EmpowerChiro
A Family Health America Company

Preferred Provider Application

FULL NAME ______________________________ **GENDER** M / F **DOB** ____________________
SS#______________________ **MEDICARE#**____________________ **MEDICAID#**____________________
NPI INDIVIDUAL#______________________________ **NPI GROUP#**______________________________
PRIMARY E-MAIL ______________________________ **WEBPAGE:** ______________________________

#1 W9/LEGAL BUSINESS NAME		#2 W9/LEGAL BUSINESS NAME	
TAX ID #		TAX ID #	
ADDRESS		ADDRESS	
CITY		CITY	
COUNTY/STATE/ZIP		COUNTY/STATE/ZIP	
PHONE #	FAX #	PHONE #	FAX #
CONTACT PERSON		CONTACT PERSON	
CONTACT EMAIL		CONTACT EMAIL	
OFFICE HOURS		OFFICE HOURS	
BILLING ADDRESS		BILLING ADDRESS	
CITY		CITY	
STATE/ZIP		STATE/ZIP	
PHONE #	FAX #	PHONE #	FAX #
BILLING CONTACT PERSON		BILLING CONTACT PERSON	
BILLING EMAIL		BILLING EMAIL	

PRACTICE INFORMATION (Please "x" and complete as appropriate.)

List some of the techniques and special services you provide: ______________________________
What language, other than English, is spoken in your practice? ______________________________
Are you accepting new patients? ____ Yes ____ No Do you accept walk-ins? ____ Yes ____ No
Can you see emergency care patients immediately, urgent care patients w/in 24 hrs & symptomatic patients w/in 72 hrs? ___Yes ___ No
Can you see patients at your primary location at least 20 hours per week on at least 4 days of the week? ___ Yes ___ No
Do you rent office space to other types of providers? ___ Yes ___ No - If Yes, do you refer patients to these providers? ___ Yes ___ No
If Yes, how often do you refer? ___ occasionally ___ frequently - Do any MDs have an equity position in your practice? ___ Yes ___ No

EDUCATION

Chiropractic College Name ______________________________ Mo/Yr graduated ____________
Address/City/State/Zip ______________________________
My college was accredited by:
___ Chiropractic Council on Education (CCE) ___ Straight Chiropractic Standards Association (SCSA)
___ Other ______________________________

EMPLOYMENT HISTORY (Please list all employers for the past 5 years including any jobs held prior to chiropractic education/employment. ALL gaps in employment must be explained. Attach additional pages as needed.)

Name of Employer	City/State	Dates of Employment (Mo/Yr)
____________________	____________________	_____/_______ to _____/_______
____________________	____________________	_____/_______ to _____/_______
____________________	____________________	_____/_______ to _____/_______
____________________	____________________	_____/_______ to _____/_______

LICENSURE (Complete for all current and past licenses.)

State	License #	Effective Date/Expiration Date
_________	____________________	______________ / ______________
_________	____________________	______________ / ______________
_________	____________________	______________ / ______________

APPLICATION CONTINUED ON THE NEXT PAGE →

MALPRACTICE COVERAGE (Answer all questions. Do not leave blanks.)

Current Insurance Company ____ Policy # ____________________________
Insurer's City/State/Zip ____Coverage Amount _________/_________ Exp Date _______
Does your malpractice insurance policy cover ALL types of treatment that you provide? ___ Yes ___ No
If No, what types of treatment are not covered? (i.e., acupuncture, herbology, etc.) ____
Have you had your malpractice insurance through any other insurance company in the past 5 years? ___ Yes ___ No
If yes, list the other malpractice companies along with the policy numbers and effective dates: _____________________________________
____
Other than at your request, have you ever had a policy canceled by an insurance company? ___ Yes ___ No
If yes why? ____

OTHER INFORMATION (Please x "Yes" or "No". IF "YES", EXPLAIN ON A SEPARATE SHEET!)

_____ Yes _____ No Is your license currently encumbered?
_____ Yes _____ No Have you ever had a complaint filed against your license or been subject to investigation or disciplinary review by your state licensing board, county, state or professional society?
_____ Yes _____ No Have you ever had any malpractice suits filed against you, including any settled out of court?
_____ Yes _____ No Have you ever been excluded from receiving payments from Medicare/Medicaid?
_____ Yes _____ No Have you ever been excluded from receiving Federal contracts, certain subcontracts and/or certain types of Federal financial and non-financial assistance and benefits?
_____ Yes _____ No Have you ever been barred from entering the United States?
_____ Yes _____ No Have you ever been suspended or expelled from a PPO, HMO or IPA?
_____ Yes _____ No Have you ever been convicted of a felony crime or a moral crime?
_____ Yes _____ No Has your employment as a Chiropractor ever been terminated or have you had your privileges reduced due to substandard care, incompetence or misconduct?
_____ Yes _____ No Do you have any current or past physical, mental/emotional or drug abuse problem(s) that with or without accommodations would impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health and safety of your patients?

AUTHORIZATION, ATTESTATION AND RELEASE

I authorize the investigation of and release to Family Health America LC (FHA) aka EmpowerChiro and its representative from any entity or third-party source, the following information: Verification of all information on this application, including but not limited to, details regarding my education, work history, state licensure (including any disciplinary actions, suspensions or any curtailment of my professional activities), professional liability insurance, past and present, including coverage verification, a declaration page showing all applicable endorsements, claims history and certificate of insurance. Please name FHA as a certificate holder on my insurance policy. (As a certificate holder, we receive notification of any policy changes, i.e., cancellation or limit increases/decreases. FHA has no other rights in regards to the policy except to receive notification of any policy changes.) I release all persons/entities providing such information from any liability for doing so and agree that any information obtained for the credentialing/recredentialing process is not a violation of privacy. I hereby certify that the information provided by me is current, true, correct and complete to the best of my knowledge and belief, and is furnished in good faith.

