement. Provider and Practitioner agree to abide by the terms and conditions set forth in the Agreement, this Acknowledgement, and all amendments or modifications thereto.

3. **Identifying Information**- Upon execution of this Acknowledgement, Provider shall provide to Health Plan on at least an annual basis the required identifying information for Practitioner. Such information shall be provided and periodically updated by Provider in such detail and format as necessary for Health Plan to maintain accurate provider enrollment records.

PROFESSIONAL MEDICAL CORPORATION

_____
Signature

_Farhan Khan, MD_____
Name (print or type)

_Medical Director_____
Title

_____
Date

BLUE CROSS COMPLETE OF MICHIGAN

_____
Signature

_Donald Beam MD_____
Name (print or type)

_Chief Medical Officer_____
Title

_____
Date

PRACTITIONER

_____
Signature

_____
Name (print or type)

_____
Title

_____
Date

MCG PRACTITIONERS APPLICABLE GROUP PRACTICE INFORMATION

_____
Group Practice NPI number

_____
Group Practice Tax ID Number

Specialist Physicians Only: Specialists who are solo practitioners will have applicable withholds applied towards claims submitted with the individual Tax ID and Type I NPI listed above. Specialists who are part of a practice group acknowledge the following tax ID and Type II NPI numbers are accurate and appropriate for all billing with respect to this Acknowledgement. Please list applicable practice group Tax ID and their associated Type II NPI numbers:

Group Tax ID#:_____ Group Type II NPI:_____

Group Tax ID#:_____ Group Type II NPI:_____

Group Tax ID#:_____ Group Type II NPI:_____

BLUE CROSS COMPLETE OF MICHIGAN
MEDICAID COMPLIANCE ATTESTATION

WHEREAS, **_____ (Provider)** is affiliated with Blue Cross Complete of Michigan **(Blue Cross Complete)** for participation in its Medicaid risk product; and

WHEREAS, by virtue of its Blue Cross Complete affiliation, Provider has agreed to comply with applicable state and federal Medicaid regulatory requirements.

NOW, THEREFORE, Provider attests to the following:

A. Pursuant to applicable regulatory requirements, Blue Cross Complete has furnished to Provider a copy of compliance policies related to Detection and Prevention of Fraud, Waste and Abuse. Subject to applicable regulatory and Blue Cross Complete oversight, Provider agrees to comply with all such policies and procedures as a condition of continued participation in the Blue Cross Complete Medicaid risk product.

B. Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. Provider attests, to the best of Provider's knowledge, information and belief, that neither provider nor its managing employees, agents, officers, directors, or major shareholders/owners (i.e. person with beneficial ownership of 5% or more) appear in the List of Excluded Individuals/Entities (LEIE) as published by the Department of Health and Human Services Office of the Inspector General; the System for Award Management (SAM) at www.sam.gov; the Social Security Administration's Death Master File; the National Plan and Provider Enumeration System (NPPES); the Medicare Exclusion Database (MED); the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List; the Licensing and Regulatory Affairs (LARA) Disciplinary Action Report (DAR); and any other database as the Secretary of HHS may prescribe. Nor has Provider, its managing employees, officers, directors, partners, agents, or major shareholders/owners (i.e. person with beneficial ownership of 5% or more) been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610.

C. To the best of Provider's knowledge, information and belief, there are no pending investigations, legal actions, or matters subject to arbitration involving Provider on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. Additionally, Provider has not been criminally convicted nor had a civil judgment entered against him/her for fraudulent activities.

FURTHER, Provider makes the following disclosures:

A. Does any person who has ownership or control interest in the Provider, or is an agent or managing employee of the Provider, ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs? If so, please list:

1) _____ 5)_____
2) _____ 6)_____
3) _____ 7)_____
4) _____ 8)_____

B. The Michigan Department of Community Health (MDCH) requires Medicaid managed care health plans to collect the name and Social Security Number of its participating provider's managing employees for purposes of verifying eligibility to participate in Federal and State health care programs. Managing Employee can be you, your office manager, or other person(s) meeting the definition contained in 42 CFR 455.101. Please identify the name and SSN of your Managing Employee below:

1) Name:_____ SSN:_____
2) Name:_____ SSN:_____
3) Name:_____ SSN:_____

For purposes of this Attestation, Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

C. MDCH requires Medicaid managed care health plans to collect ownership information for all providers, including entities as defined in 42 CFR 455.100 (i.e. a hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or any other entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any Medicare or Medicaid program). Please identify the name and address of all individuals/entities with an ownership interest of 5% or more below.

1) Name:_____ Address:_____

SSN/Tax ID: _____ DOB: _____

2) Name:_____ Address:_____

SSN/Tax ID: _____ DOB: _____

3) Name:_____ Address:_____

SSN/Tax ID: _____ DOB: _____

4) Name:_____ Address:_____

SSN/Tax ID: _____ DOB: _____

PROVIDER

_____
Signature

_____
Name (Print or Type)

_____
Title

_____
NPI Number

_____
Date

PROVIDER ENROLLMENT FORM

This form should be used by Physician Hospital Organizations/Physician Organizations (PHOs/POs) and individual providers for non-delegated networks and direct agreements.

Instructions

To avoid delays in the credentialing process:

1. Ensure provider information on your CAQH Proview™ profile is up to date and accurate. Note: Information in your *Provider Directory Snapshot* may be used in provider directories.
2. Complete all fields below and sign the form.
3. Email completed form along with documents below to providernetwork@hap.org
   - Current W-9 (signed and dated)
   - EIN/IRS letter
   - Collaborative Physician Agreement, if applicable
   - HAP Disclosure of Ownership and Control Interest Form
   - Children's Special Healthcare Services Provider Attestation Form (for HAP CareSource)

PROVIDER INFORMATION (For multiple providers, please attach a roster)			
Name (last, first, middle):			Degree:
☐ Male ☐ Female	Race/Ethnicity:		
NPI #:		Group NPI #:	
Physician's CAQH ID number: (Make sure HAP is added to physician's CAQH Registry)		CHAMPS number: (if applicable)	
Medicare #: (HAP requires participation in Medicare. If you don't participate, stop and resubmit once Medicare # obtained)			
☐ Primary Care Physician	☐ Specialist	☐ Hospital based	
Primary specialty:			
Practicing specialty:			

PRIMARY OFFICE INFORMATION (for additional locations, complete next page)			
Practice name:			
Street address:			Suite #:
City:		State:	Zip:
Phone:	Fax:	Email:	
Do you offer telehealth services?	☐ Yes ☐ No		
Please choose one. Employed by:	☐ Health System	☐ Independent Group	
Contract with PHO and/or PO? ☐ Yes ☐ No If yes, please indicate which hospital system or PHO/PO affiliations:			

BILLING INFORMATION			
Pay to name:			
Tax identification number:		Billing NPI:	
Address:			
Phone:	Fax:	Email:	

Additional Office Locations

Attach a separate sheet with the same information if you have more office locations.

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

CONSENT AND AUTHORIZATION

By signing this form, I affirm the information provided is true and accurate to the best of my knowledge. Any incomplete or misstatements could result in denial of credentialing. I authorize HAP to access physician information from the Council of Affordable Quality Healthcare (CAQH) Proview database.

Signature

Printed name Date

Title

Email Phone

Disclosure of Ownership and Control Interest Statement

Per contracts with the state of Michigan and the Centers for Medicare & Medicaid Services, HAP is required to obtain a completed Disclosure of Ownership and Control Interest form from our contracted providers and delegates.

What are the federal regulations?

- 42 CFR 457.935
- 42 CFR 455.104-455.106 and
- 42 CFR Part 420, Subpart C sections 1124, 1124A, 1126, and 1861(v)(1)(i) of the Social Security Act

Who do the federal regulations apply to?

All providers that:

- Participate in federal and state-based health care programs, such as, Medicare, MI Health Link, Medicaid and Children's Health insurance Program (CHIP)
- Provide services pursuant to a contract between a Medicare and Medicaid Managed Care Organization such as HAP and a State Medicaid agency

What information is required?

- The identity of all owners with a control interest of 5% or greater
- Certain business transactions and significant business transactions between the provider and any wholly owned supplier or any subcontractor during the previous 5 years
- The identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity.
- Any person who has been convicted of a criminal offense related to health care programs

When is the disclosure required?

- Before entering or renewing a provider agreement with HAP
- Initial and recredentialing
- Any time there are ownership changes
- At any time by written request by state or federal regulators such as CMS, MDHHS, OIG or those contracted to work on their behalf

More information

For definitions and other helpful information, please see the last page of this form.

