INDIVIDUAL PHYSICIAN ADDENDUM

The undersigned health care Physician ("Physician"), a member of _____. ("Entity"), acknowledges and represents that Entity is his/her attorney-in-fact for the purposes of negotiating, consenting to and executing the Physician Group Agreement (the "Agreement"), between Aetna Health Inc., an Ohio corporation ("Company") and Entity and any documents related to amendments to the Agreement. Terms capitalized herein but not otherwise defined shall have the meanings ascribed to them in the Agreement.

Physician hereby acknowledges that Physician has had the opportunity to review the Agreement, under which Entity, on behalf of Physician, agrees to participate in Company's provider networks and provide Covered Services to Members enrolled in the Plans. Physician hereby agrees to be bound by the terms and conditions of the Agreement, including, without limitation, compliance with the Participation Criteria applicable to Physician and all applicable Company rules, policies and procedures.

Physician hereby agrees that in the event: (i) Physician ceases to be a member of Entity; (ii) the Agreement expires or is terminated for any reason; (iii) the Entity is dissolved; (iv) a voluntary or involuntary bankruptcy or a proposed settlement of outstanding debts under applicable reorganization or insolvency laws is filed by or against Entity, a receiver is appointed or Entity makes an assignment for the benefit of creditors; or (v) the Entity otherwise ceases to exist, either voluntarily or involuntarily, the terms of the Agreement shall, at Company's option, survive with respect to Physician for the first six (6) months after such event ("Continuation Period"), in which case Physician shall continue to provide services to Members in accordance with the terms of the Agreement during the Continuation Period and compensation during the Continuation Period shall be at the then current Aetna Market Fee Schedule (AMFS). AMFS is the Company's fee schedule, updated annually, that is based upon the contracted location where service is performed.

With the exception of services provided to Members during the Continuation Period (when Physician will bill Company directly), Physician hereby agrees to seek compensation solely from Entity for services rendered to Members under the terms of the Agreement, and shall in no event bill Company, Payors, or Members for any such services (except for any Copayments, Coinsurance or Deductibles Members may be required to pay for certain Covered Services). Physician further agrees that in no event, including but not limited to non-payment by Company, insolvency of the Company or breach by Company of the Agreement, shall Physician bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons acting on Member's behalf for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles. Physician further agrees that this provision shall be construed for the benefit of Members, shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Physician or Entity and a Member or any person acting on behalf of a Member, and shall survive the termination of the Agreement, regardless of the cause giving rise to termination.

Company, Group and Physician desire to promote continuity of care. Accordingly, upon expiration or termination of the Continuation Period for any reason, Physician agrees to provide Physician Services at Company's discretion to: (a) any Member under a Physician's care who, at the time of the expiration or termination is a registered bed patient at a Participating Facility until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Plan Sponsor for one (1) calendar year.

IN WITNESS WHEREOF, the undersigned has executed this Individual Physician Addendum as of this ___ day of _____, 2014, intending to be legally bound hereby.

PHYSICIAN: _____

PRINTED NAME: _____

Individual name, address, and social security number

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

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

Requester's name and address (optional)

City, state, and ZIP code

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 the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
			–		–				

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 on page 3.

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

General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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.

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.

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

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

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

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

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

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

Notwithstanding the foregoing, application or approval for membership as a Class A Member shall not prevent me from participating in or with any other preferred provider organizations, independent practice associations, third party payors, or healthcare service contracts.

PROVIDER	PHYSICIAN HOSPITAL ALLIANCE
_____	By: _____
Name:	Patrick Kenrick, President
Date: _____	Date: _____

Medical Mutual of Ohio

NETWORK COVERAGE AGREEMENT

(Please return completed form with Original Letter)

Attention: Credentialing Committee

This letter is to inform you that I, _____, do not have admitting privileges at any **Company network hospital**. I attest that I did not voluntarily surrender my hospital privileges, either while under investigation, or to avoid investigation for possible professional incompetence or improper conduct. In addition, I have not voluntarily surrendered my hospital privileges in return for not conducting an investigation or professional review action. I attest that I have not had my hospital, clinical and/or admitting privileges suspended, denied, diminished, revoked, or not renewed for any reason, other than medical records violations at any facility.

Should one of my Company-insured patients require inpatient or outpatient services, I understand and agree that I am contractually obligated to make arrangements for such services to be performed at a network facility. Further, when inpatient services are required, I understand and agree that I am contractually obligated to arrange for such admittance through a network provider.

I understand that noncompliance with this Agreement could adversely affect my network status, or result in termination of my agreements, with the Company.

