Introduction – Tab Vaccination Billables

Connecticut Association of Directors of Health
Vaccination Billing Project Model Site
June 29, 2012

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Introduction:

In the fall of 2011, the State Department of Public Health (SDPH) was awarded a grant from the Centers for Disease Control (CDC) to assist Local Health Departments (LHD) in billing for immunizations. Through a joint effort with the Connecticut Association of Directors of Health (CADH) a proposal was developed where CADH and the SDPH would work cooperatively in this effort. The final proposal included the support for one "Model Site" and five "Test Sites" among other objectives. The Pomperaug Health District, with extensive experience in billing for flu vaccinations, was awarded a subcontract through CADP in the spring of 2012. Our role in the "CADH Vaccination Billing Project" is three fold.

a) Develop a Billing Manual with the first phase on instructing LHD how to secure contracts for vaccination billing.
b) Second phase of Billing Manual will include information on a model billing process, which would include several methods of billing to Medicare and private payers.
c) Become a supporting member of stakeholder team to support and expand the Vaccination Billing possibility for Local Health Departments.

Billing Manual – First Phase

As described above the first phase of the billing manual (model site) is complete. We have provided information on how to secure contracts and become credentialed for most but not all of the public and private payers in CT. These include:

- National Governmental Service (NGS) – Medicare Part B
- Anthem
- Connecticare
- Aetna

We have been unable thus far to provide contracting information for:

- United Health Care
- Cigna
- Medicaid

Be advised that the stakeholder work group is actively engaging the CT Department of Social Services (DSS) in resolving barriers to Medicaid contracting.

This model site manual is a work in progress and insurance contracting is a sometimes-challenging effort. We have provided the user with valuable contact information, website links, sample contracts, applications, and important requirements for each insurer.

NGS Medicare is by far the most difficult insurer to obtain billing status partially due to the government's heightened concerns with fraud. Be advised that the acquisition of a National Provider Identifier (NPI) Number is required for all contracts. We have a section on how to do that.

Additional Note – First Phase

We have decided to include a section on a company called TransactRx. This company has an excellent real time web based interfaced and claims that by contracting with them a local health department can avoid the time consuming and expensive Medicare Part B credentialing process. The also further claim that they can assist a LHD in securing contracts for private payers in CT, at least the ones that participate with LHD. We have included them in phase 1 because some of the pilot sites may choose this path.

Medicare - Tab

Medicare Part "B" – NGS (National Governmental Services)

Provider Availability - Yes

Types of contracted immunization service available to Local Health Departments (LHD):

- Influenza vaccine
- Pneumococcal vaccine

Note: Medicare Billing for Flu & Pneumonia is through Medicare Part "B". Separate billing for Shingles vaccine, et. al. is possible through Medicare Part "D" as a pharmacy benefit. That Medicare part "D" to be discussed in separate section.

Medicare Part B Contact Person:

National Government Services
P.O. Box 6189
Indianapolis, IN 46206
Phone: 866-837-0241
Customer Care Representative
Provider Enrollment Phone: 888-379-3807

A) Provider Requirements:

Note: Application to become a public health Medicare Part "B" provider is an involved multistep process. The Medicare program continues on its path to reduce fraud, and increase compliance with provider standards. Towards that goal there is a process to prove what type of organization your health department is, along with key and sometimes sensitive information on health department employees and structure. The answers to those questions may be slightly different for a health district as compared to a municipal health department.

- Public Health Department must:
  - have an NPI (National Provider Identifier) number – see NPI Section
  - have a Tax ID number – Employer ID Number (EIN)
  - complete CMS 855b application – See Pomperaug Health District Copy
  - or fill out an online "Provider Enrollment Chain and Ownership" (PECOS) Form – an electronic 855B
  - Pay a fee of around $523
  - Supply SSN of managing officer or similar

Notes:

- LHD are providers in Medicare terminology
- LHD are probably considered a corporation
- LHD are Limited Screening in Medicare Terminology
- CMS – stand for Centers for Medicare and Medicaid Services

- CMS wants to know all – who, what, where, ownership, controls – financial
- PTAN – Provider Transaction Access Number – older term that may be part of NPI process.

B) Application Process:

- Obtain NPI Number – See NPI Section
- Website – NGSMedicare.com (screenshot) Appendix M-2
- Enrollment Tools (Screenshot) (M-3)
- Group/Organization enrolling for First Time
- Complete CMS 855b – paper form – download from NGSMedicare.com or the Internet – based Provider Enrollment Chain and Ownership System (PECOS)
- See Attachment Info. Sheet on PECOS – also applies to 855B – paper (M-4)
- Author of this manual recommends Paper 855B, as opposed to online version

C) Application Process – Tips on 855B

- Mass Immunizer Roster Biller Only
- 855R – Not Needed
- See Tips to Facilitate Medicare Enrollment Process (855B) Appendix M-5
- See Pomperaug Health District 855B Application as guide
- CMS – Constantly Updating 855B – Check for Latest Version
- Section 5, page 22 “Managing Control”
- Section 6, page 25 – SSN Required, Authorized Official
- Section 17, page 34 – Supporting Documents
    A. CMS 588 – Electronic Funds Transfer (see sample) (M-6)
    B. Copy Attestation for governmental entities (see sample) (M-7)
    C. CT State Department of Public Health Letter (M-8)
    D. Tax Payer – IRS EIN Document (M-9)
    E. Proof Payment Medicare Application Fee (M 10-11)
- Section 4 – page 15 – only one practice location
- Medicare Application Fee will be paid online after acquiring NPI Number www.pay.gov (M-12)

file copy
mailed 2/17/12 PDDH

MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices and Certain Other Suppliers

CMS-855B

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

WHO SHOULD SUBMIT THIS APPLICATION

Clinics and group practices can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855B).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll.*

Clinics and group practices who are enrolled in the Medicare program, but have not submitted the CMS 855B since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855B) as an initial application when reporting a change for the first time.

The following suppliers must complete this application to initiate the enrollment process:

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Clinic/Group Practice
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Intensive Cardiac Rehabilitation Supplier
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Part B Drug Vendor
- Portable X-ray Supplier
- Radiation Therapy Center

If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

- A **medical practice or clinic that will bill for Medicare Part B services**(e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- A **hospital or other medical practice or clinic** that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that bill Medicare Part B.
- **Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction** (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- **Currently enrolled in Medicare and need to make changes to your enrollment data** (e.g., you have added or changed a practice location). Changes must be reported in accordance with the timeframes established in 42 C.F.R. § 424.516(d). (IDTF changes of information must be reported in accordance with 42 C.F.R. § 410.33.)

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare health supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change for your existing Medicare enrollment information.** Applying for an NPI is a process separate from Medicare enrollment. As a supplier, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization (supplier) that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly.

Important: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.

To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov.* For more information about subparts, visit *www.cms.gov/NationalProvIdentStand* to view the "Medicare Expectations Subparts Paper."

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is used to identify a Medicare supplier.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in Section 2 is the supplier's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Ensure that the correct person signs the application.
- Send your application and all supporting documentation to the designated fee-for-service contractor.

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll.*

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

Certain information you provide on this application is considered to be protected under 5 U.S.CSection 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application for the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to *www.cms.gov/MedicareProviderSupEnroll.*

SECTION 1: BASIC INFORMATION

NEW ENROLLEES AND THOSE WITH A NEW TAX ID NUMBER

If you are:

- Enrolling in the Medicare program for the first time with this Medicare fee-for-service contractor under this tax identification number.
- Already enrolled with a Medicare fee-for-service contractor but are establishing a practice location in another fee-for-service contractor's jurisdiction.
- Enrolled with a Medicare fee-for-service contractor but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new application.
- A hospital or an individual hospital department that is enrolling with a fee-for-service contractor to bill for Part B services.