Instructions

1. Respond to all questions. Read the instructions in each shaded box:
   - If standard applies, complete the fields. **If standard does not apply, please check the box next to N/A.**
2. **No questions can be left blank. Please attach a separate sheet if necessary.**
3. Website and email addresses are not acceptable answers to any of the questions. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).
4. Any authorized/designated representative of the provider/disclosing entity may complete and sign this form on behalf of the provider/disclosing entity.
5. This disclosure will be renewed every three (3) years and/or at any time there is a revision to the information or upon a request for updated information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity

Name of Provider/Disclosing Entity:

DBA Name:

Complete Address:

Tax Identification Number (TIN): NPI Type 1: NPI Type 2:

Section 1 – Managing Employee

Complete the information below for any managing employees of the Disclosing Entity.

☐ **N/A**

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

Section 2 –Ownership and Control Interests

List any individual or corporation with an ownership or control interest of 5% or more in the Disclosing Entity.

- For Individuals: List the name, title, home address, date of birth (DOB) and Social Security Number (SSN)
- For Entities: List the name, TIN, business address of each organization, corporation, or entity

☐ **N/A**

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

Section 2A – Relationships

Complete this section if any of the individuals in Section 2 are related (e.g., spouse, sibling, parent, child, etc.) to each other.

☐ **N/A**

Name: Relationship:

Name: Relationship:

Section 3 – Subcontractors

List subcontractors that Disclosing Entity has direct or indirect ownership of 5% or more.

☐ **N/A**

Name of subcontractor: Name of subcontractor:

Section 3A –Subcontractors

Complete for any person with an ownership or control interest in any subcontractor in section 3. Also indicate if related to anyone in section 2 (e.g., spouse, sibling, parent, child, etc.).

☐ **N/A**

First Name: Last Name:

SSN (individual): TIN (entity): DOB: % of ownership:

Complete Address:

Relationship: Name from section 2: Relationship:

First Name: Last Name:

SSN (individual): TIN (entity): DOB: % of ownership:

Complete Address:

Relationship: Name from section 2: Relationship:

Section 4 – Other Disclosing Entity (or Fiscal Agent or Managed Care Entity)

Complete the fields below if the Disclosing Entity has an ownership or control interest for any Other Disclosing Entity.

☐ **N/A**

Other Disclosing Entity First Name:

Other Disclosing Entity Last Name:

SSN (individual) TIN (entity): DOB: % of ownership:

Complete Address:

Name of person with an ownership or control interest:

Other Disclosing Entity Firs Name:

Other Disclosing Entity Last Name:

SSN (individual): TIN (entity): DOB: % of ownership:

Complete Address:

Name of person with an ownership or control interest:

Section 5 – Business Transactions Disclosures

Indicate if the provider/disclosing entity or part B supplier has any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) months period (12-month period ending as of the date on this request).

☐ **N/A**

Subcontractor First Name: Subcontractor Last Name:

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

Subcontractor First Name: Subcontractor Last Name:

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

Section 5A – Significant Business Transactions Disclosure

Indicate if the provider/disclosing entity or part B supplier had any significant business transactions with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending on the date on this request).

☐ **N/A**

First Name: Last Name: ☐ Wholly Owned Supplier ☐ Subcontractor

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

First Name: Last Name: ☐ Wholly Owned Supplier ☐ Subcontractor

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

Section 6 – Criminal Offense Disclosure

Identify any person who has ownership or control interest in the provider; or is an agent or managing employee of the provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare and/or Medicaid, or the title XX services program since the inception of those programs.

☐ **N/A**

First Name: Last Name:

Title: SSN: TIN: DOB:

Complete Address:

Description of offenses:

First Name: Last Name:

Title: SSN: TIN: DOB:

Complete Address:

Description of offenses:

Attestation

Through signature below, I certify that the information provided herein is true, accurate and complete. Additions to or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in denial of participation. Individuals and Sole Proprietors must sign their own form. An authorized representative may sign for Partnership, Corporation, LLC or Other disclosing entities.

Provider name (please print)	Title (or indicate if authorized Agent)
Provider signature	Date

Frequently Asked Questions

1. Does this form need to be collected if a provider is an employee of the organization?
    a. Disclosure of Ownership form must be filled out for all individuals and organizations having direct or indirect ownership interests or controlling interest separately or in combination amounting to an ownership interest of 5% or more in the disclosing entity.

2. If my organization doesn't contract with group practices, does this form need to be completed for each individual provider/subcontractor in my network?
    a. Disclosure of Ownership form information must completed for the physician hospital organization/physician organization (PHO/PO) and for any groups that have a direct or indirect ownership interest.
    b. Groups that only contract with the PHO/PO and do not have a direct or indirect ownership interest do not need to fill out the disclosure form.

Definitions

Direct Ownership Interest - Possession of equity in the capital, the stock, or the profits of the disclosing entity.
Disclosing Entity - Medicaid and/or a Medicare provider (other than an individual practitioner or group of practitioners), a part B supplier (as defined in § 400.202), or a fiscal agent.
Fiscal Agent - A contractor that processes or pays vendor claims on behalf of the Medicaid agency.
Indirect Ownership Interest – An ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
Managing Employee - A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Other Disclosing Entity - Any other Medicare or Medicaid disclosing entity and any entity that does not participate in Medicare or Medicaid; but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes: a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); b) Any Medicare intermediary or carrier; and c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.
Person with an ownership or control interest - A person or corporation that: a) Has an ownership interest totaling 5% or more in a disclosing entity; b) Has an indirect ownership interest equal to 5% or more in a disclosing entity; c) Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; d) Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; e) Is an officer or director of a disclosing entity that is organized as a corporation; f) Is a partner in a disclosing entity that is organized as a partnership.
Significant Business Transaction - Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5% of a provider's total operating expenses.
Subcontractor a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicare and/or Medicaid agreement.

Children's Special Healthcare Services Provider Attestation

☐ Signed on behalf of TIN
☐ Refused

Provider Name:	
Address (city, state, zip):	
NPI:	**Tax ID:**

Criteria	Verification and provider responsibility
1. Do you currently care for children with complex chronic health conditions? ☐ Yes ☐ No	
2. Are you: ☐ Board certified ☐ Board eligible	List board:
3. Are you available 24 hours a day, 7 days a week? (Note, this is a contract requirement) ☐ Yes ☐ No	Check all that apply. ☐ On call clinician ☐ Pager ☐ Answering service with direct access to you ☐ Answering machine directing caller to a number where you can be reached immediately (answering machine alone does not count)
4. Is your practice accessible and available outside of 9am - 5pm, Monday through Friday? ☐ Yes ☐ No	Check all that apply: ☐ 24-hour on call clinician ☐ E-appointments ☐ Hours before 9 a.m. ☐ Hours after 5 p.m. ☐ Weekend hours
5. Does your practice provide expanded appointments when the child/youth has complex needs and requires more time? ☐ Yes ☐ No	
6. Does your practice have experience coordinating care for children/youth who see multiple professionals? (pediatric subspecialists, physical therapists, mental health professionals, etc.?) ☐ Yes ☐ No	
7. Does your practice have a designated professional responsible for care coordination for children who see multiple professionals? ☐ Yes ☐ No	If no: who is responsible for care coordination:
8. Is your practice open to new patients (children/youth) with complex chronic health conditions? ☐ Yes ☐ No	
9. Does your practice provide appropriate services for youth transitioning into adulthood, including, but not limited to, the use of a transition assessment tool and adoption of a transition policy that is publicly posted? ☐ Yes ☐ No If yes, complete box to the right.	The transition time frame: Transition approach: Legal changes that take place in privacy and consent at age 18:

By signing this form, you attest the responses above are true and accurate and you agree to provide care for CSHCS members.

Provider (or authorized representative) Name (Print) Date

Provider (or authorized representative) Signature

PROFESSIONAL MEDICAL CORPORATION
PHYSICIAN ACKNOWLEDGEMENT CONSENT FORM
FOR
HEALTH ALLIANCE PLAN OF MICHIGAN (HAP)

This Agreement is entered into this _____ day of _____, 20___ (hereinafter, the "Effective Date"), by _____ or Provider Affiliated Physician.

I _____(Provider Affiliated Physician) hereby acknowledge and consent that I have reviewed and agree to be bound by all terms and conditions specified in the Physicians Services Agreement between PMC and Health Alliance Plan (HAP) as it relates to providing services to Enrollees of all HAP products (HMO, PPO, AHLIC, Medicare Advantage products). I acknowledge that my participation in HAP is contingent upon meeting all credentialing standards of HAP, and being approved by PMC and HAP to participate.