PROVIDER SIGNATURE ____DATE _______________
PRINTED NAME ____
OFFICE ADDRESS ____ CITY/STATE/ZIP ________________________

REQUIRED DOCUMENTS (MUST BE RETURNED)

______ Completed EmpowerChiro Preferred Provider Application (typed or in black ink)
______ Signed and dated EmpowerChiro Family Health America LC Provider Agreement (including VA PCCC Amendment to Group Practitioner Agreement and VA PCCC Amendment to Individual Practitioner Agreement)
______ Copy of Doctor of Chiropractic college diploma ___ **If your diploma is framed and cannot be copied, please "X" this space.**
______ Copy of current state chiropractic license with expiration date (all states you hold a license)
______ Copy of malpractice liability insurance declaration page with effective dates and amount of coverage including any exclusion(s)
______ Current W9 Form
______ If you are licensed or certified in any of the following areas, please "X" appropriate area and **include a copy of your certificate(s).**
___ Acupuncture ___ Massage Therapy ___Nutrition ___ Naturopathy ___Herbology ___Other ______________________

STOP HERE! If any of the above requested materials are not returned with your application or your application is NOT completely filled out your application will automatically be DENIED! ***Please return application and required documents to:***

EMPOWERCHIRO | 7309 E 21st ST N STE 110 | WICHITA KS 67206 | PH 800-819-9571 | FX 316-687-2113 | help@empowerchiro.com

EmpowerChiro, a Family Health America Company
Family Health America L.C. Provider Agreement

This Agreement is entered into by and between Family Health America, L.C., also doing business as "EmpowerChiro", (hereinafter referred to as "EmpowerChiro" and ______________________________, a duly licensed chiropractor (hereinafter referred to as "Chiropractor") in the state of ____________________________.

Whereas, EmpowerChiro was created for the purpose of entering into health service agreements with a variety of types of entities which may include preferred provider organizations, insurers, employers, third party payers, health maintenance organizations and capitated and non-capitated health plans among others (hereinafter referred to as "Health Plans"); and

Whereas, Chiropractor desires to participate as an independent practitioner in the EmpowerChiro provider network (hereinafter referred to as "Chiropractor Panel") and to provide services for members covered in the above-mentioned Health Plans (members are hereinafter referred to as "Covered Members") and to receive compensation for such rendering of services; and

Whereas, both EmpowerChiro and Chiropractor agree that the goal of their relationship under this Agreement is to provide safe, effective treatment for Covered Members covered through Health Plans contracting with EmpowerChiro, it is mutually agreed by both parties hereto as follows:

SECTION ONE – EMPOWERCHIRO RESPONSIBILITIES

1. Marketing of Chiropractor Panel. EmpowerChiro agrees to continually market its Chiropractor Panel to Health Plans for the purpose of providing treatment services to Covered Members. EmpowerChiro will do its best to ensure that Chiropractor's name and practice information is marketed to Covered Members through provider directories, telephone and internet referral services or other forms of referral mechanisms.

2. Credentialing. EmpowerChiro agrees to consider each applicant based on EmpowerChiro's established credentialing criteria. EmpowerChiro may perform site visits as a part of the credentialing process if required by the health plan. Chiropractor understands that he or she may not be chosen to participate in every Health Plan that works with EmpowerChiro.

3. Customer Service. EmpowerChiro agrees to maintain a Provider Relations Department for the purpose of assisting Chiropractor with claims payment issues, credentialing questions and other administrative issues or problems.

SECTION TWO - GENERAL INFORMATION

1. Service Standards. Chiropractor agrees to perform only those services that are within his or her experience and training. These services should be within the scope of chiropractic practice, as defined by the state in which the Chiropractor practices. Chiropractor agrees to provide treatment in an ethical, moral manner and to deliver care consistent with reasonable and conservative chiropractic standards.

2. Treatment Decisions. Chiropractor agrees that all decisions regarding patient treatment rest solely with the Chiropractor. EmpowerChiro's input is only with regard to Health Plan reimbursement. Under no circumstances shall any EmpowerChiro opinion regarding which treatment services may or may not be covered/reimbursable by Health Plan ever be used by Chiropractor as a reason to use or not use any form of treatment that Chiropractor deems to be in the Covered Member's best interest. Chiropractor must always exercise his or her best professional judgment regarding the treatment of each Covered Member.

3. Non-Discrimination. Chiropractor may not discriminate for or against a certain patient because he or she is or is not a Health Plan Covered Member. Chiropractor also agrees not to discriminate in the provision of Covered Services to Members because of race, color, national origin, ancestry, religion, gender, marital status, sexual orientation, age, veteran status, health status, health insurance coverage or any other issue used to differentiate between Covered Members; and to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as services are offered to other patients consistent with existing medical, ethical and legal requirements for providing continuity of care to patients.

4. Treatment Referrals. Chiropractor should call the number listed on the back of the Covered Member's insurance card to inquire about any stipulations surrounding making such a referral. In capitated Health Plans, Chiropractor agrees that if a referral to another provider is needed, Chiropractor will call the Health Plan or refer the patient back to their primary care physician to make such a referral. Chiropractor agrees that failure to follow this guideline to obtain pre-approval for a non-emergency referral from the Health Plan or the patient's primary care physician, as applicable, prior to the referral means (1) Chiropractor may not receive further insurance reimbursement for the Covered Member in question and that Chiropractor may not bill the Covered Member for any service(s) provided; and (2) Chiropractor may be terminated from the EmpowerChiro Chiropractor Panel.