The following actions apply to Medicare suppliers already enrolled in the program:

ENROLLED MEDICARE SUPPLIERS

Reactivation

To reactivate your Medicare billing privileges, submit this enrollment application. In addition, prior to being reactivated, you must be able to submit a valid claim and meet all current requirements for your supplier type before reactivation may occur.

Voluntary Termination

A supplier should voluntarily terminate its Medicare enrollment when it:

- Will no longer be rendering services to Medicare patients, or
- Is planning to cease (or has ceased) operations.

Change of Ownership

If a hospital, ambulatory surgical center, or portable X-ray supplier is undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 C.F.R. 489.18, the entity must submit a new application for the new ownership.

Change of Information

A change of information should be submitted if you are changing, adding or deleting information under your current tax identification number.

Changes in your existing enrollment data must be reported to the fee-for-service contractor in accordance with 42 C.F.R. § 424.516 (Physician and Non Physician Practitioner Organizations). (IDTF changes of information must comply with the provisions found at 42 C.F.R. § 410.33.)
If you are already enrolled in Medicare and are not receiving Medicare payments via EFT, any change to your enrollment information will require you to submit a CMS-588 form. All future payments will then be made via EFT.

Revalidation

CMS may require you to submit or update your enrollment information. The fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by the fee-for-service contractor.

SECTION 1: BASIC INFORMATION
ALL APPLICANTS MUST COMPLETE THIS SECTION *(See instructions for details.)*

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **enrolling in another fee-for-service contractor's jurisdiction**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4. Medicare Identification Number(s) *(if issued):* National Provider Identifier *(if issued):*	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**
☐ You are **voluntarily terminating** your Medicare enrollment. (This is not the same as "opting out" of the program)	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued):* National Provider Identifier *(if issued):*	Sections **1, 2B1, 13,** and either **15 or 16** If you are terminating an employment arrangement with a physician assistant, complete Sections **1A, 2G, 13,** and either **15 or 16**

SECTION 1: BASIC INFORMATION *(Continued)*
ALL APPLICANTS MUST COMPLETE THIS SECTION *(See instructions for details.)*

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are **changing** your Medicare information	Medicare Identification Number: [redacted] National Provider Identifier *(if issued)*: [redacted]	Go to Section 1B
☒ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections** **Ambulance suppliers** must complete **Attachment 1** **IDTF suppliers** must complete **Attachment 2**

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☒ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Final Adverse Actions/Convictions	**1, 2B1, 3, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Practice Location Information, Payment Address & Medical Record Storage Information	**1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Change of Ownership (Hospitals, Portable X-Ray Suppliers & Ambulatory Surgical Centers Only)	**Complete all sections and provide a copy of the sales agreement**
☒ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B1, 3, 6, 13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are an authorized official) **or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Authorized Official(s)	**1, 2B1, 3, 13, 15 or 16** (if you are a delegated official), and **6** for the signer if that authorized or delegated official has not been established for this supplier
☒ Delegated Official(s) (Optional)	**1, 2B1, 3, 13, 15, 16,** and **6** for the signer if that delegated official has not been established for this supplier.

SECTION 1: BASIC INFORMATION *(Continued)*

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (ONLY)	REQUIRED SECTIONS
☐ Geographic Area	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(A)**
☐ State License Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(B)**
☐ Paramedic Intercept Services Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(C)**
☐ Vehicle Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 1(D)**
ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)	**REQUIRED SECTIONS**
☐ CPT-4 and HCPCS Codes	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(B)**
☐ Interpreting Physician Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(C)**
☐ Personnel (Technicians) Who Perform Tests	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(D)**
☐ Supervising Physician(s)	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(E)**
☐ Liability Insurance Information	**1, 2B1, 3, 13, and 15** if you are the authorized official **or 16** if you are the delegated official **Attachment 2(F)**

SECTION 2: IDENTIFYING INFORMATION

A. Type of Supplier

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

TYPE OF SUPPLIER: ***(Check one only)***

- ☐ Ambulance Service Supplier
- ☐ Ambulatory Surgical Center
- ☐ Clinic/Group Practice
- ☐ Hospital Department(s)
- ☐ Independent Clinical Laboratory
- ☐ Independent Diagnostic Testing Facility
- ☐ Intensive Cardiac Rehabilitation
- ☐ Mammography Center
- ☒ Mass Immunization (Roster Biller Only)
- ☐ Pharmacy
- ☐ Physical/Occupational Therapy Group in Private Practice
- ☐ Portable X-ray Supplier
- ☐ Radiation Therapy Center
- ☐ Other *(Specify)*: _____

B. Supplier Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Pomperaug District Department of Health

Tax Identification Number

[redacted]

Other Name	Type of Other Name
	☐ Former Legal Business Name ☐ Doing Business As Name ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. **(NOTE:** If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☒ Non-Profit

NOTE: If a checkbox indicating Proprietary or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership
☐ Sole Proprietor ☒ Other *(Specify)*: Local Health Dept.

Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the supplier has a State license/certification to operate as the supplier type for which you are enrolling.

☒ State License Not Applicable

License Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification Information

☒ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

3. CORRESPONDENCE ADDRESS

Provide contact information for the entity or person listed in Question 1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*

800 Main Street South

Mailing Address Line 2 *(Suite, Room, etc.)*

Suite 124

City/Town		State	ZIP Code + 4
Southbury		CT	06488-4212
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	
203-264-9616	203-262-1960	pomphealth@earthlink.net	

C. Hospitals Only

This section should only be completed by hospitals that are currently enrolled or enrolling with a fee-for service contractor (the Part A Medicare contractor), and will be billing a fee-for-service contractor for Medicare Part B services, as follows:

- Hospitals that need departmental billing numbers to bill for Part B practitioner services.
- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.
- If the hospital requires more than one departmental Part B billing number, list each department needing a number.

If your organization is not a hospital,and believes it will need a Part B billing number, contact the designated fee-for-service contractor to determine if this form should be submitted.

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. Hospitals Only *(Continued)*

NOTE: If your hospital is enrolling a clinic that is not provider-based, do not complete this section.

Check ☐ "Clinic/Group Practice" in Section 2A and complete this entire application for the clinic.

1. Are you going to:
   ☐ bill for the entire hospital with one billing number? (If yes, continue to Section 2D.)
   ☐ separately bill for each hospital department? (If yes, answer Question 2.)
2. List the hospital departments for which you plan to bill separately:

DEPARTMENT	MEDICARE IDENTIFICATION NUMBER	NPI

D. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location, the method by which you render health care services, etc.

As the local health department for 3 towns, we are a mass immunizer, providing approximately 3200 influenza and pneumococcal vaccines each year. We may roster bill or bill electronically.

E. Physical Therapy (PT) and Occupational Therapy (OT) Groups Only

1. Are all of the group's PT/OT services rendered in patients' homes or in the group's private office space? ☐ YES ☐ NO
2. Does this group maintain private office space? ☐ YES ☐ NO
3. Does this group own, lease, or rent its private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for the group's private practice? ☐ YES ☐ NO
5. Does this group provide PT/OT services outside of its office and/or patients' homes? ☐ YES ☐ NO

If you responded YES to any of the questions 2–5 above, submit a copy of the lease agreement that gives the group exclusive use of the facilities for PT/OT services.

F. Accreditation for Ambulatory Surgical Centers (ASCs) Only

NOTE: Copy and complete this section if more than one accreditation needs to be reported.

Check one of the following and furnish any additional information as requested:

☐ The enrolling ASC supplier is accredited.

☐ The enrolling ASC supplier is not accredited (includes exempt providers).

Name of Accrediting Organization

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration of Current Accreditation *(mm/dd/yyyy)*

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

G. Termination of Physician Assistants *(Only)*

Complete this section to delete employed physician assistants from your group or clinic.