I shall in no event, including but not limited to nonpayment by HAP, insolvency of HAP, breach, or termination of the Agreement; bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Enrollee, the State of Michigan or a person (other than HAP) acting on behalf of the Enrollee for Covered Services provided pursuant to the Agreement or the difference between my charge and the contracted payment rate for Covered Services. This provision does not prohibit collection of coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for Non-Covered Services delivered on a fee-for-service basis to Enrollees. Nor does this provision prohibit me and an Enrollee from agreeing to continue services solely at the expense of the Enrollee, so long as I have clearly informed the Enrollee that HAP may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit me from pursuing any available legal remedy.

I agree in the event HAP becomes insolvent as such state is declared by the State of Michigan or the courts, to continue services to Enrollees for the duration of the period for which payment has been made to PMC and/or me. In the event of an Enrollee's confinement to an inpatient facility on the date of HAP's insolvency, I shall continue to provide Covered Services to any such Enrollee until his or her discharge from that facility or transfer to another HAP Affiliated Provider.

These provisions shall survive the cancellation or termination of the Medical Services Agreement regardless of the cause for termination or cancellation, and shall be construed to be for the benefit of HAP Enrollees. These provisions are not intended to apply to services provided after the Medical Services Agreement has been terminated. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PMC and/or me, and Subscriber, Enrollee or persons acting on their behalf.

I agree to abide by Policies and Procedures of HAP and PMC and to abide by the decisions of PMC or HAP in establishing, interpreting and implementing such policies during the term of this Agreement.

I agree to abide fully with the applicable terms and conditions of the HAP/PMC Professional Service Agreement as if set forth herein, including, but not limited to the following:

a. To provide Covered Services in accordance with the standards and procedures applicable to my other patients;
b. To participate in and actively cooperate with HAP's and PMC's Utilization Review and Quality Assurance programs, including, by way of example but not by way of limitation, pre-admission certification, emergency admission certification, and extension of hospital stays;
c. To maintain, in adequate amounts, policies of general liability and professional liability insurance, and to provide notification to PMC after receiving notice of any material adverse change in coverage within five (5) days of such change in coverage.
d. To represent and warrant that I am currently and shall remain licensed to provide medical services and shall provide immediate notification to Provider of any formal action to suspend or revoke my license which is pending;
e. To utilize HAP Affiliated Physicians whenever medically appropriate;
f. To agree that HAP may list me as a participant;
g. To maintain records for at least six (6) years, or such other period as may be required by any federal or state authority and to certify the accuracy and completeness of such records as requested by HAP;
h. To submit Clean Claims to HAP within forty five (45) days whenever possible, but in all cases to submit clean claims to payor within one (1) year of the date of service. Provided however, in case of coordination of benefits, I shall bill within ninety (90) days of receipt of denial or payment from the primary carrier;
i. That I have received and read a copy of the Medicare Benefit Program Agreement between HAP and PO which is incorporated into and made a part of this Subcontractor Acknowledgement and Consent Form by reference.
j. To provide Covered Services to Medicare Members in accordance with the Medicare Benefit Program Agreement between HAP and PHO.
k. To fulfill all the obligations set forth in the Medicare Benefit Program Agreement between HAP and PO, which are applicable to PO Affiliated Physicians.
l. To accept as payment in full from HAP the amounts set forth in the Medicare Benefit Program Agreement between HAP and PO and any attached payment Exhibits, and that I shall not bill any Medicare Enrollee of HAP for any amounts except any Copayments and charges for services not covered under the Medicare Benefit Contract.

m. I agree to maintain the confidentiality of personal health information and information contained in the medical records of all Enrollees, and, except for the dissemination of such records to authorities as required by law, to accrediting bodies and to committees which monitor the quality of care rendered by me, to authorized regulatory agencies, or to HAP and others as permitted by law, or the Enrollee, not to disclose such information without the consent of the Enrollee. I understand that HAP has obtained its Enrollee's consent for HAP and/or its designee to review said records through its application process, subscriber contract and identification cards.

HAP's commercial HMO, Medicare Complimentary, PPO and POS products

☐ YES ☐ NO

HAP's Medicare Advantage products

☐ YES ☐ NO

The undersigned have duly executed this Acknowledgement and Consent Form.

PROFESSIONAL MEDICAL CORPORATION AFFILIATED PHYSICIAN:

By:_____
Signature

Name:_____
Signature

Date:_____

PROFESSIONAL MEDICAL CORP.

By:_____
Signature

Name: Farhan Khan, MD
Printed Name

Its: Medical Director

HEALTH ALLIANCE PLAN OF MICHIGAN

By:_____
Richard E Swift

Its: Chief Financial Officer

Dated:_____ Effective Date_____

EXHIBIT D

ACKNOWLEDGEMENT AND AGREEMENT

The undersigned provider hereby acknowledges and agrees: (i) to the terms of the Plan Physician/Physician Organization Participation Agreement ("Agreement") between HAP MHP and Contractor, (ii) that he or she provides or will be providing services pursuant to such Agreement on behalf of Contractor, (iii) to be bound by the terms and conditions of the Agreement with respect to his/her provision of services thereunder, and (iv) that he or she is not now and has never been excluded from Medicare, Medicaid or any other third party payor program, and will promptly notify HAP MHP and Contractor of any change in his/her participation status with any such program. The undersigned is responsible for notifying HAP' MHP of any changes to the information contained in this acknowledgement. Amendments to this exhibit may be submitted to HAP's Contracting Department by sending a written notice to 2850 W. Grand Blvd., Detroit, MI 48202 or by faxing such written notice to the attention of the HAP Contracting Department at 313-664-8264.

Signature:_____

Print Name:_____

Type of provider: _____

Date:_____

-make additional copies if necessary-

Primary Care or Specialist Provider

HOURS OF AVAILABILITY

PROVIDER NAME:_____

Hours of availability can often differ from actual clinic/practice hours.
PCP must show at least 20 hours at each location.
Please fill in hours below for each location – the hours cannot overlap:

Location 1_____

Monday _____am to _____pm

Tuesday _____am to _____pm

Wednesday _____am to _____pm

Thursday _____am to _____pm

Friday _____am to _____pm

Saturday _____am to _____pm

Sunday _____am to _____pm

Location 2_____

Monday _____am to _____pm

Tuesday _____am to _____pm

Wednesday _____am to _____pm

Thursday _____am to _____pm

Friday _____am to _____pm

Saturday _____am to _____pm

Sunday _____am to _____pm

Location 3_____

Monday _____am to _____pm

Tuesday _____am to _____pm

Wednesday _____am to _____pm

Thursday _____am to _____pm

Friday _____am to _____pm

Saturday _____am to _____pm

Sunday _____am to _____pm

Please list addresses here:

1. _____
_____

2. _____
_____

3. _____
_____

Michigan Department of Community Health requires that Midwest Health Plan and other groups with contracts with the State of Michigan collect and report all providers RACE and ETHNICITY. Attached is a new required form that must be completed and return with each application for participation. Absence of the completed form will make the application incomplete and it will not be processed. Any questions/concerns about this requirement should be directed to MDCH: 517-373-3740 or written inquiries: Capitol View Bldg., 201 Townsend Str., Lansing, Mi 48913

Provider's Printed Name: _____ **Provider's NPI**: _____

Provider's RACE: _____

HEDIS Categories: Write in above or circle below

White

Black

American Indian /Alaska Native

Asian/Pacific Islander

Hispanic

Other

Unknown

Hispanic/Latino/white

Hispanic/Latino/Black

Multiple Races

Provider's Ethnicity: _____

HEDIS Categories: Write in above or circle below

Not Hispanic/Latino

Hispanic/Latino

Unknown

Failure to return completed form will make application/renewal incomplete and will not be processed.

Not completing the renewal/re-credentialing timely will automatically terminate your contracts.

Provider's Signature: _____ Form dated: _____

LETTER OF AGREEMENT
ATTACHMENT

WHEREAS, Humana Health Plan, Inc. and Humana Insurance Company and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**") and Professional Medical Corporation (hereinafter referred to as "**IPA**") entered into a IPA Participation Agreement (hereinafter "**Agreement**") on April 1, 2015, **AND**

WHEREAS, IPA and **Humana** agreed to be bound by the terms and conditions of the Agreement, **AND**

WHEREAS, the undersigned Provider (hereinafter referred to as "**Participating Provider**") is a member of IPA, and a **Participating Provider** pursuant to the Agreement between IPA and **Humana** , **AND**

WHEREAS, **Participating Provider** acknowledges and agrees that the joinder of the **Humana** companies above shall not be construed as imposing joint responsibility or cross guarantee between or among **Humana** companies.

