PREMIER PROVIDER NETWORK, INC.

PARTICIPATING PROVIDER AGREEMENT (1354)

Provider agrees to render professional medical services, as defined in Provider Application and is incorporated into this Agreement between PPNI and the undersigned Provider, to PREMIER PROVIDER NETWORK, INC. (PPNI) Members ("Patients") with the same level of care and services given to private patients and at the rates agreed to in the Provider Fee Schedule. Provider understands that neither PPNI nor its affiliates are claims paying agents (Payors) and that the Patient is responsible for payment of the rates as agreed to in the Provider Fee Schedule at time of service.

Provider agrees that PPNI Patients are not excluded from participating in sales or other promotions offered by the Provider to the general public where the rates offered are lower than the discounted rates set forth in this agreement. Provider agrees to offer PPNI Patients said promotional/sales rates.

Provider agrees to the provisions set forth in the Minimum Standards for Provider Participation and agrees to comply with PPNI's Policies for Provider Participation including but not limited to the Credentialing and Re-Credentialing, Dispute Resolution, Quality Assurance, Grievance Programs and PPNI's provider Procedure Manual. Provider authorizes PPNI to lease out this contractual agreement to other medical plan organizations for the purpose of solicitation to its Patients for medical services. Provider agrees to abide by the PPNI coverage, availability, and accessibility policies and procedures and acknowledges the PPNI will monitor accessibility, quality of care and conformance. Provider also agrees to practice within the scope of his/her licensure and will provide twenty-four (24) hours per day, seven (7) days per week coverage.

Provider agrees that any and all licenses or certifications required by local, state or federal agencies, boards, associations or committees have been obtained and are maintained in an active status throughout the term of this agreement. Provider agrees to notify PPNI immediately if a loss of legal authority to provide medical services should occur.

Provider agrees to notify PPNI of any change in the information provided in the Provider Application for PPNI participation within five (5) business days, including changes in hours of operation and whether the provider is accepting new patients. Provider authorizes PPNI to contract with discount medical plan organizations on its behalf. PPNI shall notify discount medical plan organizations on a monthly basis of changes in provider information, including changes of status in provider participation.

Provider agrees that all services billed under the Tax Identification Number indicated in this Agreement, the Application, or through Amendment or Addendum will be subject to the reimbursement rates as identified in the Provider Fee Schedule and will not charge patients more than the discounted rates.

Provider agrees to maintain malpractice insurance in the amounts of $1,000,000/$3,000,000.

The term of this Agreement shall commence upon the date executed by PPNI and shall continue in effect until terminated by either party with or without cause upon ninety (90) days prior written notice. Upon termination of this Agreement Provider agrees to continue to honor discounted rates for all Members who are undergoing treatment until the course of treatment is complete.

For California providers only: PPNI is subject to the requirements of Chapter 2.2 of Division 2, and of Chapter 1 of Title 28 of the California Code of Regulations ("the Act"). Any provision required to be in this Agreement by the Act or the implementing regulations, shall bind PPNI, whether or not provided for in this Agreement.
WHEREAS, Section 1300.67.04 of Title 28 of the California Code of Regulations ("Language Assistance Program Regulations") requires PPNI to establish and implement a language assistance program.

WHEREAS**,** Section 1300.67.04(e)(4) of the Language Assistance Program Regulations requires the Agreement to be amended to require Provider to comply with PPNI's language assistance program.

WHEREAS, the purpose of this language is to satisfy the contractual requirements of the Language Assistance Program Regulations. This Amendment does not include or infer PPNI delegation of any PPNI obligations under the Language Assistance Program Regulations.

1. Definitions. Unless otherwise provided in this Agreement, capitalized terms have the same meaning as set forth in the Language Assistance Program Regulations.

2. Language Assistance Program. PPNI shall establish and maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Enrollees have appropriate access to language assistance while accessing health care services as required by the Language Assistance Program Regulations. Provider shall cooperate and comply, as applicable, with PPNI's language assistance program; however, PPNI shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the language assistance program for Enrollees.