Sincerely,

_____ Date _____

Provider's Signature

_____

Printed Name

Credentials Attestation, Authorization and Release

I acknowledge and agree that Health Net Federal Services, LLC (Health Net) has a valid interest and legal requirement to obtain and verify information concerning my professional competence, therefore:

1. I authorize Health Net and/or any entity with which it may contract for verification services to consult with hospital administrators, physicians, malpractice carriers and other persons or entities to obtain and verify information concerning my professional competence, character, moral and ethical qualifications. I release Health Net and its employees, managers, agents and consulting committees form any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluating such information.

2. I consent to and authorize the release by any person or entity to Health Net of all information and documents that may be relevant to an evaluation of my professional competence, character, morality and ethical qualifications, including any information or material relating to any disciplinary or criminal action, professional competence, suspension or curtailment of medical or surgical privileges (including malpractice claims and/or coverage). I hereby release any such person or entity providing such information from any and all liability for doing so. If I have contracted with a medical group, Individual Physician Association or similar entity as a participating provider with Health Net or such other health plans, they also may receive the credentialing information or quality assurance data relating to me.

3. I understand that I have the burden and legal responsibility of providing adequate information to Health Net to demonstrate my professional competence, character, moral ethics and other qualifications.

4. I attest to the fact the information submitted by me in this application is true, correct and complete to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from, this application may constitute cause for denial of participation or cause for summary dismissal from the Health Net Provider Network, or be subject to applicable state or federal penalties for perjury.

5. If any material changes occur affecting my professional status, I agree to notify Health Net within five days, as per Section 2.16 of the Professional Provider Agreement.

6. I have attached my Professional Liability Insurance (PLI) with this form, or I have posted a current copy of my PLI on CAQH, which expires:

Note: Application will be returned if there is no current copy of PLI on CAQH.

Date of Professional Liability Insurance Expiration

Provider Name
(Type or use block print)

Provider Signature

Date

Note: Must be signed and dated within 30 days of submittal.

Print Form

SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R. 424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Authorized or Delegated Official of Group Practice/Clinic

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

Section 4 – Provider information questions and answers

Answer the questions below. Please explain any yes answer in the space below. Attach a separate sheet if needed. All yes answers must have a written explanation.

1. Have you ever been or are you now dependent on, impaired by, being treated for alcohol or any other drug substance? ☐ Yes ☐ No
2. Do you have any emotional or physical disabilities or impairments that may limit your ability to practice, or that may jeopardize a patient's health? ☐ Yes ☐ No
3. Have you ever (submit five-year history) had a malpractice judgment entered against you, have any pending malpractice suits against you in any court proceeding or arbitration hearing, or have you ever been a party to an out-of-court settlement involving actual or claimed malpractice? ☐ Yes ☐ No
4. Have you ever voluntarily surrendered or had your license or certificate to practice suspended, revoked or denied, or subject to disciplinary restrictions, (including but not limited to disciplinary restrictions related to chemical dependency or substance abuse) that affect your ability to treat patients or that compromise patient care? ☐ Yes ☐ No
5. Have you ever been subject to disciplinary action by any state or local medical society, state board of medical examiners or any other professional organization? ☐ Yes ☐ No
6. Have you ever been excluded or removed from participation in Medicare or Medicaid? ☐ Yes ☐ No
7. Have you ever been excluded or removed from participation in any other health-care plan or third-party payer (i.e. HMO, PPO) for cause? ☐ Yes ☐ No
8. Have you ever had your hospital privileges suspended, restricted, revoked or denied for cause? ☐ Yes ☐ No

Do you have a history of:

9. A felony conviction in any jurisdiction; a conviction under a federal controlled substance act; a conviction for an act involving dishonesty, fraud, or misrepresentation; a conviction for a misdemeanor committed in the course of practice or involving moral turpitude; or court supervised intervention or treatment in lieu of conviction pursuant to Section 2951.041 of the Ohio Revised Code or the equivalent law of another state (including expunged convictions); ☐ Yes ☐ No
10. A conviction or plea of guilty to a violation of Sections 2913.48 (workers' compensation fraud) or 2923.31 to 2923.36 (corrupt activity) of the Ohio Revised Code; or any other criminal offense related to the delivery of or billing for health-care benefits by the provider, or any person having a 5 percent or greater ownership interest in the provider, or an officer, authorized agent, associate, manager, or employee of the provider (including expunged convictions); ☐ Yes ☐ No
11. An entry of judgment against the provider, or its owner, or an officer, authorized agent, associate, manager, or employee with proof of the specific intent of the provider, or any person having a 5 percent or greater ownership interest in the provider, or an officer, authorized agent; associate, manager, or employee of the provider, in a civil action involving payment by deception brought pursuant to Section 4121.444 of the Ohio Revised Code; ☐ Yes ☐ No
12. An entry of judgment against the provider, or any person having a 5 percent or greater ownership interest in the provider, or an officer, authorized agent, associate, manager, or employee of the provider in a civil action brought pursuant to Sections 2923.31 to 2923.36 (corrupt activity) of the Ohio Revised Code? ☐ Yes ☐ No
13. Do you refer patients for testing or treatment to any facility with which you or an immediate family member have a 5 percent or greater ownership or investment interest, or a compensation arrangement? ☐ Yes ☐ No
14. I am accepting: new ☐ (or) existing patients only ☐ in my practice.