5. Covered Services. Chiropractor understands that different Health Plans may have different specifications regarding precertification, utilization review, and reimbursement criteria (in a given Health Plan, reimbursement for some treatment services may not be covered). Chiropractor should attempt to make every effort to determine Covered Services by contacting the insurer listed on the Covered Member's insurance card. Chiropractor understands that prior to each Health Plan's implementation, EmpowerChiro or the Health Plan may furnish Chiropractor, if available, with a list of precertification, utilization review criteria for that Health Plan or information about how the Chiropractor may obtain this information from the Health Plan. Chiropractor will keep the criteria on file and refer to it whenever a particular Health Plan Covered Member presents himself/herself for treatment.

6. Health Plan Marketing Efforts. Chiropractor agrees that EmpowerChiro may use his or her name as part of a list of Chiropractors in marketing efforts to prospective Health Plans; in the form of provider lists distributed to Covered Members; through EmpowerChiro's toll-free referral service; and through EmpowerChiro's Internet listing.

7. Patient Records and Procedures. Chiropractor agrees to maintain adequate records of each Covered Member's treatment according to the reasonable and accepted standards of the state in which Chiropractor practices. Chiropractor will maintain complete medical records on each patient in addition to recording the types and monetary values of services performed. Chiropractor agrees to allow EmpowerChiro or Health Plan access to all records and documents pertaining to a given Covered Member's care whenever EmpowerChiro or Health Plan deems this information necessary. Chiropractor agrees not to have Covered Members sign a contract or agreement with the Chiropractor for a certain number of treatment sessions or a predetermined schedule of visits.

8. Confidentiality/HIPAA. Chiropractor agrees to maintain all Covered Member records under strictest confidence according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its accompanying regulations (including any future HIPAA changes, additions and/or deletions) and refrain from disclosing such information except with the consent of the Covered Member or when the information is requested by EmpowerChiro or the Health Plan. Chiropractor also agrees to hold in strict confidence all information regarding EmpowerChiro's or Health Plan's business practices or documents. All such practices and documents are proprietary to EmpowerChiro or Health Plan. The terms of this Agreement, including, but not limited to, the provision regarding compensation, together with all provider and administrative manuals, policies, procedures, directives and quality improvement and utilization review reports are confidential and shall not be disclosed by Chiropractor to any third party, except as necessary for the performance of this Agreement or as required by law. This provision shall be strictly construed and may be enforced by EmpowerChiro or Health Plan by injunctive relief or otherwise.

9. Independent Relationship. None of the provisions of this Agreement are intended to create, or shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities with each other acting in cooperation solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their representatives or employees shall be construed to be the agent, employer, or representative of the other. Chiropractor agrees to hold Health Plan(s) and EmpowerChiro harmless from any and all demands, claims and expenses of any kind. This includes the cost of legal defense that may result from any alleged misconduct or malpractice claim(s) against Chiropractor.

10. On-Site Examination. Chiropractor agrees to allow EmpowerChiro or Health Plan on-site access to all Covered Member records. When required by a particular Health Plan, Chiropractor agrees to allow EmpowerChiro or Health Plan to perform initial or periodic site inspections. In this event, EmpowerChiro or Health Plan will give Chiropractor at least one week's notice and arrange a specific inspection time at Chiropractor's convenience. Prior to this inspection, Chiropractor will be given a copy of the site inspection criteria in order for Chiropractor to be prepared for the inspection.

11. Patient Surveys. Chiropractor agrees to allow EmpowerChiro or Health Plan to randomly survey Covered Members to determine the quality of treatment provided by Chiropractor.

12. Provider Manual. Chiropractor agrees to abide by EmpowerChiro's protocols and procedures as outlined in the Provider Manual which is available upon request.

13. Chiropractor Discounts. Chiropractor agrees to discount the cost of his/her services according to the fee schedule information contained in this Agreement, including all amendments, correspondence and/or Network Selection Form(s).

14. Indemnification. Each party hereto indemnify to hold each other (including its officers, agents, and employees) harmless against any and all charges, demands, damages, liabilities and costs incurred by the other party, including reasonable attorney's fees resulting from any act or omission by or under the direction of the indemnifying party or its employees or agents relating to the subject matter of this agreement.

SECTION THREE - BILLING PROCEDURES

1. Claims Submission. Chiropractor agrees to submit all claims for services to the Health Plan address listed on the patient's insurance card, or to EmpowerChiro if directed to do so. The submitted claim should contain the Chiropractor's full retail charges for the services delivered and should be submitted on accepted billing forms with all information necessary to properly adjudicate each claim, including accurate CPT codes and current ICD-9 codes. Chiropractor agrees that he/she must submit claims to EmpowerChiro or Health Plan within ninety (90) days unless otherwise required herein or there may be no reimbursement. If EmpowerChiro /Health Plan is a secondary payer on a claim, Chiropractor agrees to submit such claims to EmpowerChiro or Health Plan within thirty (30) days of receipt of the determination-of-benefits from the payer. Chiropractor agrees that if he/she improperly submits claims for payment, this may be grounds for non-payment and Chiropractor agrees to write off the charges associated with the claim.

2. Fee Schedule for Preferred Provider Network "PPO" Plans. Chiropractor understands that the reimbursement will vary between Health Plans and geographic regions. On all current PPO accounts, EmpowerChiro will send Chiropractor client information once Chiropractor has been accepted into the EmpowerChiro network. Chiropractor will then have thirty

(30) days in which to decline membership in a current PPO account. Otherwise, Chiropractor will automatically be included in all current PPO accounts.

Prior to the implementation of a new PPO Health Plan, EmpowerChiro will provide Chiropractor with the applicable fee schedule or discount information unless the discount or fee schedule follows a plan currently in place with EmpowerChiro or if the discount is 25% or less. Chiropractor agrees to accept the above types of plans without notification from EmpowerChiro. If the fee arrangement is different from a plan in place with EmpowerChiro, EmpowerChiro will notify Chiropractor and Chiropractor will have thirty (30) days in which to send EmpowerChiro notice, in writing sent by certified mail, return receipt requested, in order to decline membership in that particular PPO Plan.