EFFECTIVE DATE OF DEPARTURE	PHYSICIAN ASSISTANT'S NAME	PHYSICIAN ASSISTANT'S MEDICARE IDENTIFICATION NUMBER	PHYSICIAN ASSISTANT'S NPI

H. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all suppliers that also furnish and will bill Medicare for ADI services. All suppliers furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI modality this supplier will furnish and the name of the Accrediting Organization that accredited that ADI Modality for this supplier.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse actions listed on page 13 of this application imposed against it?

   ☐ YES–Continue Below ☒ NO–Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse action documentation and resolution.

FINAL ADVERSE ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

This section captures information about the physical location(s) where you currently provide health care services. If you operate a mobile facility or portable unit, provide the address for the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units.

Only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you have practice locations in another Medicare fee-for-service contractor's jurisdiction, complete a separate enrollment application (CMS-855B) for those practice locations and submit it to the Medicare fee-for-service contractor that has jurisdiction over those locations.

Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box. If you provide services in a hospital and/or other health care facility for which you bill Medicare directly for the services rendered at that facility, provide the name and address of the hospital or facility.

MOBILE FACILITY AND/OR PORTABLE UNIT

A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A "portable unit" is when the supplier transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render services to the patient.

The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray suppliers, portable mammography, and mobile clinics. Physicians and non-physician practitioners (e.g., nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

If you see patients in more than one practice location, copy and complete Section 4A for each location.

To ensure that CMS establishes the correct association between your Medicare legacy number and your NPI, providers and suppliers must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Pomperaug District Department of Health

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

800 Main Street South

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

Suite 124

City/Town	State	ZIP Code + 4
Southbury	CT	06488-4212

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
203-264-9616	203-262-1960	pomphealth@earthlink.net

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

10/01/1993

Medicare Identification Number *(if issued)*	National Provider Identifier
[redacted]	[redacted]
Medicare Identification Number *(if issued)*	National Provider Identifier
Medicare Identification Number *(if issued)*	National Provider Identifier
Medicare Identification Number *(if issued)*	National Provider Identifier
Medicare Identification Number *(if issued)*	National Provider Identifier

Is this practice location a:

- ☐ Group practice office/clinic
- ☐ Hospital
- ☐ Retirement/assisted living community
- ☐ Skilled Nursing Facility and/or Nursing Facility
- ☒ Other health care facility
  (Specify): Local Health Dept-Mass Immuniz

CLIA Number for this location *(if applicable)*

Attach a copy of the most current CLIA certifications for each of the practice locations reported on this application

FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

Attach a copy of the most current FDA certifications for each of the practice locations reported on this application.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where do you want remittance notices or special payments sent?
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payments will be made by EFT, the "Special Payments" address should indicate where all other payment information (e.g., remittance notices, special payments) should be sent.

☒ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). Skip to Section 4C.

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

C. Where do you keep patients' medical records?
If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4E, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. The records must be the supplier's records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4A or 4E.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. Rendering Services in Patients' Homes

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Furnish the city/town, State and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate CMS-855B enrollment application for each Medicare fee-for-service contractor's jurisdiction.

If you are adding or deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If you are providing services in selected cities/towns, furnish the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Check here ☐ and skip to Section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

Street Address Line 1 *(Street Name and Number)*

Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than two vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE *(van, mobile home, trailer, etc.)*	VEHICLE IDENTIFICATION NUMBER
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Geographic Location for Mobile Or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855B) for each Medicare fee-for-service contractor's jurisdiction.

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services you are deleting are furnished in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: Only report organizations in this section. Individuals must be reported in Section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: *www.cms.hhs.gov/MedicareProviderSupEnroll*. If there is more than one organization that should be reported, copy and complete this section for each.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the supplier to furnish management services for the business.

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations

If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program.

Non-Profit, Charitable and Religious Organizations

Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a board of trustees or other governing body. The actual name of the board of trustees or other governing body should be reported in this section. While the organization should be listed in Section 5, individual board members should be listed in Section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

All organizations that have any of the following must be reported in Section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

A. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Check all that apply:

☐ 5 Percent or More Ownership Interest ☐ Partner ☒ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

Pomperaug District Department of Health

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

800 Main Street South

Address Line 2 *(Suite, Room, etc.)*

Suite 124

City/Town	State	ZIP Code + 4
Southbury	CT	06488-4212

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
203-264-9616	203-262-1960	pomphealth@earthlink.net

NPI *(if issued)*	Tax Identification Number *(Required)*	Medicare Identification Number(s) *(if issued)*
[redacted]	[redacted]	[redacted]

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this organization acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* 7/1/1986

NOTE: Furnish both dates if applicable.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

B. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☒ NO–Skip to Section 6

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on "direct" and "indirect" owners, go to *www.cms.hhs.gov/MedicareProviderSupEnroll.*

The supplier MUST have at least ONE owner and/or managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A. Based on this example, the supplier would check the "5 percent or Greater Direct/Indirect" box in Section 6A.

NOTE: All partners within a partnership must be reported on this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the supplier, each limited partner must be reported on this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

Non-Profit, Charitable or Religious Organizations: If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should submit with your application a 501(c)(3) document verifying non-profit status.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

Officer is any person whose position is listed as being that of an officer in the supplier's "articles of incorporation" or "corporate bylaws," or anyone who is appointed by the board of directors as an officer in accordance with the supplier's corporate bylaws.

Director is a member of the supplier's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "directors." Thus, if the supplier has a governing body titled "board of trustees" (as opposed to "board of directors"), the individual trustees are considered "directors" for Medicare enrollment purposes.

Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the supplier is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported, except those who are listed as authorized or delegated officials on this application.

Any information on final adverse actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual. Owners, Authorized Officials and/or Delegated Officials must complete this section.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

A. Individuals with Ownership Interest and/or Managing Control—Identification Information
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name	Middle Initial	Last Name	Jr., Sr., etc.	Title
Neal	A.	Lustig		Director of Health

Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth
[redacted]	[redacted]	[redacted]

Social Security Number *(Required)*	Medicare Identification Number *(if issued)*	NPI *(if issued)*
[redacted]	[redacted]	[redacted]

What is the above individual's relationship with the supplier in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☒ Authorized Official
- ☐ Delegated Official
- ☐ Partner
- ☐ Director/Officer
- ☐ Contracted Managing Employee
- ☐ Managing Employee (W-2)

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* 04/04/1988

NOTE: Furnish both dates if applicable.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☒ NO–Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

A. Individuals with Ownership Interest and/or Managing Control—Identification Information
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name	Middle Initial	Last Name	Jr., Sr., etc.	Title
Mona	D.	LaBissoniere		Health Educator

Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth
[redacted]	[redacted]	[redacted]

Social Security Number *(Required)*	Medicare Identification Number *(if issued)*	NPI *(if issued)*
[redacted]	[redacted]	[redacted]

What is the above individual's relationship with the supplier in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Authorized Official
- ☒ Delegated Official
- ☐ Partner
- ☐ Director/Officer
- ☐ Contracted Managing Employee
- ☐ Managing Employee (W-2)

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? *(mm/dd/yyyy)* 12/1/1987

NOTE: Furnish both dates if applicable.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☒ NO–Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☒ **Check here if this section does not apply and skip to Section 13.**

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service	If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*
"Doing Business As" Name *(if applicable)*	Tax Identification/Social Security Number *(required)*
Billing Agency Street Address Line 1 *(Street Name and Number)*	
Billing Agency Street Address Line 2 *(Suite, Room, etc.)*	

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 12: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below.

☐ Contact an Authorized Official listed in Section 15.

☒ Contact a Delegated Official listed in Section 16.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Mona	D.	LaBissoniere	

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
203-264-9616	203-262-1960	mlabiss@earthlink.net

Address Line 1 *(Street Name and Number)*

800 Main Street South

Address Line 2 *(Suite, Room, etc.)*

Suite 124

City/Town	State	ZIP Code + 4
Southbury	CT	06488-4212

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

   Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

   The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:

   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;

   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION *(Continued)*

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a) was not provided as claimed; and/or

   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.