Explanation: _____

Contact person *(person completing form)*		Title
Telephone number ( )	Fax number ( )	Email address

Section 5 – Provider application/agreement

By signing this application/agreement, the provider agrees to, and may be decertified pursuant to Ohio Administrative Code (OAC) 4123-6-02.5 and OAC 4123-6-17 for failure to adhere to conditions below.

Provider agrees to abide by the Ohio Revised Code (ORC) and rules promulgated thereunder by BWC and the Industrial Commission of Ohio. In addition, provider agrees to accept and abide by all billing and/or other policies, procedures and criteria as set forth and amended from time to time in BWC's *Provider Billing and Reimbursement Manual*, which is incorporated by reference into this application/agreement, and all other terms of this application/agreement.

Provider agrees to notify BWC within 30 days of any change in the provider's business address/location, business name, National Provider Identifier (NPI) number, Social Security number (if applicable), employer ID number, tax identification number and/or ownership, or any change in the provider's status regarding any of the credentialing criteria of paragraphs (B) or (C) of OAC 4123-6-02.2.

Provider agrees to provide health services that are applicable to a work-related injury and not to substantially engage in the practice of experimental modalities of treatment; provide adequate on-call coverage for patients; use BWC-certified providers when making referrals to other providers; and timely schedule and treat injured workers to facilitate a safe and prompt return to work.

Provider agrees to practice in a managed care environment and to adhere to managed care organization (MCO) and BWC procedures and requirements concerning provider compliance, outcome measurement data, peer review, quality assurance, utilization review, bill submission, dispute resolution and reporting of injuries and occupational diseases of employees.

Section 5 – Provider application/agreement (cont.)

Provider agrees to acknowledge and treat injured workers in accordance with BWC recognized treatment guidelines and the vocational rehabilitation hierarchy, adhere to BWC's confidentiality and sensitive data requirements, and to use information obtained from BWC by means of electronic account access for the sole purpose of facilitating treatment and no other purpose, including but not limited to engaging in advertising or solicitation directed to injured workers.

Provider agrees to maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable. Provider agrees to maintain adequate, current professional malpractice and liability insurance (commercial liability insurance if applicable).

Provider agrees to bill BWC, self-insuring employer, appropriate certified MCO and/or qualified health plan (QHP) in accordance with the statute of limitations only for services and supplies that the provider has delivered, rendered or directly supervised and that are medically necessary, cost-effective and reasonably related to the claimed or allowed condition related to the industrial injury or occupational disease. Provider understands BWC, self-insuring employer, appropriate certified MCO and/or QHP does not reimburse for failed or missed appointments (no-shows).

Provider agrees to charge BWC, self-insuring employer, appropriate certified MCO and/or QHP no more than the usual fee billed non-industrial patients for the same service. Provider further agrees not to seek additional payment from the injured worker or employer for the difference between the amount allowed and the provider's billed charge when a provider's fee bill for services or supplies has been approved for payment by BWC, self-insuring employer, appropriate certified MCO and/or QHP. Provider agrees to assume responsibility for the accuracy of all bills submitted for payment to BWC, self-insuring employer, appropriate certified MCO and/or QHP by provider, or any employee or agent of provider.

Provider agrees to create, maintain and retain sufficient records, papers, books and documents in such form to fully substantiate the delivery, value, necessity and appropriateness of goods and services provided to injured workers under the Health Partnership Plan (HPP) or of significant business transactions, as provided by OAC 4123-6-45.1. Provider further agrees to make such records available for review by BWC, self-insuring employer, appropriate certified MCO and/or QHP within 30 days or such time as agreed to by the parties, in accordance with OAC 4123-6-45.

Provider agrees to keep injured worker patient records (including but not limited to those records set forth under OAC 4123-6-45.1) confidential, and to maintain the confidentiality of injured worker patient records in accordance with all applicable state and federal statutes and rules, and prevent such information from further disclosure or use by unauthorized persons.

If the provider is of a type listed in Section 1 as requiring malpractice and liability insurance coverage, provider attests that it presently has adequate, current malpractice and liability insurance, and that it shall maintain such coverage at all times during the course of this contract. Provider agrees to provide proof of such coverage to BWC upon request.