If Chiropractor wishes to later opt out of a PPO Network or Plan in which he or she participates, Chiropractor must send this request to EmpowerChiro in writing by certified mail, return receipt requested. EmpowerChiro will then have 180 days in which to remove Chiropractor from selected Plan. Chiropractor agrees to continue to service Covered Members at the agreed upon discounted rate or fee schedule during this 180 day period.

3. Fee Schedule for Capitated Programs. Chiropractor understands that different Health Plans have differing needs and that some Health Plans may access EmpowerChiro's Chiropractors through a preferred provider network arrangement while other Health Plan's may access EmpowerChiro's Chiropractors through a capitated arrangement. Chiropractor understands that the capitated arrangements under each Health Plan may be different. Chiropractor agrees to participate in any capitated program that reimburses Chiropractor according to one of the following reimbursement methods. If EmpowerChiro or Health Plan does not reimburse according to one of the following methods, EmpowerChiro or Health Plan will send Chiropractor details of the account and Chiropractor may opt out with 30 days notice in writing sent by certified mail, return receipt requested. Otherwise, Chiropractor will automatically be included in the Capitated Program. The following are the capitated reimbursement methods in which the Chiropractor agrees to participate:

a. Fee for Service Reimbursement. If the reimbursement is based on a fee for service fee schedule, Chiropractor agrees to accept any fee schedule that falls within the fee range as set forth below. Chiropractor understands that a Health Plan has the right to limit the number or type of services which may be reimbursed in a given visit or within a given time period.

CPT	DESCRIPTION	MIN. FEE	MAX. FEE
97010	Hot or cold pack	$ 8.00	$ 16.00
97012	Traction	$ 8.00	$ 16.00
97014	Electrical Muscle Stimulation	$ 8.00	$ 16.00
97016	Vasopneumatic Devices	$ 8.00	$ 16.00
97024	Diathermay	$ 8.00	$ 16.00
97026	Infrared	$ 8.00	$ 16.00
97035	Ultrasound	$ 8.00	$ 16.00
97112	Neuromuscular Reeducation	$ 8.00	$ 16.00
97124	Massage	$ 8.00	$ 16.00
72010	Full spine AP/LAT	$ 42.00	$123.50
72020	Spine (single view)	$ 25.20	$ 53.00
72040	Cervical spine AP/LAT	$ 38.10	$ 79.00
72050	Cervical complete (4 views)	$ 48.50	$113.00
72052	Davis series (7 views)	$ 62.60	$143.00
72070	Thoracic spine AP/LAT	$ 40.10	$ 79.00
72100	Lumbosacral AP/LAT	$ 40.10	$ 85.00
72110	Lumbosacral with obliques	$ 48.00	$123.00
72220	Sacram/Coccyx AP/LAT	$ 34.20	$ 69.00
98940	CMT (1-2 body regions)	$ 21.00	$ 41.00
98941	CMT (3-4 body regions)	$ 25.00	$ 47.00
98942	CMT (5 or more regions)	$ 30.00	$ 54.00
98943	CMT (extraspinal, 1 or more regions)	$ 21.00	$ 41.00

b. All-inclusive Reimbursement. Although the vast majority of plans are fee for service, some plans may choose to use an all-inclusive per visit rate as the allowed amount. Under this type of plan, the allowed amount is an all-inclusive per visit rate regardless of the number or type of services performed during the visit.

4. Submitted Charges. Chiropractor agrees to submit to EmpowerChiro or Health Plan the full retail charge for all treatment services rendered. The Chiropractor shall **not** reduce his/her fees on the claims submitted.

5. Balance Billing of Covered Member. Chiropractor agrees that, except for copayment and deductibles, he/she will not bill Covered Members for the amount above the allowed amount.

6. Patient Copayments. Chiropractor agrees not to waive a Covered Member's insurance copayment. Chiropractor understands that the patient's copayment should be collected at the time of service.

7. Non-Covered Services. Chiropractor agrees to provide only those services that are actually necessary to effectively treat the Covered Member. Chiropractor also agrees to perform only those tests that are needed to properly diagnose and treat a Covered Member. Services that are determined to be non-covered may not be billed to the Health Plan. Non-covered services may include maintenance care, experimental procedures, Health Plan exclusions, and additional services that are requested by Covered Member. Chiropractor understands that payment for any service deemed not medically necessary will be denied and that Chiropractor must write off the amount for this service and may not bill Covered Member or Health Plan. If the patient wishes to allow the Chiropractor to deliver any non-covered services, the Chiropractor may have the patient sign an agreement that he or she understands that the Health Plan will not reimburse for such services and that the Covered Member will pay the Chiropractor for these services.

8. Billing and Other Health Plan Related Disputes. Chiropractor agrees to communicate with his/her patients in an honest and truthful manner regarding payment, billing and other treatment issues. Chiropractor may not mislead his/her patients in any way in regards to these issues. If EmpowerChiro finds that Chiropractor has misled any of his/her patients, Chiropractor must correct the misinformation immediately and will be subject to EmpowerChiro's Compliance Policy. Chiropractor understands that if a payer pays a claim or takes a discount in error, EmpowerChiro is not responsible. In this event, Chiropractor must contact the payer to resolve the issue.