7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

NOTE: Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855B, you must complete Section 6 for that individual.**

By his/her signature(s), an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.520(b). (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

A. Additional Requirements for Medicare Enrollment

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. § 424.516. I understand that any change in the business structure of this supplier may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

B. 1ST Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*
Neal	A.	Lustig	

Telephone Number	Title/Position
203-264-9616	Director of Health

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*
Neal Lustig, MD	02/14/2012

(blue ink preferred)

C. 2ND Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position

Authorized Official 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: DELEGATED OFFICIAL (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. A delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, a delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*
Mona	D.	LaBissoniere	

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*
Mona LaBissoniere	02/14/2012
☒ Check here if Delegated Official is a W-2 Employee	Telephone Number: 203-264-9616
Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)* 02/14/2012

(blue ink preferred)

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

B. 2ND Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

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

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

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

(blue ink preferred)

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 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. 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

- ☐ 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.)"
- ☒ 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 its banking information, the CMS-588 is not required.)

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or State licenses or certification for IDTF non-physician personnel.
- ☐ Copy(s) of all documentation verifying the State licenses or certifications of the laboratory Director or non-physician practitioner personnel of an independent clinical laboratory.

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.
- ☐ 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.
- ☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom 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.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☒ Copy of an attestation for government entities and tribal organizations.
- ☐ Copy of FAA 135 certificate (air ambulance suppliers).
- ☐ Copy(s) of comprehensive liability insurance policy (IDTFs only).

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment.

A. Geographic Area

This section is to be completed with information about the geographic area in which this company provides ambulance services. If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Provide the city/town, State, and ZIP code for all locations where this ambulance company renders services.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

NOTE: If the ambulance company has vehicles garaged within a different Medicare contractor's jurisdiction, a separate CMS-855B enrollment application must be submitted to that fee-for-service contractor.

1. INITIAL REPORTING AND/OR ADDITIONS

If services are provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	STATE	ZIP CODE

2. DELETIONS

If services are no longer provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	STATE	ZIP CODE

B. State License Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Crew members must complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be retained with the employer in case it is required by the Medicare fee-for-service contractor.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Is this ambulance company licensed in the State where services are rendered and billed for? ☐ YES ☐ NO

If **NO**, explain why:

If **YES**, provide the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

License Number	Issuing State *(if applicable)*	Issuing City/Town *(if applicable)*

Effective Date *(mm/dd/yyyy)*	Expiration Date *(mm/dd/yyyy)*

C. Paramedic Intercept Services Information

Paramedic Intercept Services involve an arrangement between a Basic Life Support (BLS) ambulance company and an Advanced Life Support (ALS) ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract. For more information, see 42 C.F.R. 410.40.

If reporting a change to information about a previously reported agreement/contract, check "Change" and provide the effective date of the change.

☐ Change
Effective Date:_____

Does this ambulance company currently participate in a paramedic intercept services arrangement?

☐ YES ☐ NO

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS *(Continued)*

D. Vehicle Information

Complete this section with information about the vehicles used by this ambulance company and the services they provide. If there is more than one vehicle, copy and complete this section as needed. Attach a copy of each vehicle registration.

To qualify as an air ambulance supplier, the following is required:

- A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility, and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Type *(automobile, aircraft, boat, etc.)*	Vehicle Identification Number

Make *(e.g., Ford)*	Model *(e.g., 350T)*	Year *(yyyy)*

Does this vehicle provide:

Advanced life support (Level 1)	☐ YES	☐ NO	Specialty care transport	☐ YES	☐ NO
Advanced life support (Level 2)	☐ YES	☐ NO	Land ambulance	☐ YES	☐ NO
Basic life support	☐ YES	☐ NO	Air ambulance–fixed wing	☐ YES	☐ NO
Emergency runs	☐ YES	☐ NO	Air ambulance–rotary wing	☐ YES	☐ NO
Non-emergency runs	☐ YES	☐ NO	Marine ambulance	☐ YES	☐ NO

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES

INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) PERFORMANCE STANDARDS

Below is a list of the performance standards that an IDTF must meet in order to obtain or maintain their Medicare billing privileges. These standards, in their entirety, can be found in 42 C.F.R section 410.33(g).

1. Operate its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 calendar days.
3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.
   (i) The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.
   (ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
4. Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.
5. Maintain a primary business phone under the name of the designated business. The primary business phone must be located at the designated site of the business, or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local directory and through directory assistance.
6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must:
   (i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and
   (ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.
7. Agree not to directly solicit patients, which include, but is not limited to, a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Nonphysician practitioners may order tests as set forth in §410.32(a)(3).

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:
   (i) The name, address, telephone number, and health insurance claim number of the beneficiary.
   (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
   (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.
9. Openly post these standards for review by patients and the public.
10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.
11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.
12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.
13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.
14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must be accessible during regular business hours to CMS and beneficiaries and must maintain a visible sign posting the normal business hours of the IDTF.
15. With the exception of hospital-based and mobile IDTFs, a fixed base IDTF does not include the following:
   (i) Sharing a practice location with another Medicare-enrolled individual or organization.
   (ii) Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.
   (iii) Sharing diagnostic testing equipment using in the initial diagnostic test with another Medicare-enrolled individual or organization.
16. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.
17. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act.

Instructions

If you perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF, you must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards including, but not limited to, those listed on page 40 of this application. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF.

Diagnostic Radiology

Many diagnostic tests are radiological procedures that require the professional services of a radiologist. A radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. If enrolling as a diagnostic radiology group practice or clinic and billing for the technical component of diagnostic radiological tests without enrolling as an IDTF (if the entity is a free standing diagnostic facility), it should contact the carrier to determine that it does not need to enroll as an IDTF.

A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier.

Regulations governing IDTFs can be found at 42 C.F.R. 410.33.

CPT-4 and HCPCS Codes—Report all CPT-4 and HCPCS codes for which this IDTF will bill Medicare. Include the following:

- Provide the CPT-4 or HCPCS codes for which this IDTF intends to bill Medicare,
- The name and type of equipment used to perform the reported procedure, and
- The model number of the reported equipment.

The IDTF should report all Current Procedural Terminology, Version 4 (CPT-4) codes, Healthcare Common Procedural Coding System codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

Consistent with IDTF supplier standard 6 on page 40 of this application, all IDTFs enrolling in Medicare must have a comprehensive liability insurance policy of at least $300,000 per location, that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the date the insurance lapsed. Malpractice insurance policies do not demonstrate compliance with this requirement.

All IDTFs must submit a complete copy of the aforementioned liability insurance policy with this application.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

A. Standards Qualifications

Provide the date this Independent Diagnostic Testing Facility met all current CMS standards *(mm/dd/yyyy)*

B. CPT-4 and HCPCS Codes

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

All codes reported here must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported. Clinical laboratory and pathology codes should not be reported. This page may be copied for additional codes or equipment.

	CPT–4 OR HCPCS CODE	EQUIPMENT	MODEL NUMBER *(Required)*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

C. Interpreting Physician Information

Check here ☐ if this section does not apply because the interpreting physician will bill separate from the IDTF.

All physicians whose interpretations will be billed by this IDTF with the technical component (TC) of the test (i.e., global billing) must be listed in this section. If there are more than three physicians, copy and complete this section as needed. All interpreting physicians must be currently enrolled in the Medicare program.

If you are billing for interpretations as an individual reassigning benefits, the interpreting physician must complete the Reassignment of Benefits Form (CMS 855R). Note: Both the IDTF and individual physician must be enrolled with the fee-for-service contractor where the IDTF is located.