Conflict of interest and ethics law compliance certification

Provider affirms it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict, in any manner or degree, with the performance of services that are required to be performed under this contract. In addition, provider affirms a person who is or may become an agent of provider not having such interest upon execution of this contract shall likewise advise BWC in the event it acquires such interest during the course of this contract.

Provider agrees to adhere to all ethics laws contained in chapters 102 and 2921 of the ORC governing ethical behavior, understands such provisions apply to persons doing or seeking to do business with BWC and agrees to act in accordance with the requirements of such provisions; and warrants that it has not paid and will not pay, has not given and will not give, any remuneration or thing of value directly or indirectly to BWC or any of its board members, officers, employees, or agents, or any third party in any of the engagements of this contract or otherwise, including, but not limited to a finder's fee, cash solicitation fee, or a fee for consulting, lobbying or otherwise.

Certification statements

I certify the information submitted by me in this application is true, accurate and complete to the best of my knowledge and belief, and that the application is without misrepresentation, misstatement or omission of a relevant fact, or other acts involving dishonesty, fraud, or deceit.

I hereby authorize BWC to consult with persons, companies, governmental authorities, organizations and others who may have any information or documents regarding my character, background qualifications, professional competence and credentials. I hereby consent to the release of any such information or documents to BWC for purposes of its evaluation of me in connection with the HPP.

I hereby release from liability any such person, company, government authority, organization and others that provide information as part of this credentialing process.

Any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled is subject to a felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Applicant signature ***(Required)***	Date
Please print or type name	

Ohio | **Bureau of Workers' Compensation**

30 W. Spring St.
Columbus, OH 43215-2256

Request to Change Provider Information

Instructions

- **Please print or type.**
- **Return completed form to: Ohio Bureau of Workers' Compensation, Provider Enrollment Unit, P.O. Box 15249, Columbus, OH 43215-0249, or submit by fax: 614-621-1333**

Questions?

Call **1-800-OHIOBWC** to reach BWC's provider relations department

Points to review before completing this form

- You must determine if you are updating an individual person's provider number or a business/organizational provider number, and complete a separate form for each number to be updated. Submit National Provider Identifier (NPI) verification if applicable.
- Business/Organization providers:
  - If you have a new tax ID without change of ownership, complete this form and send us a new W-9 Internal Revenue Service (IRS) form for our records. This form is found at **www.irs.gov/pub/irs-pdf/fw9.pdf.** Include the date former number became invalid, and the date new number became effective. (Note: no bills will be payable for dates of service after the termination date of the previous provider number).
  - If you are new owners of a tax ID already established in our database, please complete a new provider application (MEDCO-13 or MEDCO-13A) for our files to show authorized agreement signature and ownership information. You do not need to complete this form.

Date effective	New tax identification number ☐ or Social Security number ☐ *(Attach a copy of the IRS form W-9. This number will be used for IRS purposes).*
Legal name associated with tax identification number *(Must appear as recognized by the IRS)*	
DBA name of group/business or individual provider name	
Business type ☐ Individual ☐ Sole proprietor ☐ Partnership ☐ Corporation ☐ S Corporation ☐ LLC ☐ Non-profit	
NPI number *(attach Fox Systems, Inc. verification)*	Taxonomy code *(attach Fox Systems, Inc. verification)*

Previous demographic information

Current BWC provider number	Date no longer valid	
Previous owner name(s)		
Practice location street address *(Indicate the address where you render services, including suite, floor, etc. We will accept a P.O. Box only if you include additional street address information.)*		
City, State, ZIP code		
Telephone ( )	Fax ( )	E-mail address
Reimbursement address *(Indicate the address to which we should send all payments, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		
Correspondence address *(Indicate the address to which we should send all correspondence, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		

New information

New owner name(s)		
Practice location street address *(Indicate the address where you render services, including suite, floor, etc. We will accept a P.O. Box only if you include additional street address information.)*		
City, State, ZIP code		
Telephone ( )	Fax ( )	E-mail address
Reimbursement address *(Indicate the address to which we should send all payments, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		
Correspondence address *(Indicate the address to which we should send all correspondence, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		

Applicant or authorized personnel signature ***(Required)*** Reimbursement change information requires provider's signature	Title
Please print or type name	Date

Mount Carmel Health Plan, MediGold
6150 E Broad St. Ste EE320
Columbus, Ohio 43213

Re: Inpatient Coverage

In the event of a planned admission, I understand that it is my responsibility to refer patients to an approved Mount Carmel Health Plan (MCHP) MediGold Network Provider or to hospitalist (s) who currently maintain (s) admitting/clinical privileges at a participating MediGold hospital or medical facility.

_____/_____
Physician Signature Date

_____
Print Name