SECTION FOUR - UTILIZATION REVIEW

1. Utilization Review. Please be aware that if EmpowerChiro does not inform Chiropractor about specific utilization review requirements prior to the commencement of a given Health Plan, it is Chiropractor's responsibility to call the number listed on the Covered Member's insurance card to determine what, if any, utilization review requirements the Health Plan may have. Chiropractor agrees to accept the utilization review, peer review and appeals process as deemed appropriate by EmpowerChiro or Health Plan. On accounts that require utilization review, Chiropractor agrees to accept the utilization review, peer review and appeals process as deemed appropriate by EmpowerChiro or Health Plan. The utilization review program may include but is not limited to the following: (1) preauthorization of patient treatment; (2) proper completion and submission of a preauthorization form which lists a requested treatment plan; (3) concurrent record review of Covered Members receiving chiropractic services; (4) discussions with Chiropractor regarding Covered Members receiving treatment; (5) conferences with Covered Members, if necessary; and (6) any other activities necessary to coordinate the chiropractic services received by Covered Members. If requested, Chiropractor agrees to furnish EmpowerChiro or Health Plan with Covered Member's complete medical record at no charge and to provide any verbal and written information which EmpowerChiro or Health Plan deems appropriate. Chiropractor will comply with all final determinations rendered by EmpowerChiro or Health Plan. EmpowerChiro is not responsible for Health Plan's utilization management systems, protocols, etc.

2. Quality Improvement. Chiropractor agrees to cooperate with any recommendations or procedural changes regarding quality improvement that EmpowerChiro or Health Plan establishes.

SECTION FIVE - CREDENTIALING/RECREDENTIALING

Chiropractor agrees that he/she meets the following criteria:

1. State Licensure. Chiropractor agrees that he/she holds a current, valid state license to practice chiropractic in the state in which he/she practices. If Chiropractor's license is suspended, revoked or becomes inactive during the term of this Agreement, Chiropractor must inform EmpowerChiro within 48 hours. At that time, Chiropractor will be suspended from the EmpowerChiro program for the entire term in which the license is suspended, revoked or inactive and must request reconsideration for EmpowerChiro membership when license is reinstated.

2. Malpractice Coverage and Indemnification. Chiropractor agrees to maintain, at his or her expense, a policy of comprehensive and general and professional liability coverage under a legally established insurance trust or self-insured plan of not less than $1,000,000/$3,000,000 unless Chiropractor's state law allows for a lower minimum. If, at any time in the future, Chiropractor's insurance status changes for any reason or a malpractice action is brought against Chiropractor, he or she must notify EmpowerChiro of such action and the reasons behind the action within 48 hours. At that time, EmpowerChiro will make a decision regarding Chiropractor's participation in the network. EmpowerChiro reserves the right to immediately terminate Chiropractor for a malpractice issue at EmpowerChiro's discretion.

3. Felony Conviction. Chiropractor represents that he or she has never been convicted of a felony of any kind. If Chiropractor is convicted of a felony, he/she must notify EmpowerChiro within 48 hours. EmpowerChiro reserves the right to immediately terminate Chiropractor upon such notification.

4. Substance Abuse. Chiropractor agrees that he or she is not currently abusing alcohol or using any illegal narcotics or substances of any kind. Chiropractor agrees to notify EmpowerChiro in the future if Chiropractor begins to abuse/use any of the above illegal substances. At that time, Chiropractor agrees that EmpowerChiro may terminate him/her from Chiropractor Panel.

5. Limitations. Chiropractor agrees that he or she has no mental, emotional or physical limitations or problems that prohibit Chiropractor from fulfilling the normal functions of administering chiropractic medicine. If Chiropractor develops any of the above situations in the future, he/she must notify EmpowerChiro of this change in status within 30 days. EmpowerChiro reserves the right to immediately terminate Chiropractor upon such notification.

6. Recredentialing Process. Chiropractor agrees to cooperate with EmpowerChiro's re-credentialing process and to furnish any and all information deemed necessary by EmpowerChiro including any applicable fees. Chiropractor understands that annual membership fees will automatically be billed to the Provider's credit card or debited from the Provider's checking account either annually or monthly based upon the payment method selected by Provider on the initial Preferred Provider Application and/or Provider Information Form.

7. Notification of Practice/Contact Information Changes. Chiropractor agrees to notify EmpowerChiro in writing within forty-eight (48) hours of any change in Chiropractor's practice/contact information, including, but not limited to address, city, state, zip, phone, fax, email address, tax ID number,

etc.). If Chiropractor fails to provide said notification and EmpowerChiro attempts to contact Chiropractor in a formerly valid way, EmpowerChiro is not responsible and Chiropractor accepts that appropriate valid notice has been made.

SECTION SIX - APPEALS PROCEDURE

1. Appeals Process. In Health Plans in which EmpowerChiro provides its Appeals Program, Chiropractor must appeal treatment reimbursement decisions as follows: Chiropractor must send a written request for an appeal to EmpowerChiro by certified mail, return receipt requested. This request should include the patient's full medical record and all supportive materials Chiropractor wishes to furnish. Chiropractor agrees to abide by EmpowerChiro's appeals determinations. EmpowerChiro's Appeals Process is as follows:

> Level One (Chiropractic Reviewer). A chiropractic reviewer will review the patient's medical records and completed Treatment Review Form to make a determination of medical necessity. EmpowerChiro will send the reviewer's decision to Chiropractor. For plans in which there is no avenue for a Level Two Appeal through the Health Plan, the decision of the chiropractic reviewer shall be final.
>
> Level Two (Health Plan). If Chiropractor is not satisfied with the results of the Level One review, he or she may request a final review from the Health Plan if the Health Plan provides such an appeals process. The Health Plan will review the patient's medical records and completed Treatment Review Form to make a determination of medical necessity. EmpowerChiro will forward the Health Plan's decision to Chiropractor. The Health Plan's decision shall be final.