If you are billing for purchased interpretations, all requirements for purchased interpretations must be met.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF cannot bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

1ST Interpreting Physician Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*
Medicare Identification Number *(if issued)*	**NPI**

2ND Interpreting Physician Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*
Medicare Identification Number *(if issued)*	**NPI**

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

3RD Interpreting Physician Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*

Medicare Identification Number *(if issued)*	NPI

D. Personnel (Technicians) Who Perform Tests

Complete this section with information about all non-physician personnel who perform tests for this IDTF. Notarized or certified true copies of the State license or certificate should be attached.

1ST PERSONNEL (TECHNICIAN) INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*

Is this technician State licensed or State certified? *(see instructions for clarification)* ☐ YES ☐ NO

License/Certification Number *(if applicable)*	License/Certification Issue Date *(mm/dd/yyyy) (if applicable)*

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization *(if applicable)*	Type of Credentials *(if applicable)*

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: _____

2ND Personnel (Technician) Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*

Is this technician State licensed or State certified? *(see instructions for clarification)* ☐ YES ☐ NO

License/Certification Number *(if applicable)*	License/Certification Issue Date *(mm/dd/yyyy) (if applicable)*

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization *(if applicable)*	Type of Credentials *(if applicable)*

Is this technician employed by a hospital? ☐ YES ☐ NO

If **YES**, provide the name of the hospital here: _____

E. Supervising Physicians

Complete this section with identifying information about the physician(s) who supervise the operation of the IDTF and who provides the personal, direct, or general supervision per 42 C.F.R. 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from your Medicare fee-for-service contractor. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 C.F.R. 410.32(b)(3). All supervisory physician(s) must be currently enrolled in Medicare.

The type of supervision being performed by each physician who signs the attestation on page 47 of this application should be listed in this section.

Definitions of the types of supervision are as follows:

- **Personal Supervision** means a physician must be in attendance in the room during the performance of the procedure.
- **Direct Supervision** means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- **General Supervision** means the procedure is provided under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. General supervision also includes the responsibility that the non-physician personnel who perform the tests are qualified and properly trained and that the equipment is operated properly, maintained, calibrated and that necessary supplies are available.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

E. Supervising Physicians *(Continued)*

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy) (Required)*

Medicare Identification Number *(if issued)*	NPI

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

TYPE OF SUPERVISION PROVIDED

Check the appropriate box below indicating the type of supervision provided by the physician reported above for the tests performed by the IDTF in accordance with 42 C.F.R. 410.32 (b)(3) (See instructions for definitions).

☐ Personal Supervision ☐ Direct Supervision ☐ General Supervision

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement, in accordance with 42 C.F.R. 410.33(b), the enrolling IDTF must have at least one supervisory physician for each of the three functions. For example, two physicians may be responsible for function 1, a third physician may be responsible for function 2, and a fourth physician may be responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. Each physician should only check the function(s) he/she actually performs.

☐ Assumes responsibility for the overall direction and control of the quality of testing performed.

☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.

☐ Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

OTHER SUPERVISION SITES

Does this supervising physician provide supervision at any other IDTF? ☐ YES ☐ NO

If yes, list all other IDTFs for which this physician provides supervision. For more than five, copy this sheet.

	NAME OF FACILITY	ADDRESS	TAX IDENTIFICATION NUMBER	LEVEL OF SUPERVISION
1.				
2.				
3.				
4.				
5.				

E. Supervising Physicians *(Continued)*

ATTESTATION STATEMENT FOR SUPERVISING PHYSICIANS

All Supervising Physician(s) rendering supervisory services for this IDTF must sign and date this section. All signatures must be original.

1. I hereby acknowledge that I have agreed to provide (IDTF Name)_____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in this Attachment. (See number 2 below if all reported CPT-4 and HCPCS codes do not apply). I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I undertake supervisory responsibility at any additional IDTFs, I understand that it is my responsibility to notify this IDTF at that time.
2. I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in this Attachment.

CPT–4 OR HCPCS CODE	CPT–4 OR HCPCS CODE	CPT–4 OR HCPCS CODE

3. Signature of Supervising Physician *(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)*	Date *(mm/dd/yyyy)*

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

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395l(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0373

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*
Pomperaug Health District 800 Main Street South, Suite 124 Southbury, CT 06488	[redacted]

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC)/carrier with whom this agreement is being filed.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date:** If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____. Currently enrolled NGS
3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
   a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
   b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant (or authorized representative of participating organization)		Date
[signature]		11/22/11
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Director of Health		203-264-9616
Received by (name of carrier)	Initials of Carrier Official	Effective Date

Pomperaug District Department of Health
800 Main Street, South • Suite 124 • Southbury, Connecticut 06488
(203) 264-9616 • Woodbury (203) 266-4785 • Oxford (203) 888-6891
Fax: (203) 262-1960 • Website: www.pomperaughealthdistrict.org

January 6, 2012

NGS
Attn: Revaluation
P.O. Box 50437
Indianapolis, IN 46250-0437

RE: NPI #[redacted] – Attestation for Government Entities

To Whom It may Concern:

This letter is to attest that The Pomperaug District Department of Health will be legally and financially responsible for Medicare payments received and in the event that there is any outstanding debt owed to CMS.

As the Director of Health, I have authority to legally and financially bind the Pomperaug District Department of Health to the laws, regulations, and program instructions of Medicare. By Connecticut State Statute, I am also the Secretary and Treasurer for Pomperaug District Department of Health.

If you have any questions, please do not hesitate to call me at 203-264-9616.

Yours truly,

Neal Lustig, M.P.H.
Director of Health

[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

- [X] New EFT Authorization
- [ ] Revision to Current Authorization
  (e.g. account or bank changes)
- [ ] Check here if EFT payment is being made to the Home Office of Chain
  (Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

- [ ] Change of Ownership, and/or
- [ ] Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name
Pomperaug District Department of Health

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address
800 Main Street South, Suite 124

Account Holder's City	Account Holder's State	Account Holder's Zip Code
Southbury	CT	06488

Tax Identification Number: (designate ☐ SSN or ☐ EIN)
[redacted]

Medicare Identification Number (if issued)
☐☐☐☐☐☐☐☐☐☐☐☐

National Provider Identifier (NPI)
[redacted]

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name
Wells Fargo

Financial Institution City/Town	Financial Institution State
San Francisco	CA
Financial Institution Telephone Number	**Financial Institution Contact Person**
1-800-289-3557	

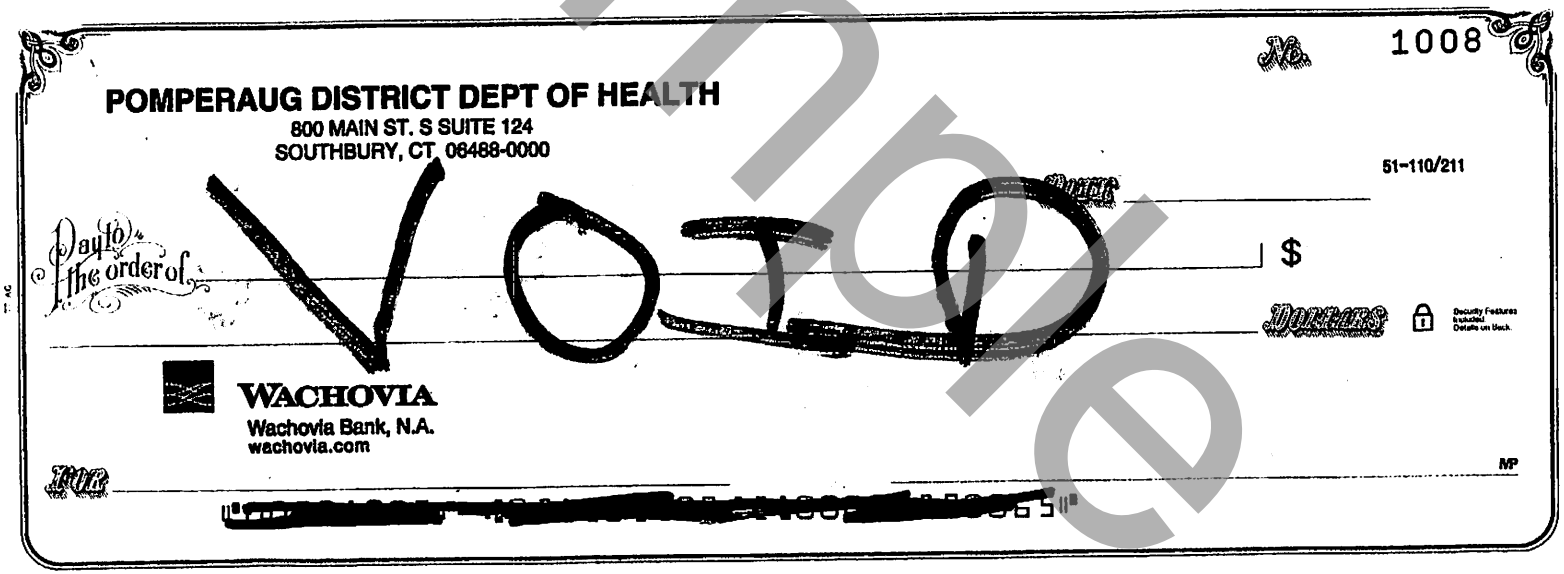
Financial Institution Routing Transit Number (nine digit)
[redacted]