NOW, THEREFORE, the parties hereby agree as follows:

Participating Provider agrees to abide by all of the terms and conditions set forth in the Agreement, and to abide by all **Humana** policies and procedures established and revised from time to time by **Humana** including, but not limited to, quality assurance, quality improvement, risk management, utilization management, credentialing and recredentialing, and grievances/appeals.

Participating Provider unconditionally authorizes **Humana** and IPA to share information, including but not limited to credentialing, recredentialing, quality management and utilization management information as related to treatment of individuals covered under those **Humana** health benefits plans covered under the Agreement (hereinafter "**Members**"). However, it is understood expressly that the information shall not be shared with anyone not a party to the Agreement, unless required by law or pursuant to prior written consent of **Participating Provider**.

Participating Provider acknowledges that **Participating Provider** has been provided an opportunity to read the Agreement, all of the terms of which are hereby incorporated by reference.

Participating Provider further agrees that payment to IPA or **Participating Provider**, as applicable, from **Humana**, less any Copayments owed by the Member, is payment in full for Health Care Services provided or arranged for Members in accordance with the applicable Member health benefits contract and the terms and conditions of this Agreement. **Participating Provider** shall look solely to IPA for payment and agrees that payments made by **Humana** to IPA for Covered Services rendered to Members by **Participating Provider** constitutes payment in full to **Participating Provider**.

Participating Provider further agrees that in the event of termination or expiration of the Agreement, or in the event IPAis dissolved for whatever reason, **Participating Provider** shall continue to provide Health Care Services under the terms and conditions of the Agreement and **Humana** agrees to continue to pay **Participating Provider** in accordance with the fee-for-service payment arrangements stated in the Payment Attachment of the Agreement, for a period of one hundred and eighty (180) days after notice of dissolution of IPA or the effective date of termination or expiration of the Agreement, during which time a new IPA agreement may be negotiated between **Humana** and the individual **Participating Provider**. **Humana** may terminate such **Participating Provider** participation at any time after dissolution of IPA or termination or expiration of the Agreement upon written notice to **Participating Provider**.

PARTICIPATING PROVIDER	**HUMANA**
Signature: _____	Signature: _____
Print Name: _____	Print Name:_____
Date: _____	Date: _____

McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

PROVIDER INFORMATION FORM

Please complete this form to ensure accurate provider directory and payment information.
If needed, copy this form for additional sites.

Group Name (or Name of Practice): _____ **Fed Tax:** _____

Hospital Affiliation(s): _____

Contact Name: _____

Email Address: _____ **How many physicians within practice?** _____

Service Location(s):

PRIMARY ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

SECONDARY ADDRESS (if applicable)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

Please list additional service locations submitted on a separate sheet.

Billing Location:

ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

Is Payment Location the same as Billing ☐ **Yes** ☐ **No** **If No, Please list Payment Address:**

ADDRESS	SUITE	CITY	STATE	ZIP- 9 DIGIT
				-

E-Prescribing: ☐ **Yes** ☐ **No**
Patient Portal: ☐ **Yes** ☐ **No**
Certified Patient Centered Medical Home (PCMH): ☐ **Yes** ☐ **No**

McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

Please complete one form for each provider within the practice. INDIVIDUAL AND GROUP NPI IS REQUIRED FOR ALL PROVIDERS. IF THE PROVIDER DOES NOT USE A GROUP NPI, PLEASE SIGNIFY WITH N/A.

Provider Information:

Last Name	
First Name	

Title		**Type - Circle One**	Primary Care Specialist
CAQH #		**Specialty**	
Individual NPI #		**Group NPI #**	
Alt. Language(s)		**State License #**	
American Sign Language	☐ Yes	☐ No	

Race - Circle One	American Indian or Alaskan Native Asian White Other _____ Black or African American Native Hawaiian or other Pacific Islander
Ethnicity - Circle One	Hispanic or Latino Not Hispanic or Latino
Champs Enrolled?	☐ **Yes** ☐ **No**

Meaningful Use Participation

Please check the appropriate box if you have received incentive payments from Medicare or Medicaid.

Medicare	Stage 1 ☐ _____	Stage 2 ☐ _____	Stage 3 ☐ _____
Medicaid	Stage 1 ☐ _____	Stage 2 ☐ _____	Stage 3 ☐ _____

Completed Cultural Competency? (CLAS) Attestation Required	☐ Yes	☐ No
Children's Special Health Provider? Attestation Required	☐ Yes	☐ No
Does Provider practice at each location?		

ATTACHMENT TO
AGREEMENT BETWEEN

McLAREN HEALTH PLAN, INC AND

PROFESSIONAL MEDICAL CORPORATION

PHYSICIAN AFFILIATION ACKNOWLEDGEMENT AGREEMENT

This acknowledgement is effective _____ (date assigned by McLaren Health Plan), by and among **McLaren Health Plan (MHP), Professional Medical Corporation**, a Physician Organization (**PO**) and _____ (**PO Physician**), who is a member of PO.

For the purpose of providing health care services to MHP Members and in consideration of the mutual promises of the parties to the Health Care Professionals Agreement **(Agreement),** PO Physician agrees as follows:

1. **Member Hold-Harmless:** Except in the event that Member has primary coverage with another carrier or third party payer and except for applicable co-payments or deductibles, PO Physician agrees to look solely to MHP or TPA for payment for covered services rendered under the Agreement and to accept payment made in accordance with the Agreement as payment in full. PO Physician will in no event, including but not limited to nonpayment, insolvency or breach of the Agreement, bill, charge, collect a deposit from, seek payment from, maintain any action at law or in equity or have any other recourse against a Member or person (other than MHP or TPA) acting on behalf of Member for covered services provided pursuant to the Agreement. This provision does not prohibit PO Physician from collecting charges for supplemental benefits or co-payments or deductibles, where appropriate, or for non-covered services delivered to Members on a fee-for-service basis. This provision shall survive termination of the Agreement for covered services rendered prior to termination regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Member. This provision is not intended to apply to services provided after termination of the Agreement. This provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between PO Physician and Member or person acting on Member's behalf, insofar as such contrary agreement relates to liability for payment of covered services provided under the Agreement.

2. **MHP Administrative/Educational Programs:** PO Physician shall at all times cooperate with MHP's quality management, medical management, network management, Member education,

Member grievance, claims processing and administration, clinical and non-clinical performance measurement and improvement programs, and other policies, procedures and corrective measures reasonably established by MHP to effect the terms and provisions of this Agreement.

3. **Qualifications/Standards of Care:** PO Physician shall maintain all licenses, certifications and accreditations required by law. PO Physician shall provide proof of all applicable licenses, certifications, accreditations and hospital p1ivileges upon request by PO or MHP and shall immediately notify PO and MHP of any loss, revocation or suspension of any such licenses, certifications, accreditations or hospital privileges. PO Physician shall provide all covered services in a manner consistent with professionally recognized standards of health care.

4. **False Claims Act.** Federal law prohibits an employer from disc1iminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. PO and PO's staff and PO Physician and Physician's staff should report possible violations to MHP by contacting the compliance hotline, which is listed on the MHP website and in the MHP Provider Manual. Further, MHP shall provide continuing educational opportunities regarding programs for identifying, addressing and reporting instances of fraud and abuse and whistleblower protections as part of the Deficit Reduction Act of 2005.

5. **Notification Requirements:** PO Physician shall provide at least thirty (30) days advance written notice of significant changes in the practice, such as address or phone number changes, or changes in participation status with any of the MHP products.

6. **General:**

   A. MHP may designate specific health care providers, agencies and facilities as preferred or exclusive providers of specific services not covered by this Agreement.

   B. PO Physician has been offered the opportunity to review and/or is familiar with the existing Agreement between PO and MHP and also with the MHP Provider Manual, which is available at MHP's website at www.mclarenhealthplan.org.

   C. PO Physician is fully aware of the responsibilities and requirements pertinent to his/her designated role as a Primary Care Physician or Specialty Care Physician.

   D. PO Physician agrees to be bound by and accept the applicable terms and conditions of this Acknowledgement, the Agreement, the Provider Manual, and all amendments or modifications thereto.

7. **Signature** - Execution of PO Physician Affiliation Acknowledgement by use of facsimile or electronically scanned signatures will have the same force and effect as original signatures.

PHYSICIAN AFFILIATION ACKNOWLEDGEMENT AGREEMENT

PROFESSIONAL MEDICAL CORPORATION
PO PHYSICIAN

_____
Signature

_____
Name (Print)

_____
Date

Provider agrees to participate in the following by placing his/her initials next to the Product.

____ ☐ McLaren Health Plan Commercial HMO & POS

____ ☐ McLaren Health Plan Medicaid HMO

____ ☐ McLaren Medicare Advantage HMO

____ ☐ Health Advantage (PPO)

If Provider does not initial any of the above Products, MHP assumes Provider participation in all MHP Products.