SECTION SEVEN - FEES AND TERMS

1. Credentialing Fee. Chiropractor agrees to pay EmpowerChiro the agreed upon application and renewal fees.

2. Chiropractor Credentialing. Please note that in the interest of implementing a Chiropractor Panel in a timely manner, from time to time, EmpowerChiro may have Chiropractor sign this Agreement before the credentialing process is completed. In other words, EmpowerChiro may not have received verification from Chiropractor's malpractice insurer, state licensing board or other entities that may provide EmpowerChiro with information which would prohibit EmpowerChiro from forming an Agreement with a certain Chiropractor. In the event this occurs, EmpowerChiro will notify the Chiropractor that he or she did not meet EmpowerChiro's credentialing criteria and this Agreement will be null and void. At any time, Chiropractor has the right to evaluate information obtained by EmpowerChiro during the credentialing process (not including internal EmpowerChiro memoranda). In addition, EmpowerChiro will contact Chiropractor regarding any information received by EmpowerChiro during the credentialing process which substantially differs from the information received from Chiropractor and Chiropractor has the right to correct the information received by EmpowerChiro.

3. Additional Fees from Chiropractor. Chiropractor understands that EmpowerChiro may bill Chiropractor in the form of a percentage of the allowed amount on some accounts or a flat monthly rate. Chiropractor understands that these fees will automatically be billed to the Provider's credit card or debited from the Provider's checking account based upon the type of payment selected by Provider on the initial Preferred Provider Application and/or Provider Information Form and/or any other means such as by telephone, fax, mail, email, invoice, etc. EmpowerChiro will make every effort to notify Provider at least five days in advance of the credit card billing or ACH transfer. Chiropractor understands that the above billing procedure is in accordance with the laws of the state of Kansas. It is solely Chiropractor's responsibility to know the laws of his/her own State and act accordingly.

If EmpowerChiro contracts with a new account under this arrangement, EmpowerChiro will notify Chiropractor regarding the specifics of the account. After notification has been made by EmpowerChiro, Chiropractor has thirty (30) days to opt out of that particular account. Chiropractor must make the notification by certified letter with return receipt requested. A decision to opt out of a particular account will not affect Chiropractor's future referrals or relationship with EmpowerChiro.

4. Contract Term. This Agreement shall become effective as of the date on which Family Health America L.C. signs the Agreement and shall continue in effect for a three (3) year "Initial Term" unless otherwise terminated as provided herein. After expiration of the Initial Term, this Agreement shall automatically be renewed for additional three year terms unless either party terminates ninety (90) days prior to the end of the three year term with notice sent in writing by certified mail, return receipt requested to the other party.

5. Dismissal from the EmpowerChiro Chiropractor Panel. EmpowerChiro reserves the right to remove a Chiropractor from its Chiropractor Panel if deemed necessary with thirty (30) days notice to the Chiropractor. Chiropractor may appeal such a panel dismissal by sending a certified letter with return receipt to the Family Health America L.C. Quality Improvement (QI) Committee requesting a review of the dismissal. The decision of the Family Health America L.C. QI Committee is final.

6. EmpowerChiro as Billing Address. Chiropractor understands that his/her reimbursement on some accounts may come directly from EmpowerChiro. In such cases, Chiropractor will bill the payor listed on the back of the patient's insurance card his/her normal charges. The payor will then send reimbursement to EmpowerChiro using Family Health America's tax identification number. EmpowerChiro will then reimburse Chiropractor based upon the rates provided to Chiropractor. If EmpowerChiro contracts with a new account under this arrangement, EmpowerChiro will notify Chiropractor regarding the specifics of the account. After notification has been made, Chiropractor has thirty (30) days in which to opt out of that particular account. A decision to opt out of a particular account will not affect Chiropractor's future referrals or relationship with EmpowerChiro.

7. Health Plan Termination. Chiropractor agrees that if an EmpowerChiro client, insurer, provider network or other type of entity terminates its relationship with EmpowerChiro, Chiropractor agrees to continue to service members at the agreed upon discounted rate or fee schedule for a period of 180 days thereafter.

SECTION EIGHT - ADDITIONAL NOTICES AND INFORMATION

1. Headings. The headings of sections and paragraphs contained in this Agreement are for reference purposes only and have no legal meaning. The order of aforementioned sections and paragraphs has no importance.

2. Arbitration/Legal Fees. In the event of any arbitration and/or legal action, all arbitration and legal fees of any type (attorney's fees, court costs, etc.) shall be paid by the filing party.

3. Amendment. This Agreement is subject to EmpowerChiro amendment at any time. When this occurs, EmpowerChiro will notify Chiropractor of such amendments and Chiropractor will have thirty (30) days to respond by certified mail that the stated Amendment to this Agreement is not acceptable to Chiropractor. If Chiropractor does not provide EmpowerChiro with such written notice in the time allotted above, Chiropractor accepts the amendments to this Agreement as outlined by EmpowerChiro.

4. Entire Agreement. This Agreement together with any attachments, exhibits or future amendments supersedes any prior agreements, promises, negotiations, or representations, either oral or written relating to the subject matter of this Agreement.

5. Binding Arbitration. All disputes and differences among the Chiropractor and EmpowerChiro or any Health Plan which accesses the Chiropractor Panel upon which an amicable understanding cannot be reached will be decided exclusively by binding arbitration. This binding arbitration shall be conducted by someone who is licensed under the American Arbitration Association who operates in Sedgwick County; in the state of Kansas. If such arbitration is appealed, it shall be filed exclusively in the Eighteenth Judicial District Court, Wichita, Sedgwick County, Kansas.

6. Severability. In this event that any provision of this Agreement is rendered invalid or unenforceable by an Act of Congress, the State Legislature or by any regulation duly promulgated by officers of the United States or this state acting in accordance with the law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the Agreement will remain in full force and effect.

7. Effect of Severability. In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided above and its removal has the effect of materially altering the obligations of either party in such manner as (1) will cause serious financial hardship to such party; or (2) will cause such party to act in violation of its corporate articles or By-Laws, the party so affected shall have the option to terminate upon thirty-days written notice to the other party.