Depositor Account Number	Type of Account (check one)
[redacted]	☒ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Neal Lustig	Director of Health
Contact Person's Telephone Number	**Contact Person's E-mail Address**
203-264-9616	Pomphealth@earthlink.net



No. 1008

POMPERAUG DISTRICT DEPT OF HEALTH
800 MAIN ST. S SUITE 124
SOUTHBURY, CT 06488-0000

51-110/211

Pay to the order of VOID $

Dollars

Security Features Included Details on Back.

WACHOVIA
Wachovia Bank, N.A.
wachovia.com

For

MP

PART V: AUTHORIZATION

I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMS may assign its rights and obligations under this agreement to CMS' designated fee-for-service contractor. CMS may change its designated contractor at CMS' discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CMS has received written notification from me of its termination in such time and such manner as to afford CMS and the Financial Institution a reasonable opportunity to act on it. CMS will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMS an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Neal Lustig	203-264-9616
Authorized/Delegated Official Title	**Authorized/Delegated Official E-mail Address**
Director of Health	Pomphealth@earthlink.net
Authorized/Delegated Official Signature *(Note: Must be original signature in black or blue ink.)*	**Date**
Neal Lustig, MPH	2/16/12

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Per 42 CFR 424.510(d)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request; and (2) submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

J. Robert Galvin, M.D., M.P.H.
Commissioner

M. Jodi Rell
Governor

February 8, 2007

Mr. Neal Lustig, MPH, RS
Director of Health
Pomperaug Health District
800 Main Street, Suite 130
Southbury, CT 06488

Dear Mr. Lustig:

This is to certify that the Pomperaug Health District has been properly organized in accordance with Sections 19a-241 to 19a-245 of the General Statutes of Connecticut, as amended, so that it is constituted as an official governmental health district and comes under the definition of municipalities insofar as the municipal employees' retirement program is concerned.

As an official governmental agency receiving its entire support from the towns of Oxford, Southbury, Woodbury and from the State of Connecticut, the Pomperaug Health District therefore has tax-exempt status and is eligible for prices on materials in the same way as municipalities.

Sincerely,

J. Robert Galvin, MD, MPH
Commissioner

JRG/ljs

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II: PROVIDER OR SUPPLIER INFORMATION

Line 1: Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.

Line 2: Enter the chain organization's name or the home office legal business name if different from the chain organization name.

Line 3: Enter the account holder's street address.

Line 4: Enter the account holder's city, state, and zip code.

Line 5: Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

Line 6: If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

Line 7: Enter the 10 digit NPI number. The NPI is required to process this form.

PART III: FINANCIAL INSTITUTION INFORMATION

Line 8: Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds). Note: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.

Line 9: Enter the city or town where your financial institution is located. Enter the state where your financial institution is located.

Line 10: Enter the bank or financial institutional telephone number and contact person's name.

Line 11: Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.

Line 12: Enter the depositor's account number, including applicable leading zeros. Select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV: CONTACT PERSON

Line 13: Enter the name and title of a contact person who can answer questions about the information submitted on this CMS-588 form.

Line 14: Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

Line 15: By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions with the effective date of the EFT authorization. You must notify CMS regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CMS-855 Medicare enrollment application which the Medicare contractor has on file. Include a telephone number where the Authorized Representative or Delegated Official can be contacted.

Mail this form with the original signature in black or blue ink (no facsimile signatures can be accepted) to the Medicare contractor that services your geographical area. An EFT authorization form must be submitted for each Medicare contractor to whom you submit claims for Medicare payment. To locate the mailing address for your fee-for-service contractor, go to: *www.cms.gov/MedicareProviderSupEnroll.*

Department of the Treasury
Internal Revenue Service

08011320 L

Date of This Notice

07-17-86

If you inquire about your account, please refer to this number or attach a copy of this notice.

Employer Identification Number

▶ [redacted]

POMPERAUG DISTRICT DEPARTMENT OF
HEALTH
ATTN THEODORE J WITEK JR TOWN HALL
501 MAIN ST S
SOUTHBURY CT 06488

NOTICE OF NEW EMPLOYER IDENTIFICATION NUMBER ASSIGNED

Thank you for your Form SS-4, Application for Employer Identification Number. The number assigned to you is shown above. This number will be used to identify your business account and related tax returns and documents, even if you do not have employees.

Please keep a copy of this number in your permanent records. Use this number and your name, exactly as shown above, on all Federal tax forms that require this information, and refer to the number on all tax payments and tax-related correspondence or documents.

If your business is a partnership which must obtain prior approval for its tax year, the tax year you entered in Block 3 of your Form SS-4 does not establish a tax year. For guidance in determining if you must request prior approval and the method of doing so, see IRS Publication 538, Accounting Periods and Methods, available at most IRS offices.

For Exempt Organizations, please see the message on the reverse side.

Thank you for your cooperation.

575 B 941E

Subject: Pay.Gov Payment Confirmation
Date: Thursday, November 3, 2011 11:33:18 AM ET
From: paygovadmin@mail.doc.twai.gov
To: pomphealth@earthlink.net

THIS IS AN AUTOMATED MESSAGE. PLEASE DO NOT REPLY.

Transaction Summary

Application Name: Medicare Application Fee
Pay.gov Tracking ID: 254S2[redacted]
Agency Tracking ID: 2011110300000[redacted]
Transaction Type: Sale
Transaction Date: Nov 3, 2011 11:33:18 AM

Account Holder Name: Neal Lustig
Transaction Amount: $505.00
Billing Address: 5 Pheasant Lane
City: Madison
State/Province: CT
Zip/Postal Code: 06443
Country: USA
Card Type: MasterCard
Card Number: **********7411

[redacted]

Appendix M - 2

National Government Services.

Site Search
Enter Keyword(s) -- Please Select -- Search

Web Services

Obtain claims status and eligibility information, request an appeal, view financials, and much more using the Connex online Web application.

Training Events Calendar
Upcoming training and events for Medicare suppliers and providers.

Medicare University
Online Medicare-related interactive training services for suppliers and providers.

NGS CEDI
National Government Services CEDI information.

Meeting Your Medicare Needs

NGSMedicare.com offers valuable Medicare-related content for providers and suppliers of Medicare services and products.