ACKNOWLEDGMENT
of Agreement between **Meridian Health Plan of Michigan, Inc.** and **Professional Medical Corp**

I am a physician, hospital or other health care provider employed by or under contract with the above named Organization to furnish health care services at, as a member of, or on behalf of such Organization.

I have received and reviewed a copy of the Participation Agreement between Meridian Health Plan of Michigan, Inc. ("the Plan") and the above named Organization and, wishing to provide health care services to Enrollees of the Plan encompassed by that Practitioner Agreement and to obtain the benefit of the terms of that Agreement, agree to abide by and be bound by its terms. I acknowledge and agree that the terms and conditions of the Plan's standard Practitioner Agreement are incorporated herein by reference as material terms hereof and shall also be binding upon and apply to me except as, and only to the extent that, they are contradicted by the express terms of the Organization Master Agreement, and that in the event of any conflict between the terms and conditions of that Practitioner Agreement and the terms and conditions of the applicable Participation Agreement, the terms and conditions of that Practitioner Agreement shall supersede and govern with respect to me.

I agree to submit for review by the Plan all required information necessary for my credentialing and re-credentialing in accordance with the standards established by the Plan and described in the Plan's Quality Improvement Plan. I acknowledge and agree that my Participating Provider status is dependent upon my successful completion of credentialing and re-credentialing in accordance with the Plan's Quality Improvement Plan. I further agree to participate in the Plan's credentialing and re-credentialing processes and to be bound by all Plan decisions with respect thereto.

I agree to look only to the Plan for compensation (other than normal deductibles, coinsurance or co-payments) for services rendered to an Enrollee when such services are covered by the Plan's individual Enrollee or group contracts. I agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Enrollee or persons acting on behalf of Enrollee (other than the Plan), except as permitted under the Coordination of Benefits Section of the applicable Participation Agreement. I agree not to maintain any action at law or in equity against an Enrollee to collect sums that are owed by the Plan to me under the terms of this Agreement, even in the event the Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This provision shall survive termination of this Agreement or the Participation Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Enrollees. This provision is not intended to apply to services provided after my Participation Agreement has been terminated, except as otherwise provided in the Practitioner Agreement or my Participation Agreement, or to non-covered services. I further agree that this provision supersedes any oral or written agreement, hereinafter entered into between myself and Enrollee or persons acting on Enrollee's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of my Participation Agreement. Any payment by the Plan to the Contracting Organization pursuant to the Annual Specialty Services Shared Risk Fund Settlement will extinguish the Plan's liability to the Organization Providers for such payment

I agree to be bound by all Federal and State Laws and regulations and to comply with participate in and be bound by all policies, procedures and protocols set forth in the Plan's Quality Improvement Plan and Provider Manual. I further agree to submit to requests by the plan (and authorized regulatory agencies) to review my books and records as outlined in this agreement.

As a further condition precedent to my Participating Provider status, I hereby acknowledge the authority of the above named Organization to execute participation agreements and other participation-related contracts and documents with the Plan on my behalf and to thereby bind me to the terms thereof.

I agree to participate in the following Meridian Health Plan of Michigan, Inc. Line(s) of Business:

1. **Medicaid - Meridian Health Plan of Michigan, Inc.** (check one provider type to participate):
   - ☐ PRIMARY CARE PRACTITIONER Plan 1 - Fee-For-Service – 100% of current **Medicaid** fees plus quality incentive bonuses
   - ☐ SPECIALTY CARE PRACTITIONER Plan 2 - Specialty Care Practitioner – 100% of current **Medicaid** fees.

2. **Medicare - Meridian Health Plan of Michigan, Inc.** (check one provider type to participate):
   - ☐ PRIMARY CARE PRACTITIONER Plan 1 - Fee-For-Service – 100% of current **Medicare** fees minus any applicable copays, coinsurance or deductibles.
   - ☐ SPECIALTY CARE PRACTITIONER Plan 2 - Specialty Care Practitioner – 100% of current **Medicare** fees minus any applicable copays, coinsurance or deductibles.

3. **Commercial - Meridian Health Plan of Michigan, Inc.** (check to participate):
   - ☐ PP/PPG's total reimbursement for Covered Services for Commercial Enrollees shall be the lesser of:
     (a) The maximum fee for the particular Covered Services as determined by Plan (pursuant to Plan's fee schedule); or
     (b) PP/PPG's usual and customary charge for such services.
     (c) Less any applicable coinsurance, copayments and/or deductibles.

_____
(Provider Signature)

_____
(Date)

Specialty:_____

Address:_____

City, State, Zip:_____

Phone:_____

Fax:_____

Provider Disclosure Information Request

Has any person who has ownership or controlling interest in the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of the programs? YES☐ NO☐

Has any agent or managing employee for the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of the programs? YES☐ NO☐

If yes to either question, please list those specific individuals along with their address and Social Security number below:

Name:_____ SSN:_____

Name:_____ SSN:_____

Individuals listed above will be reported to the HHS/Office of Inspector General (OIG) and to MDCH.

Please provide a list of all owners with a controlling interest of 5% or more in the organization:

Name Addresses

_____

_____

_____

In addition, please list all managing employees along with their Social Security Number below. *A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.*

Name:_____ SSN:_____

Name:_____ SSN:_____

*Individuals listed will be reviewed for inclusion on the Excluded Parties List System

APPENDIX III
Meridian Health Plan of Michigan
-Provider Disclosure of Ownership and Control Interest Form-

The federal regulations set forth in 42 CFR 455.104-106 require all providers who are entering into or renewing a provider agreement ("Disclosing Entities") to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: a) the identities of all owners with a control interest of 5% or greater, b) all agents or managing employees of the Disclosing Entity c) details of certain familial relationships between owners or owners of subcontractors owned by the Disclosing Entity, and d) the identities of any excluded individual or entity with an ownership or control interest in the Disclosing Entity. As used herein, a 'person' includes individuals and corporations or other business entities. ***Please attach additional sheets as necessary.***

- *Individuals listed in Sections 1-6 will be reviewed for inclusion on the Excluded Parties List System.*
- *Individuals listed in Section 7 will be reported to the HHS/Office of Inspector General (OIG) and to DHS.*

DISCLOSING ENTITY		
Check one that mostly describes you: ☐ **Individual** ☐ **Group Practice** ☐ **Disclosing Entity**		
Name of Disclosing Entity:		
DBA Name:		
Address:		
City:	**State:**	**Zip:**
Phone:	**Fax:**	**Email:**
Tax ID Number (TIN):	**NPI (Individual)**	**NPI (Organizational)**

SECTION 1 — Ownership and Control of Disclosing Entity
List the name, address, date of birth (DOB) and Social Security Number (or TIN for corporations) for each person with an ownership or control interest of 5% or more in the Disclosing Entity (including corporate entities, officers, directors, or partners). (42 CFR 455.104)

Name of Individual or Entity:	**Date of Birth** (for individuals)	**Address(es)** (for corporations, include primary business address, every business location, and P.O. Box address)	**Social Security Number** (or TIN for corporation)

SECTION 2 — Ownership and Control of Disclosing Entity by Relatives

Are any of the individuals listed in Section 1 related to each other? ☐ Yes ☐ No
If yes, disclose each person listed in Section 1 who are related to another person with ownership or control interest in the Disclosing Entity as a spouse, parent, child, or sibling. (42 CFR 455.104)

Name of Individual	**Relationship**

SECTION 3 — Ownership And Control of Subcontractors

Are there any subcontractors that the **Disclosing Entity** has direct or indirect ownership of 5% or more? ☐ Yes ☐ No
If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the Disclosing Entity has direct or indirect ownership **of 5% or more**. (42 CFR 455.104)

Name of Individual or Entity with an Ownership Interest and Name of Subcontractor	**Date of Birth** (for individuals)	**Address(es)** (for corporations, include primary business address, every business location, and P.O. Box address)	**Social Security Number** (or TIN for corporation) of owner and SSN or TIN for subcontractor

Continued on next page

SECTION 4 — Ownership and Control of Disclosing Entity by Relatives of Subcontractors

Are any of the individuals or entities listed in Section 3 related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling? ☐ Yes ☐ No

If yes, disclose each person listed in Section 3 who is related to another person with an ownership or control interest in the Disclosing Entity as a spouse, parent, child or sibling. (42 CFR 455.104)

Name of Individual from Section 3	Relationship

SECTION 5 — Ownership and Control of any Other Disclosing Entity

Is there any Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which a person listed in Section 1 has an ownership or control interest? ☐ Yes ☐ No

If yes, list each Other Disclosing Entity (such as a provider, fiscal agent or managed care entity) in which the person listed in Section 1 has an ownership or control interest.