3. Controlling Language. The Agreement shall continue in full force and effect.

PROVIDER FEE SCHEDULE (40506)

All fees will be paid by the member at one hundred percent (100%) of the current Medicare allowable and will be updated accordingly and in conjunction with governmental rates. Codes not recognized by Medicare will be paid by the member at seventy percent (70%) of the Provider's reasonable and customary billed charges. If the Provider's billed charges are equal to or lesser than the contractual fee, a fifteen percent (15%) courtesy discount will be applied to the Provider's billed charges.

Obstetrics: $2200.00 Global Case Rate

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date(s) set forth below.

Provider/Authorized Signatory

Group Name

Address

City State Zip

Signature Printed Name

Tax ID # Date

Premier Provider Network, Inc. (PPNI)
11111 Richmond Avenue, Suite 243
Houston, Texas 77082

Signature

Printed Name

Title

Date

PREMIER PROVIDER NETWORK, INC.

ANCILLARY PROVIDER APPLICATION

Please complete the application information in its entirely for each participating facility to expedite the processing of this Agreement. Return the Provider Agreement, Ancillary Application and all supporting documentation in the postage paid envelope supplied for you to Premier Provider Network, Inc. (PPNI) Attn: Director of Provider Relations, 11111 Richmond Avenue, Suite 243 Houston, Texas 77082 or you may fax your return to (713) 414-4953.

Facility Name			Tax Identification Number(s)	
Facility Services Offered				County
Facility Address (include suite #)		City	State	Zip
Phone	Facsimile		Hours of Operation	
(2) Facility Name			Tax Identification Number(s)	
(2) Facility Address (include suite #)		City	State	Zip
Phone	Facsimile	Hours of Operation		County
State Licensed	State License Number	Languages Spoken		Accepts New Patients? Y or N
Certifications				
Malpractice Insurance Carrier	Limits of Liability		Policy Number	
Billing Address		City	State	Zip
Contact Person	Phone Number		Email Address	

Please submit current copies of the following documentation with numbers and expiration dates.

☐ **State Licensure** ☐ **Liability Insurance Face Sheet** ☐ **Certifications**

The provider attests that all information contained in this application is true and accurate. The provider agrees that if changes occur to the aforementioned, that he/she will notify PPNI of such changes within five (5) business days.

PPNI Use Only

PPNI Representative	Effective Date	PID#

PREMIER PROVIDER NETWORK, INC.

PROVIDER APPLICATION

Please complete the application information in its entirety for each participating provider to expedite the processing of your agreement. Return the Provider Agreement, Provider Application and all supporting documentation in the postage paid envelope supplied for you to Premier Provider Network, Inc. (PPNI) Attn: Director of Provider Relations, 11111 Richmond Ave, Ste 243, Houston, Texas 77082 or you may fax your return to (713) 414-4953.

Physician Name (First, MI, Last, degree)			Tax Identification Number	
(1) Primary Practice/Clinic Name			Specialty	County
(1) Primary Practice Address (include suite #)			City	State / Zip
Phone	Facsimile	Office Hours		
(2) Practice/Clinic Name			Tax Identification Number	
(2) Practice Address (include suite #)			City	State / Zip
Phone	Facsimile	Office Hours	County	
State Licensed	State License Number	Social Security #	Languages Spoken	
DEA Number	DPS Number	ECFMG # (*if applicable*)	Date of Birth	
Malpractice Insurance Carrier	Policy Number		NPI Number	
Provider Billing Address		City	State	Zip
Provider Contact Person	Contact Phone Number		Email Address	

Please submit current copies of the following documentation with numbers and expiration dates.