8. Notice. Any notice required by Chiropractor to be given pursuant to the terms and provisions of this Agreement shall be sent in writing by certified mail, return receipt requested, to EmpowerChiro's current address.

9. Controlling Law. This Agreement and all questions regarding its validity, interpretation, performance and enforcement shall be governed by the laws of the State of Kansas as effective and in force on the commencement date.

10. Waiver of Breach. Waiver of breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

11. Jurisdiction. Any legal proceedings relating to this Agreement shall be brought exclusively in the Eighteenth Judicial District Court, Wichita, Sedgwick County, Kansas, USA or in the United States District Court for the District of Kansas at Wichita, Kansas, USA. Both parties consent to the jurisdiction of the above courts. Any court action brought by either party will be subject to all attorney's fees and other fees to be paid by the filing party.

12. Assignment. Chiropractor may not assign his/her rights under this Agreement in total, however, anyone in Chiropractor's practice who bills under the Chiropractor's Tax ID number will be subject to this Agreement. Chiropractor may direct payment of claims to his/her practice or corporate entity. EmpowerChiro may assign its rights under the agreement to any other party.

The undersigned have executed this Agreement as of the day Chiropractor is approved by EmpowerChiro.

Chiropractor's Signature:

____Date:___________

Chiropractor's Printed Name:

____

Chiropractor's Printed Address:

____

____TIN___________________

President, Family Health America, L.C.:

____Date:_________

ADDENDUM TO THE FAMILY HEALTH AMERICA, L.C. AGREEMENT (AKA EmpowerChiro, Family Health America Company, Family Health America, L.C.)

Effective February 24, 2014, the following changes are incorporated into the above Agreement:

PURPOSE. TriWest Healthcare Alliance (TriWest) has subcontracted with EmpowerChiro to establish a provider network for TriWest to provide health care services to Department of Veterans Affairs (VA) Beneficiaries under the Patient Centered Community Care (VA PC3) program. The purpose of this Addendum is to include Provider in the VA PC3 network to provide health care services to VA Beneficiaries and to establish terms of participation in the VA PC3 network. In the event of a conflict between the terms of this Addendum and the terms of the Agreement, the terms of this Addendum shall govern. In addition to the terms and conditions of the Agreement, the following terms and conditions are applicable to the VA PC3 program:

1. **DEFINITIONS**. The following definitions shall be added:

   VA PC3 Covered Services – Service, items and supplies for which benefits are available to VA Beneficiaries in accordance with the rules, regulations, polices and instructions of Veterans Administration and the Veterans Health Administration.

   Veterans Health Administration (VA) – The division of the Department of Veterans Affairs that provides health care services and administers health care benefits for eligible beneficiaries.

   VA Beneficiary - Any person eligible to receive VA PC3 Covered Services under the rules, regulations, policies and instructions of the VA.

2. Provider agrees to treat VA Beneficiaries according to the terms and conditions of the Addendum and the Agreement as applicable and in accordance with the applicable laws, rules and regulations. Provider shall accept the Reimbursement Rates set forth in Exhibit 1 to this Addendum as the only payment expected for such services. In order for Provider to be reimbursed for services provided to VA Beneficiaries all services, with the exception of urgent or emergent services, must be Preauthorized by TriWest. In no event will Provider be paid for such services more than the amount payable by the VA.

   As applicable, Provider shall also comply with the following VA-specific requirements for certain services and professionals:

   a. Office-based Diagnostic and Therapeutic Tests and Procedures – tests and procedures must be performed in a sage manner by qualified physicians within their scope of practice; which includes ensuring that physicians are appropriately trained and proficient in performing the procedures.

3. Provider shall comply with applicable laws and regulations and all TriWest rules, policies and procedures including without limitations credentialing, peer review, referrals, utilization review/management, practice guidelines, case management and quality assurance programs and procedures established by TriWest and VA, including submission of information concerning Provider and compliance with Preauthorization requirements, pharmacy utilization requirements, care approvals, concurrent reviews, retrospective reviews, discharge planning for inpatient admissions, critical event notifications, and return of medical reports. Provider shall complete training provided by the Subcontractor or TriWest regarding participation in the VA PC3 program. Provider agrees that TriWest and its designee shall have access, upon demand and at reasonable times, to the books, records and papers of Provider relating to the health care services provided to VA Beneficiaries for VA PC3 Covered Services.

4. Provider shall submit claims for VA PC3 Covered Services on behalf of VA Beneficiaries in accordance with the Claims Submission Guidelines attached to and incorporated as Exhibit 2 to this Addendum. Provider shall use best efforts to submit claims within thirty (30) days after the provision of the services. No payment shall be made for; a claim submitted more than one hundred and twenty (120) days after the provision of the Covered Services, for services provided to VA Beneficiaries that were not authorized by TriWest, or for services for VA Beneficiaries for which required medical reports have not been received by TriWest.

5. Medical documentation recording the delivery of authorized VA PC3 Covered Services shall be submitted to TriWest in the form and within the timeframes required by the VA PC3 program, but in no event later than fourteen (14) calendar days after completion of the outpatient services and thirty (30) calendar days after discharge for inpatient care. Provider shall provide TriWest with a valid email address and receive communication from TriWest via email. To the extent practicable, Provider shall use electronic methods (e.g. email, secure website, etc.) in performing transactions for the VA PC3 program.

6. VA Beneficiaries shall not be billed for any services or supplies furnished under this Addendum. If Provider sets up in preparation for medical treatment, but the treatment is never started, e.g., the VA Beneficiary never arrives, there can be no service claim or other fee for those intended services, and there will be no payment or penalty fees. Provider shall not bill a VA Beneficiary and/or the VA Beneficiary's other insurance (if applicable) for these services. This Agreement does not prohibit Provider from collecting payments from VA Beneficiaries for non-Covered Services or services that were not Medically Necessary, but only where Provider has entered into a written agreement with the VA Beneficiary in advance that notifies the VA Beneficiary of their payment responsibilities in accordance with federal law and the Agreement.