An "Other Disclosing Entity" is usually an entity that either participates in Medicaid or is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Grants for Planning Comprehensive Action to Combat Mental Retardation), or XX (Block Grants to States for Social Services) of the Social Security Act. (42 CFR 455.104)

Name of Individual or Entity from Section 1	Name of the other Disclosing Entity	% Interest

SECTION 6 — Managing Employees

List all managing employees of the Disclosing Entity along with the additional information indicated below. *A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.* (42 CFR 455.104)

Name of Individual or Entity:	Date of Birth (for individuals)	Address(es) (for corporations, include primary business address, every business location, and P.O. Box address)	Social Security Number (or TIN for corporation)

SECTION 7 — Criminal Offenses

Has any person with an ownership or control interest in the Disclosing Entity, or any agent or managing employee of the Disclosing Entity ever been convicted of a crime related to that individual or entity's involvement in any program under Medicaid, Medicare, or Title XX program since the inception of those programs? ☐ Yes ☐ No (verify through HHS-OIG Website)

If yes, please list those individuals below. (42 CFR 455.106)

Name if Individual or Entity:	Date of Birth (for individuals)	Description of Offense(s)	Social Security Number (or TIN for corporation)

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature **Title**

Printed Name **Date**

Molina Healthcare - Ownership/Controlling Interest Disclosure Form

ALL INFORMATION DISCLOSED IN THIS SECTION WILL REMAIN ENTIRELY CONFIDENTIAL AND WILLONLY BE USED FOR THE PURPOSES SPECIFIED IN FEDERAL LAW (42 CFR, SECTION 455).

1) Have you or any person who has ownership or control interest in your practice who is an agent or managing employee been convicted of a criminal offense related to the involvement of your practice in any program under Medicare, Medicaid or the Title XX services since the inception of those programs? (42 CFR §455.106) If yes, give the name(s) of person(s) and descriptions(s) of offenses(s). Please use additional pages if necessary.

☐ *Check this box if: there is not any known history of criminal offense as detailed above.*

Name	Social Security Number (9 Digits)	Individual Tax ID #	Individual NPI	Date of Birth	License #	Description

2) Federal regulation requires the following information to be disclosed on all managing employees. (42CFR §455.101) Please use additional pages if necessary.
A managing employee is a "general manager, business manager, administrator, director, officer, governing board member, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." (42 CFR section 455.101).

Name	Social Security Number (9 Digits)	Individual Tax ID #	Individual NPI	Date of Birth	License #	Address

3) Provide the name and address of each person or organization with a direct or indirect ownership or control interest of five percent or more (5%+) of your practice. (42CFR §455.104) Please use additional pages if necessary.						
Name	Social Security Number (9 Digits)	Individual Tax ID #	Individual NPI	Date of Birth	License #	Address

ATTESTATIONOFINFORMATION

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with Plan/Network. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.	
NAME, SIGNATURE AND TITLE OF INDIVIDUAL COMPLETING THIS FORM:	DATE:

Provider information form

PriorityHealth

Complete the applicable sections to add or make a change to a provider.
Save it for your records, then email to *PH-PELC@priorityhealth.com*.

Is this request for COVID-19 only? ☐ Yes ☐ No

About the provider			
Name/degree		Provider NPI	
DOB		Provider CAQH ID	
Gender		Provider specialty	
Race/ethnicity		Provider primary hospital*	
Group/facility name		Group/facility NPI	
Provider ID/vendor number		Primary billing taxonomy code	
Provider Michigan state license number			
Description of request			
Has the provider completed Cultural Competence training?		☐ Yes	☐ No

Physician organization (PO)/physician hospital organization (PHO)/Clinically Integrated Network (CIN)		
Is this provider a member of a PO, PHO, or CIN?	☐ Yes	☐ No
If yes, what is the PO, PHO or CIN you would like to be aligned to for contracting purposes?		

Contact/person responsible for completion of this form			
Name		Today's date	
Mailing address			
Phone number			
E-mail address			

Provider's practice setting			
Is the provider changing from a PCP to a specialist?	☐ Yes	☐ No	
Is the provider a hospitalist?	☐ Yes	☐ No	
Is this provider practicing exclusively within the hospital setting?	☐ Yes	☐ No	
Does this provider practice concierge medicine?	☐ Yes	☐ No	
Does this provider offer acupuncture services?	☐ Yes	☐ No	
Does this provider offer virtual visits?	☐ Yes, both virtual and physical	☐ Yes, virtual only	☐ No, physical only
Does this practice act as a Patient Center Medical Home?	☐ Yes ☐ No	If yes, which source designated the PCMH? ☐ PGIP ☐ TJC ☐ NCQA ☐ Other:	

Change a Provider's name, tax ID or NPI			
Current name		New name	
Current tax ID		New tax ID	
Current NPI		New NPI	
Current DBA name		New DBA name	

*Required field for all primary care providers and specialty care providers except DC's, OD's and BH APP's.

continued>

Change age panel limit

☐	Family practice (0-99+ years)	☐	General practice (0-99+ years)
☐	IM/peds (0-99+ years)	☐	Internal medicine (16-99+ years)
☐	Pediatrics (0-21 years)	☐	Gynecology (13-99+ years)
☐	OB/Gyn (13-99+ years)	☐	Other:

Product participation status

	Add new product	Term existing product	Reason for term existing product		
			Panel full	Part-time	Other
HMO	☐	☐	☐	☐	
PPO	☐	☐	☐	☐	
Medicaid*	☐	☐	☐	☐	
Are you requesting a new Medicaid contract for your group?			Yes ☐	No ☐	*If yes, you must attach a Medicaid Disclosure Form. (see page 6)
Medicare	☐	☐	☐	☐	

Product Open/Close Status (PCP only)

	Open to new members	Closed to new members	Reason for closing to new members		
			Panel full	Part-time	Other
HMO	☐	☐	☐	☐	
PPO	☐	☐	☐	☐	
Medicaid**	☐	☐	☐	☐	
**Do you participate with Children's Special Health Care Services (CSHCS)? If yes, complete the CSHCS Individual or Group Provider Attestation form. (see pages 7–8)					☐ Yes ☐ No
Medicare	☐	☐	☐	☐	

Demographic information (attach additional addresses to this form)

☐ **Add location** Must complete demographic information section in full				**Effective date**	
Group billing name (name on claim)					
Group "Name on the Door" of this location					
Practice website					
Address					
City		**State**		**Zip**	
County					
Phone				**Fax*** **	
Can Priority Health members call this phone number to make an appointment with the provider at this location?	☐ Yes	☐ No			
Address type	☐ Primary	☐ Secondary			
	☐ Billing/remit	☐ Tax (include updated W9)			
	☐ Other:				
Is this location an FQHC, RHC, or THC?	☐ No	☐ FQHC	☐ RHC	☐ THC	
Billing TIN					
Group billing NPI					
Provider's scope at this location	☐ PCP, physician	☐ Specialist, physician			
	☐ Hospitalist/rounding	☐ Assisting in surgeries			
	☐ APP/midlevel PCP	☐ APP/midlevel specialist			
	☐ Other:				

APP only

NPI of the supervising Priority Health participating physician with whom the APP holds a current practice agreement (also know as a collaboration agreement)		
How does the APP provider bill?	☐ Bills independently	☐ Bills under a supervising physician

continued>

Provider office hours (hours available for appointments)							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open – If blank, provider directory will read "Hours Vary"							
Closed – If blank, provider directory will read "Hours Vary"							
General office hours (building/facility open)							

Cross coverage (list covering providers)					
Name, title		**Specialty**			
Address		**Phone**			
Name, title		**Specialty**			
Address		**Phone**			
Name, title		**Specialty**			
Address		**Phone**			
If none, please explain					
Do you currently admit and care for your hospitalized patients?			☐ Yes	☐ No	
If no, explain the formal inpatient coverage arrangement you have for each inpatient facility.					