- ☐ State Licensure
- ☐ DEA (Federal License)
- ☐ ECFMG (if applicable)
- ☐ Liability Insurance Face Sheet
- ☐ DPS (State License)
- ☐ CLIA (if applicable)

The provider attests that all information contained in this application is true and accurate. The provider agrees that if changes occur to the aforementioned, that he/she will notify PPNI of such changes within five (5) business days.

_____

PPNI Use Only

PPNI Representative	Entry Date	PID#

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PREMIER PROVIDER NETWORK, INC.

PROVIDER SITE QUESTIONNAIRE

Provider Name:		**Telephone #:** ( )	
Address:	**City:**	**State:**	**Zip:**
Tax Identification Number:	**Specialty:**	**Facsimile #:** ( )	

1. Please list the education and training of all management, clinical personnel and equipment technicians including title of position and degree(s) and/or certification held.

Title of Position	**Degree/Training/Certification**
_____	_____
_____	_____
_____	_____
_____	_____

(Please include a separate sheet of paper if necessary)

1. **Availability of Services** (*check those that apply*):

Average length of office visit:
- ☐ 5-10 minutes
- ☐ 10-20 minutes
- ☐ 20-30 minutes
- ☐ 30 + minutes

Average length of waiting time:
- ☐ 5-10 minutes
- ☐ 10-20 minutes
- ☐ 20-30 minutes
- ☐ 30 + minutes

Average time for appointment:
- ☐ 0 - 7 days
- ☐ 7-14 days
- ☐ 14 + days

2. Does the provider site have specific policies regarding patient record security and confidentiality including appropriate access by staff?

☐ YES ☐ NO

3. Does the provider site use a standard Patient Assessment form for all patients seen?

☐ YES ☐ NO

4. Does the provider site have specific policies for scheduling appointments based on the needs of the patient?

☐ YES ☐ NO

5. Does the provider site office environment provide patients and safety, privacy and access to rest rooms?

☐ YES ☐ NO

6. Does the provider site provide sufficient patient access and availability including extended hours, parking, proximity to public transportation and accommodations for the handicapped?

☐ YES ☐ NO

7. Does the provider site provide appropriate maintenance and training in the use of clinical equipment and provisions for emergency power?

☐ YES ☐ NO

8. Does the provider site have procedures in place to assist patient that need referrals to other facilities or for additional treatments?

☐ YES ☐ NO

9. Is the provider site accredited? (*if yes, provide the following*)

☐ Joint Commission ID#:_____ Expiration Date:_____
☐ Other_____ID#:_____ Expiration Date:_____

10. How do you communicate self-care, health promotion and disease prevention to your patients?

11.

☐ Newsletter ☐ Pamphlets
☐ Brochures ☐ Other _____

12. General Comments: Please provide comments on how PPNI could serve you and your patients more effectively:

_____

_____

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PREMIER PROVIDER NETWORK, INC.

PROVIDER REFERRAL FORM

Thank you for your continued participation with PPNI. In an effort to assist PPNI in developing a comprehensive network, providing for a full continuum of care, please provide the following information for each entity you commonly refer patients to. Fax your return to (713) 414-4953 Attn: Provider Relations or mail it to The Premier Provider Network, 11111 Richmond Avenue, Suite 243, Houston, Texas 77082 and we will process your referrals immediately. Should you require additional assistance please contact the Provider Relations Department at (866) 776-4872.

Referral #1

Physician Name (Last, First , MI)		Degree		
Primary Practice/Clinic Name		Specialty		
Primary Practice Address (include suite #)		City	State	Zip
Phone	Facsimile	Contact Name		

Referral #2

Physician Name (Last, First , MI)		Degree		
Primary Practice/Clinic Name		Specialty		
Primary Practice Address (include suite #)		City	State	Zip
Phone	Facsimile	Contact Name		

Referral #3

Physician Name (Last, First , MI)		Degree		
Primary Practice/Clinic Name		Specialty		
Primary Practice Address (include suite #)		City	State	Zip
Phone	Facsimile	Contact Name		

Referring Provider Information

Provider Name	Phone