Part A	Part B	DME	FQHC	HHH
Medical Policy (LCDs, SIAs, Coverage)	**Medical Policy** (LCDs, SIAs, Coverage)	**Medical Policy** (LCDs, PAs, Coverage)	**Contact Us** (IVR, Telephone, Addresses)	**EDI** (Enrollment, Software)
EDI (Enrollment, Software)	**Fee Schedules** (Pricing All Part B Regions)	**Fee Schedules** (Pricing Information)	**FAQs** (ASCA, ABN, Revenue Codes)	**Contact Us** (IVR, Telephone, Addresses)
Contact Us (IVR, Telephone, Addresses)	**EDI** (Enrollment, Software)	**Manuals** (Supplier Manual, CMS IOMs)	**EDI** (Enrollment, Software)	**Self-Service Center** (Calculators, Status Tools)
Forms (855, EDI, Appeals)	**Self-Service Center** (Calculators, Status Tools)	**Forms** (Appeals, CMNs, Overpayments)	**Manuals** (FISS/DDE, EDI, CMS IOMs)	**Manuals** (FISS/DDE, EDI, CMS IOMs)
Appeals (Levels, Filing & Dollar Limits)	**Contact Us** (IVR, Telephone, Addresses)	**FAQs** (ASCA, DME, Oxygen, O&P)	**Medical Policy** (LCDs, SIAs, Coverage)	**Forms** (855, EDI, Appeals)
Enrollment (New, Modify Existing, Forms)	**Forms** (855, EDI, Overpayment)	**EDI** (CEDI Enrollment, ERA)	**Forms** (855, EDI, Appeals)	**FAQs** (Enrollment, EDI, ASCA)
Self-Service Center (Calculators, Status Tools)	**Enrollment** (New, Modify Existing, Forms)	**Self-Service Center** (Calculators, Status Tools)	**Self-Service Center** (Calculators, Status Tools)	**Enrollment** (New, Modify Existing, Forms)

We also provide helpful resources for Medicare beneficiaries and Congressional offices.
People with Medicare and Congressional Offices

National Government Services.

Site Search: Enter Keyword(s) | Part B | Search

Advanced Search

Part B >

Home | Resources | Enrollment | FAQs

E-mail This Page | Print This Page | Bookmark This Page | Text Size | Language English | Change Business Type

Quick Links

- Connex Online Inquiry
- Customer Service (IVR and Telephone)
- Fee Schedules
- Forms
- Mailing Addresses
- Medical Policy Center (LCDs)
- Medicare Monthly Review
- News Articles
- Training Events Calendar

Expand All | Collapse All

- **Publications**
  - E-mail Updates
  - Manuals
  - Medicare Monthly Review
  - News Articles
- **Claims**
  - Administrative Simplification Compliance Act
  - Coordination of Benefits
  - Electronic Submissions (EDI)
  - Fee Schedules
  - HCPCS Codes
  - Medicare Secondary Payer
  - Top Claims Submission Errors
- **Coverage Determinations**
  - Medical Policy Center
- **Education and Training**
  - Clinical Education
  - Medicare University
  - POE Advisory Group
  - Training Events Calendar
  - Training Summaries
  - Welcome New Providers
- **Review Process**
  - Appeals
  - Comprehensive Error Rate Testing
  - Fraud & Abuse
  - Medical Review
  - Recovery Audit Program

Medicare Part B Home

Self-Service Center

View All Self-Service Tools

Hot Topic — Quick access to important Medicare, CMS, and National Government Services initiatives

- » CERT Program
- » CMS Electronic Submission of Medical Documentation for J13/JB MAC Providers and Suppliers EXTRA
- » CMS Incentive Payment Information
- » Check Your Provider Enrollment Application Status
- » EDI Self-Service Password Portal
- » Enrollment Forms and Information
- » File Appeals Online with Connex!
- » Important J8 MAC Transition Information for Part B IN Providers EXTRA
- » PECOS Web
- » Register Now for the Jurisdiction 13 2012 Medicare Regional Conferences! EXTRA

Urgent 5010 Message

The compliance deadline for the transition to Version 5010 has arrived!

17 days, 04 hours, 32 minutes, 05 seconds left before CMS enforcement of the 5010/D.0 compliance.

Read More

Latest Production Alerts

View Details for All Alerts

203 | [RESOLVED] Electronic Data Interchange Gateway Outage | 06/05/2012
The NGS EDI Gateway was experiencing technical issues and was temporarily shut down between 8:49 to 9:35 a.m. eastern time (ET).

170 | Incorrect Skilled Nursing Facility Consolidated Billing | 11/22/2011
The Common Working File (CWF) System Maintainer has identified a problem impacting Skilled Nursing Facility (SNF) Consolidated Billing (CB) claims and coded a system correction that was implemented on Monday, November 21, 2011.
The CWF is incorrectly denying some services excluded from SNF CB with the following reason code messages:
109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
N538 - A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.

162 | Physician Quality Reporting System Duplicate Payment Issue Checks | 10/10/2011
National Government Services identified an issue with the Physician Quality Reporting System (PQRS) that resulted in a duplicate payment situation for Part B providers in Connecticut and New York.

146 | HPSA and HSIP Bonus Payments Calculated Incorrectly for Q1 and Q2 2011 | 06/20/2011
Incorrect files were inadvertently loaded in the production region for health professional shortage area (HPSA) and HPSA surgical incentive program (HSIP) bonus payments.

Latest Part B News Articles

View All News Articles

- » (SE1213 Revised) Questionable Billing By Suppliers of Lower Limb Prostheses PDF
- » (PE201206-17) Advance Payment ACO Model: New Opportunity to Apply
- » (PE201206-16) July 2012 Average Sales Price Files Now Available
- » (PE201206-14) Medicare Fee-for-Service to Reject Version 4010 Electronic Transactions July 1, 2012
- » (MM7821) Advance Beneficiary Notice of Noncoverage, Form CMS-R-131, Updated Manual Instructions PDF

uick Links

Connex Online Inquiry
Customer Service (IVR and Telephone)
Fee Schedules
Forms
Mailing Addresses
Medical Policy Center (LCDs)
Medicare Monthly Review
News Articles
Training Events Calendar

and All | Collapse All

Publications
- E-mail Updates
- Manuals
- Medicare Monthly Review
- News Articles

Claims
- Administrative Simplification Compliance Act
- Coordination of Benefits
- Electronic Submissions (EDI)
- Fee Schedules
- HCPCS Codes
- Medicare Secondary Payer
- Top Claims Submission Errors

Coverage Determinations
- Medical Policy Center

Education and Training
- Clinical Education
- Medicare University
- POE Advisory Group
- Training Events Calendar
- Training Summaries
- Welcome New Providers

Review Process
- Appeals
- Comprehensive Error Rate Testing
- Fraud & Abuse
- Medical Review
- Recovery Audit Program

Enrollment Tools

Select the scenario that best applies to you to access instructions, forms, and enrollment information, or choose from the Supplemental Enrollment Resources options below.

Enrollment Change Scenarios

» Change of Ownership
» Change of Tax ID

Initial Enrollment Scenarios

» Active Medicare Provider Joining Established Medicare Group
» Enroll as an Ordering/Referring Provider Only
» Group/Organization Enrolling for the First Time
» Individual or Sole Provider Enrolling for the First Time

Revalidation Scenarios

» Revalidations--Required CMS-855 Forms and Helpful Hints

Supplemental Enrollment Resources

» Application Fee
» Application Status Inquiry Tool
» Contact and Mailing Information
» Deactivation of Billing Privileges/Suspension of Payment
» Electronic Funds Transfer
» Enroll to Receive Remittance Advice Electronically
» Enroll to Submit Claims Electronically
» Forms
» Frequently Asked Questions
» Internet-Based PECOS EXTERN

Before You Start: A Checklist for a Provider or Supplier Organization using PECOS

Below is a checklist of information that will be needed to complete enrollments using Internet-Based PECOS:

- ✓ An active National Provider Identifier (NPI).
- ✓ Pecos Identification and Authentication (I&A) user Id and password
  - o Be an authorized official
  - o Security Consent Form