Type of change – Provider leaving a participating provider group of Priority Health Network. Priority Health requires a written notice 90 days in advance. Visit requirements and responsibilities in the provider center at www.priorityhealth.com for more information. (Attach additional addresses to this form)

Priority Health maintains that the primary care relationship resides between the member and the PCP. Members will remain with their current PCP as long as the change of location distance is less than 30 miles. When applicable, Priority Health will reach out to the provider group to determine where members should be transferred. Members will be transferred to a new PCP when any of the following reasons exist:

- Provider deceased or retired
- Provider changes from a PCP to SPC
- PCP moved out of current Priority Health Michigan service area or PCP moved greater than 30 miles from their current primary location
- PCP is no longer participating/contracted
- Age panel limit with member transfer
- Network termination due to sanction/license suspension

☐ **Remove location**	**Termination/effective date**				
Group billing name (name on claim)					
Group "name on the door" of this location					
Group TIN		**Type 2 NPI**			
Address					
City		**State**		**Zip**	
Reasons for leaving		☐ Deceased ☐ Leave of absence ☐ Retired ☐ Moving to another group ☐ Moving outside the service area ☐ Moving to another location under the same group			
PCP authorizing EOC?		☐ EOC terms accepted ☐ EOC terms refused			

continued>

Behavioral health providers only		
Type of practice	☐ Federally qualified health center	☐ Group practice
	☐ Facility	☐ Private practice
Accreditation(s)	☐ CARF	☐ COA
	☐ BCBA	☐ TJC/The Joint Commission
	☐ None	
Professional services	☐ Domestic violence	☐ Dual diagnostics
	☐ Gay/lesbian issues	☐ Post-traumatic stress disorder
	☐ Sexual trauma	☐ Transgender issues
	☐ Eating disorders	☐ Opiate addiction treatment
	☐ ADD/ADHD (criteria: Doctorate level, full licensure)	☐ Psychological testing (criteria: Doctorate level, full licensure)
	☐ EMDR (copy of certificate required)	☐ Neuropsychology (training and work experience required)
	☐ Autism	
Age panel	☐ Children (0 – 12 years) ☐ Adolescents (12 – 18 years) ☐ Adults (18 – 99 years) ☐ Other (specify):	

This section for facility or services only		
Are you submitting information on behalf of:	☐ Hospital	☐ Other healthcare organization
☐ Community-based health clinic (convenient care centers and walk-in clinics)	☐ Long term acute care	☐ Skilled nursing facility
☐ End stage renal dialysis	☐ Pathology	☐ Hospice
☐ Free standing ambulatory surgery facilities	☐ Urgent care facilities	☐ Laboratories
☐ Rural health clinic	☐ School-based health clinic	☐ Federally qualified health center
☐ Sleep disorder clinics (AASM accreditation is required)	☐ Retail health clinic	☐ Tribal health clinic
☐ Infusion (ambulatory, home) (Choose all that apply): ☐ Ambulatory infusion center ☐ Home infusion ☐ Home infusion with pharmacy	☐ Mental health (Choose all that apply): ☐ Behavioral analysis (BA licensure required) ☐ Inpatient services # of CMS beds: ☐ Residential ☐ Ambulatory services	☐ Home health care ☐ Do you offer telemonitoring services? ☐ Yes ☐ No
☐ Substance abuse (Choose all that apply): ☐ Behavioral analysis (BA licensure required) ☐ Inpatient services # of CMS beds: ☐ Residential ☐ Ambulatory services	☐ Rehab outpatient facilities (Choose all that apply): ☐ Behavioral analysis (BA licensure required) ☐ Occupational therapy ☐ Physical therapy ☐ Speech therapy	☐ Virtual Provider Group (Telemedicine)

continued>

Additional services – Select additional services that apply below		
☐ Ambulance	☐ Dialysis	☐ Prosthetics/orthotics
☐ Cardiac catheterization services	☐ Cardiac surgery program	☐ Critical care services/ICU
☐ Independent diagnosis services	☐ Durable medical equipment (Choose all that apply): ☐ Prosthetics/orthotics ☐ Bathroom safety bars	☐ Anesthesiology group
☐ Radiology/imaging centers (choose all that apply) ☐ Diagnostic radiology ☐ Mammography ☐ Therapeutic radiology		☐ Pathology group ☐ Emergency medicine group ☐ Health department ☐ Diabetes prevention program
☐ High tech services including: CT, MRI, PET etc. ☐ Yes ☐ No	☐ Centering Pregnancy:	☐ Audiology ☐ Hearing aid supplier ☐ Hearing screenings
Other:		

Provider information form acknowledgment – This form will be used as a supplement to the provider's Council for Affordable Quality Healthcare (CAQH) application.	
I consent to the release of this information to the Council for Affordable Quality Healthcare (CAQH), for the purpose of allowing Priority Health access to my information in the CAQH Universal Credentialing Data Source (UC). By signing this pre-application, I affirm that the information I have supplied is correct and complete; and that any misstatements in, or omissions from this pre-application may be cause for denial of credentialing. Provider agrees by submission of this request to abide by the terms of the Participation Agreement between Priority Health and the designated accountable care network entity listed on page 1.	
Physician/representative signature	Your typed name confirms your electronic signature.

Please mark any of the applicable forms listed below if you intend to attach them to your Provider Information form submission.

☐ W-9 form
☐ Medicaid Disclosure Requirement Form for Medicaid Network Providers
☐ CSHCS Provider Attestation form
☐ CSHCS Provider Group Attestation form

Send completed forms to:

Email: *PH-PELC@priorityhealth.com*
Attn: Credentialing and Provider Data Management department
Fax: 616.975.8857

**You must notify edisetup@priorityhealth.com for any fax number change where electronic claim receipt notices are sent.*

Verify all information is complete and any required supporting documentation is included. Incomplete forms and missing documentation create delays.

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Medicaid Disclosure Requirement Form for Medicaid Network Providers

Federal Regulation # 42 CFR §455.106(a), 42 CFR §455.101, and 42 CFR §455.104

Provider Group/Organization Name: _____

Provider Name: _____

Signature of person completing this form: _____ **Date:** _____

Does any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs?

☐ No

☐ Yes, if yes please list below:

	First name	Middle initial	Last name
1.			
2.			
3.			

Managing Employee Section

Please provide the name, Social Security Number, & home addresses for any employee who meets the definition of Managing Employee.*

	First name/Middle initial/Last name	Social Security Number	Home Address
1.			
2.			
3.			

Ownership Section

Please provide the name, Social Security Number, & home addresses for all owners with 5% or more ownership or control interest in the entity. (See 42 CFR §455.104)

	First name/Middle initial/Last name	Social Security Number	Home Address
1.			
2.			
3.			

* Managing employee is defined in 42 CFR §455.101 as a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day to day operation of an institution, organization or agency.

Priority Health 1231 E Beltline NE MS 2310 Grand Rapids, MI 49525 – Fax (616) 975-8857

Children's Special Health Care Services (CSHCS) Provider Attestation

The undersigned primary care physician hereby certifies as follows:

1. I currently serve children or youth with complex chronic health conditions.
2. My practice has implemented a procedure to identify children or youth with chronic health conditions.
3. My practice will provide expanded appointments when a child or youth patient has complex needs and requires more time.
4. My practice coordinates care for children or youth who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. My practice is open to (select one):
   - ☐ New patients (children or youth) with complex chronic health conditions.
   - ☐ Existing patients (children or youth) with complex chronic health conditions.

Date: _____

Signature: _____
Print Name: _____
NPI number: _____

PriorityHealth

Children's special health care services (CSHCS) provider group attestation

The undersigned single signature authority hereby certifies that Physicians within _____ (Group Name):

1. Currently serve children or youth with complex chronic health conditions.
2. Their practices have implemented a procedure to identify children or youth with chronic health conditions.
3. Their practices will provide expanded appointments when a child or youth patient has complex needs and requires more time.
4. Their practices coordinate care for children or youth who receive services from multiple professionals including, but not limited to, pediatric subspecialists, physical therapists and mental health professionals.
5. My practice is open to (select one):
   - ☐ New patients (children or youth) with complex chronic health conditions.
   - ☐ Existing patients (children or youth) with complex chronic health conditions.

Date: _____

Signature: _____
Print Name (Single Signature Authority)**:** _____
NPI number: _____

PriorityHealth®

PHYSICIAN ACKNOWLEDGEMENT OF
PHYSICIAN ORGANIZATION PARTICIPATION AGREEMENT

The undersigned physician hereby certifies as follows:

1. I am a member in good standing of the Professional Medical Corporation P.C. (PO)

2. I am duly licensed to practice medicine in the State of Michigan.

3. All information provided to Priority Health; Priority Health Managed Benefits, Inc.; Priority Health Government Programs; or Priority Health Insurance Company (collectively "Priority Health") with respect to my qualifications is accurate and complete.

4. I agree that Priority Health together with authorized regulatory agencies may inspect, review and copy records or reports in my possession concerning services provided to Members.

5. I agree to comply with Priority Health's quality assurance activities.

6. I agree to comply with the Medicare requirements listed in Attachment A, if the Medicare product is indicated below in section 8.