7. Provider shall provide a VA Beneficiary with a copy of his or her medical record at no charge to include narrative summary and other documentation of care, within ten (10) business days of the request.

8. Provider shall provide copies of medical records to TriWest within ten (10) business days of TriWest's request, to permit TriWest to conduct peer review, quality assurance and utilization review.

9. Appointments for VA Beneficiaries referred by TriWest will be scheduled within twenty (20) days of Provider's receipt of the referral. VA Beneficiaries should be seen within twenty (20) minutes of scheduled appointment.

10. Provider shall not advertise the award of this Addendum in its' commercial advertising in such a manner as to state or imply that the Department of Veterans Affairs endorses a product, project or commercial line of endeavor.

11. **TERMINATION**: This Addendum and Provider's participation in the VA PC3 network may be terminated immediately upon Provider's failure to meet VA PC3 program participation requirements and upon ninety (90) days' notice by any Party.

12. **SURVIVABILITY**: The obligations of Sections 2 and 4 shall survive the termination of this Agreement.

If any provision of this Addendum is deemed illegal, unenforceable or in conflict with any law of a federal, state or local government having jurisdiction over this Addendum, the validity of the remaining sections of this Addendum and of the Agreement shall not be affected. Except as amended hereby, all of the terms and conditions of the Agreement remain in full force and effect.

Exhibit 1
Reimbursement Rates

Provider acknowledges that this Exhibit 1 sets forth the exclusive reimbursement it will receive for the provision of VA PC3 Covered Services to VA Beneficiaries.

Provider acknowledges that TriWest is not the insurer, guarantor, or underwriter of the payment of Covered Service for VA Beneficiaries' benefits to the Provider. The services and payments made under this Addendum shall be subject to all applicable federal laws and VA rules and regulations. In no event will Provider be paid more than the amount payable by VA. As federal law or regulation requires change in VA reimbursement or the methodology to compute any VA payments, this Exhibit is automatically updated to comply with said change.

The terms of this Addendum, specifically including this Exhibit, are applicable for all authorized services for VA Beneficiaries billed under Chiropractor’s TIN.

Professional Services
Provider agrees to accept a percentage discount off the current applicable Medicare Fee Schedule, as updated from time to time, as follows: 85% of Medicare

When a given medical procedure or service is not payable under Medicare or is payable under Medicare but does not have established pricing at the national or local level, Provider agrees to accept the lesser of the usual, customary and reasonable rate (UCR) established by TriWest based on nationally recognized UCR schedules and methodologies, or 60% of Provider's billed charge as the Reimbursement Rate.

Exhibit 2

Claims Submission Guidelines

The following guidelines are necessary in order to submit claims electronically to TriWest via Wisconsin Physicians Services (WPS)

1. In transmitting EDI, Provider will transmit such claims edited and formatted according to the specifications indicated within the most current Provider User Guide or the ANSI X12 837 Implementation Guide and EDI Companion Guide supplied by WPS. Provider understands the WPS Provider User and EDI Companion Guide are proprietary and are authorized for use only by Provider and its employees working on behalf to transmit such EDI and that any other use or distribution of the WPS Provider User Guide or EDI Companion Guide is strictly prohibited without the express written consent of WPS. WPS shall be the final authority in resolving any disputes about how electronic data shall be submitted.

2. Provider agrees that all claims submitted via EDI, for all legal and other purpose, will be considered signed by the Provider or Provider's authorized representative.

3. Provider agrees to maintain a patient signature file. Provider understands WPS may validate through file audits, those claims submitted via EDI which are included in any quality control or sampling method required by WPS. Provider understands if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to EDI submission to WPS.

4. Provider acknowledges that WPS shall have no obligation with respect to the content of the information in claims either to verify, check or otherwise inspect the information supplied by the health care provider, except to reformat the claim data to the specification required by TriWest. Provider further acknowledges that TriWest will determine whether Provider has submitted enough information in the EDI claims in order to determine the completeness, accuracy and validity of the information and claims and that source documents for claims data the responsibility of the Provider.

Form **W-9**
(Rev. December 2011)
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) ▶

☐ Exempt payee

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).

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 4.

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

General Instructions

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

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, 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.

Note. If 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 on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the 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 withholding on your share of partnership income.

THIS FORM MUST BE COMPLETED AND SENT TO YOUR MALPRACTICE COMPANY

(Do not return to EmpowerChiro/Family Health America LC)

Date: ______________________________________

To: ____ **(Name of Malpractice Insurance Company)**

Please add the following company as a certificate holder on my professional liability policy:

Family Health America LC
Attn: Provider Relations
7309 E 21st St N Ste 110
Wichita KS 67206

AUTHORIZATION, ATTESTATION AND RELEASE

I authorize the investigation of and release to Family Health America LC (FHA) and its representative from any entity or third-party source, the following information: professional liability insurance, past and present, including coverage verification, a declaration page showing all applicable endorsements, claims history and certificate of insurance. Please name FHA as a certificate holder on my insurance policy. (As a certificate holder, FHA receives notification of any policy changes, i.e., cancellation or limit increases/decreases. FHA has no other rights in regards to the policy except to receive notification of any policy changes.) I release all persons/entities providing such information from any liability for doing so and agree that any information obtained for the credentialing/recredentialing process is not a violation of privacy. I hereby certify that the information provided by me is current, true, correct and complete to the best of my knowledge and belief, and is furnished in good faith.

SIGNATURE ____ DATE _________________

PRINTED NAME ____

POLICY #____