7. I agree to look solely to Priority Health for payment of services rendered pursuant to the Agreement (defined below). I further agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member, with respect to Covered Services provided to a Member, except to the extent that the applicable Plan specifies a copayment or deductible or as permitted under the Coordination of Benefits Act. I further agree not to maintain any action at law or in equity against a Member to collect sums that are owed to me under the terms of the Agreement, even if Priority Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of the Agreement. This section will survive termination of the Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. The parties do not intend this section to apply to the collection of sums that are owed to me for services provided after the Agreement has terminated, except as otherwise provided in the Agreement, or to services that are not Covered Services or to copayments, coinsurance or deductibles. I further agree that this provision supersedes any oral or written agreement hereinafter entered into between me and a Member or a person acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of the Agreement.

8. I agree to all of the terms and conditions of the Physician Organization Participation Agreement(s) between Priority Health and Physician Organization with respect to the following products: HMO, PPO, and Medicare (the "Agreement"). Capitalized terms used herein and not otherwise defined carry the meanings given them in the Agreement.

Date: _____ By: _____

Print Name: _____

Medicare Number: _____

ATTACHMENT A

1. Activities and Responsibilities of Physician. Physician shall provide services as described in the Agreement.

2. Hold Harmless. Group Physician agrees that it, he or she will hold Members harmless from payment obligations that are the legal obligation of Priority Health and shall not look to Members for payment for Covered Services rendered to a Member.

   (a) Physicians agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, attempt in any way to hold a Member liable or have any recourse against a Member or persons acting on behalf of Member for payment of any fees for covered services that are the responsibility of Priority Health, except to the extent that the Plan specifies a copayment, coinsurance or deductible or as permitted under Coordination of Benefits statutes, rules, and regulations. Members shall not have copayments or other cost-sharing imposed upon them for influenza or pneumococcal vaccine Covered Services.

   (b) Physician agrees not to maintain any action at law or in equity against a Member to collect sums that are owed to Physician under the terms of this Agreement, even in the event Priority Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This section will survive termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. Physician further agrees that this provision supersedes any oral or written agreement hereinafter entered into between Physician and Member or person acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement.

   (c) Physician agrees not to charge Members for services other than Covered Services unless:

      (i) the Member has been informed in writing prior to receiving the services that the services are not covered under the Plan, and

      (ii) the Member has agreed in writing to pay for such services on such forms as may be required by Priority Health from time to time.

3. Record Keeping. Physician will maintain medical, financial, and administrative records concerning Covered Services provided to Members and will keep these records for at least 10 years from the date Physician rendered the Covered Services.

   (a) Physician shall maintain such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Amendment. Physician will make available to Plan and CMS, or their designees, all records, including without limitation, prescription dispensing records, reports of service plan reports or complaints, grievances, quality and utilization data for fiscal audit, quality, utilization and risk management, and other periodic monitoring upon request of authorized representatives of Plan and authorized federal and state regulating agencies.

   (b) Physician agrees that Plan, CMS, U.S. Department of Health and Human Services ("HHS"), the Comptroller General of HHS, or their designees (the "Entities") may audit, evaluate or inspect any records of Physician, any treating entity, contractor, subcontractor, or transferee that pertain to any aspect of the services performed under this

Amendment, reconciliation of benefit liabilities and determination of amounts payable, or as the Entities may deem necessary (the "Treatment Records"). The right of the Entities to audit, evaluate, or inspect extends to ten (10) years after the date of services or after termination of the CMS Contract. Physician agrees to make available its physical premises, facilities, equipment, and all Treatment Records or additional information the Entities may require.

(c) Physician shall safeguard the security and privacy of Member information and records as required by federal and state law and regulations, including but not limited to the confidentiality and security provision stated in 42 CFE 423.136 and the applicable provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), which require reasonable administrative, technical, and physical safeguards to ensure the integrity and confidentiality of Member information. Physician will only use and release such information to third parties in accordance with HIPAA and applicable federal and state statutes, rules, and guidance or pursuant to court order or subpoena. Physician shall have procedures that specify for what purposes Member information will be used by Physician and to whom and for what purposes Physician will disclose Member information. Physician acknowledges that no formal consent is necessary for Physician to provide information to Plan for purposes of payment, treatment, or healthcare operations.

(d) Physician shall grant Members access to their records in accordance with applicable state and federal law, including right to review, request to amend, and obtain a copy.

(e) Physician acknowledges that the CMS Contract requires Plan to submit to CMS all data necessary to characterize the context and purposes of each encounter between a Member and Physician, to certify the accuracy, completeness, and truthfulness of such data, and submit prescription records for validation of any such data. Physician agrees to cooperate with and assist Plan in meeting this requirement under the CMS Contract. Physician agrees that each time it submits a claim to Plan for services rendered hereunder, Physician is certifying the accuracy, completeness, and truthfulness of the claim. Physician agrees to submit records to Plan, CMS, or their designees if requested to validate any claims submitted and being adjudicated.

4. Delegation. Physician agrees not to delegate any professional duties under this Agreement to any subcontractor without the approval of Plan. Upon Plan's approval, Physician shall submit to Plan credentials for Physician to whom professional duties may be delegated. Physician acknowledges and agrees that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a written agreement with Physician will be consistent and comply with Plan's obligations under the CMS Contract. Physician also acknowledges and agrees that if any of Plan's activities or responsibilities under the CMS Contract are delegated to Physician or other parties, all delegation requirements under applicable federal regulations must be met and Plan must oversee and remain accountable to CMS for any delegated functions. Plan shall monitor the performance of Physician. Plan retains all its legal remedies, including the right of revocation, if the activities are not performed satisfactorily.

5. Prompt Payment. For timely submitted clean claims, Priority Health will make or deny payment within thirty (30) days. Such thirty (30) day time period will begin when Priority Health receives a Clean Claim from Physician or Physician's agent, including all required supporting documentation. Plan will reimburse Physician at the applicable rates as set forth in the Agreement's Exhibit A.

6. Compliance With Laws. Physician acknowledges and agrees that payments received from Plan are, in whole or in part, federal funds. As a recipient of federal funds, Physician shall comply with all applicable state and federal laws, rules, and regulations in effect or as hereinafter

amended applicable to recipients of federal funds including the following: (a) Title VI of the Federal Civil Rights Act; (b) Section 403 of the Federal Rehabilitation Act of 1973; (c) the Federal Age Discrimination Act of 1975; (d) Titles I and II of the Federal Americans with Disabilities Act; (e) Section 542 of the Federal Public Health Service Act (pertaining to nondiscrimination against substance abusers); (f) 45 CFR part 46, pertaining to research involving human subjects; and (g) all Medicare laws, regulations and CMS instructions and requirements of the CMS Contract. Both parties agree to comply with all state and federal laws, rules, and regulations applicable to the provision of Covered Services to Members.

7. Accountability. Plan oversees and is accountable to CMS for any functions or responsibilities that are described in 42 CFR 422.502.

8. Reporting Requirements. Physician understands that the Plan is required by CMS to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data, including encounter data. Physician agrees to submit all complete and accurate data necessary for the Plan to fulfill their obligations within the timeframes as specified by the Plan.

9. Benefit Continuation. In the event of termination of this Agreement Priority Health shall arrange for, and Physician shall cooperate with, the orderly transfer of all Members then under the care of the Physician:

(a) At Priority Health's option Physician will continue to provide Covered Services to Members who are in Active Treatment at the time of termination until the "End Date", which shall be the date upon which both: (i) the Member is no longer in Active Treatment; and (ii) Priority Health assigns such Members to another Participating Provider. For purposes of this Section, a Member shall be considered to be in "Active Treatment" if he or she is: (a) hospitalized; (b) undergoing treatment; or (c) in the second or third trimester of pregnancy through the completion of normal post-partum care. Both parties will comply with the terms of this Agreement while the Member is in Active Treatment until the End Date, except that Priority Health shall compensate Physician in accordance with the standard Original Medicare rates, or an amount agreed to by both parties. Physician shall notify affected Members and/or their employer groups of termination and obligations of Physician following termination as described in this Section.

(b) Upon termination, Physician shall promptly supply to Priority Health all information necessary for the reimbursement of any outstanding claims.

(c) Upon termination, Physician shall continue to provide Covered Services to Members until the end of the period for which Priority Health has received premiums from CMS.

(d) In the event of the insolvency of Priority Health, Physician shall continue to provide Covered Services to hospitalized Members through discharge.

10. Exclusion of Services. Physician who has not been excluded from any federal healthcare program, and has not opted out of Medicare. Physician shall not employ or contract with any individual who is excluded from participation in the Medicare program, and acknowledges and agrees that Priority Health may immediately terminate this Agreement should Physician or any employee, contractor, or agent of Physician lose Medicare certification or be excluded or otherwise fail to participate in the Medicare program.