  Note: If you are an Authorized Official or acting on behalf of a provider you will need to get your own user ID. For complete instructions, please visit: http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf
- ✓ Personal identifying information. This includes:
  - o Type of Provider *(Part A applicants only)*
  - o Legal Business Name on file with the Internal Revenue Service (IRS)
  - o Tax Identification Number or Employer Identification Number
  - o Business Structure, Incorporation Date and State Where Incorporated (if applicable)
- ✓ State Business license information. This includes:
  - o State license number
  - o Original effective date
  - o Expiration/Renewal date
  - o State where issued
- ✓ Certification information. This includes:
  - o Certification number
  - o Original effective date
  - o Expiration/Renewal date
  - o State where issued
- ✓ Correspondence Information *(Part A applicants only)*
- ✓ Accreditation Information *(Part A applicants only, if applicable)*
  - o Date of Accreditation
  - o Name of Accrediting Body
  - o Type of Accreditation or Accreditation Program
- ✓ Supplier Type

- ✓ If applicable, information regarding any final adverse actions. A final adverse action includes:
  - a Medicare-imposed revocation of any Medicare billing privileges;
  - suspension or revocation of a license to provide health care by any State licensing authority;
  - revocation or suspension by an accreditation organization;
  - a conviction of a Federal or State felony offense (as defined in 42 CFR 424.535(a)(3)(A)(i)) within the last ten years preceding enrollment, revalidation, or re-enrollment;
  - or an exclusion or debarment from participation in a Federal or State health care program.
- ✓ Practice location information. This information includes:
  - Organization's medical practice location
  - Base of Operations location *(Part A applicants only)*
  - Special Payment Information
  - Medical Record Storage Information
  - Rendering Services in Patient's Homes *(Part B applicants only)*
  - Mobile or Portable Providers Only – Location of Business Office or Dispatcher/Scheduler *(Part A applicants only)*
  - Vehicle Information *(Part A applicants only, if applicable)*
  - Geographic Location for mobile or portable providers where the base of operations and/or vehicle renders services *(Part A applicants only, if applicable)*
- ✓ Ownership Interest and/or Managing Control Information for Organizations
  - If applicable, information regarding any final adverse actions.
- ✓ Ownership Interest and/or Managing Control Information for Individuals
  - If applicable, information regarding any final adverse actions.
- ✓ Chain Home Office Information *(Part A applicants only, if applicable)*
- ✓ Billing Agency Information (if applicable)
- ✓ Capitalization Requirements *(HHAs only)*
- ✓ Authorized/Delegated Officials
- ✓ Any Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility.

- ✓ Electronic Funds Transfer documentation - mechanism by which providers and suppliers receive Medicare Part A and Part B payments directly into a designated bank account.

Please Note: Before any enrollment action can be taken by an individual using Internet-based PECOS on behalf of a provider or supplier organization, a number of processes must be completed. These processes will register and authenticate the Authorized Official (AO) of the provider or supplier organization and the individual(s) who will be using Internet-based PECOS on behalf of the provider or supplier organization. In addition, these processes will establish the relationship between the provider or supplier organization and the organization whose employee(s) will use Internet-based PECOS on behalf of the provider or supplier organization. These processes begin with the AO of the provider or supplier organization, and they may take several weeks to be completed. For complete instructions, please visit:
http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf

Tips to Facilitate the Medicare Enrollment Process for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

For security reasons, some information is not printed on the Medicare application. Please review your application and provide information for all Date of Birth and Social Security Number fields.

To ensure that your Medicare enrollment application is processed timely, you should:

1. **Submit the 2011 version of the Medicare enrollment application (CMS-855).**

   Effective July 2011, the Centers for Medicare & Medicaid Services (CMS) revised the CMS-855 Medicare enrollment applications. Providers and suppliers must submit the appropriate 2011 version of the CMS-855 Medicare enrollment application. The application version can be found in the lower left corner of the application.

   If an applicant submits the previous version of the CMS-855, the Medicare contractor will return this application without further review.

   An electronic copy of the current CMS-855 Medicare enrollment application follows this tip sheet.

2. **Submit the correct application for your provider or supplier type to the Medicare fee-for-service contractor servicing your State or location.**

   The Medicare contractor that serves your State or practice location is responsible for processing your enrollment application. Applicants must submit their application(s) to the appropriate Medicare feefor-service contractor. A list of the Medicare fee-for-service contractors by State can be found in the download section of www.cms.hhs.gov/MedicareProviderSupEnroll .

3. **Submit a complete application.**

   When completing the CMS-855 for the first time, each section of an application must be completed in ink (blue preferable). When reporting a change to your enrollment information, complete each section listed in Section 1B of the CMS-855.

   Note: If you are enrolled in Medicare, but have never submitted the CMS-855, you are required to submit a complete application. Providers and Suppliers should follow the instructions for completing an initial enrollment application.

   The attachment at the end of this document provides tips for completing certain sections of the CMS-855B.

4. **Request and obtain your National Provider Identifier (NPI) number before enrolling or making a change in your Medicare enrollment information**

   CMS requires that providers and suppliers obtain their National Provider Identifier (NPI) **prior to** enrolling or updating their enrollment record with Medicare. A Medicare contractor will **not** process your enrollment application without the NPI and a copy of the NPI notification letter received from the National Plan and Provider Enumeration System or from the organization requesting your NPI. The NPI notification is required with **each** CMS-855 application you submit.

   If you do not have an NPI, please contact the NPI Enumerator at https://nppes.cms.hhs.gov or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

5. **Submit the Electronic Funds Transfer Authorization Agreement (CMS-588) with your enrollment application, if applicable.**

   CMS requires that providers and suppliers, who are enrolling in the Medicare program or making a change in their enrollment data, receive payments via electronic funds transfer. Reminder: When completing the CMS-588 complete each section.

   The CMS-588 must be signed by the authorized official that signed the CMS-855.

   Note: If a provider or supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. If you are a supplier who is reassigning all of your benefits to a group, neither you nor the group is required to receive payments via electronic funds transfer.

6. **Submit all supporting documentation.**

   In addition to a complete application, each provider or supplier is required to submit all applicable supporting documentation at the time of filing. Supporting documentation includes professional licenses, business licenses, the National Provider Identifier notification received from the National Plan and Provider Enumeration System and, if applicable, an authorization agreement for Electronic Funds Transfer Authorization Agreement (CMS-588).

   See Section 17 of the Medicare enrollment application for additional information regarding the applicable documentation requirements.

7. **Sign and date the application.**

   Applications must be **signed and dated** by the appropriate individuals. Signatures must be original and in ink (blue preferable). Copied or stamped signatures will **not** be accepted.

8. **Respond to fee-for-service contractor requests promptly and fully.**

   To facilitate your enrollment into the Medicare program, respond promptly **and** fully to any request for additional or clarifying information from the fee-for-service contractor.

CMS-855B Section Specific Tips

General — Prior to completing the Medicare enrollment application, read the instructions found at the beginning of each application.

- Request and obtain your National Provider Identifier (NPI) number before enrolling or making a change in your Medicare enrollment information. A Medicare contractor will not process your enrollment application without the NPI and a copy of the NPI notification letter received from the National Plan and Provider Enumeration System or from the organization requesting your NPI with each CMS-855 application you submit. If you do not have an NPI, please contact the NPI Enumerator at https://nppes.cms.hhs.gov or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- Submit the correct application for your provider or supplier type to the Medicare fee-for-service contractor servicing your State or location. Providers and suppliers must submit their application(s) to the appropriate Medicare fee-for-service contractor. A list of the Medicare fee-for-service contractors by State can be found in the download section of http://www.cms.hhs.gov/MedicareProviderSupEnroll/ .

AVOID DELAYS IN YOUR ENROLLMENT—SUBMIT A COMPLETE APPLICATION

Below are specific tips to help you complete the CMS-855B.

Note: Applicants who submit an incomplete application will be required to resubmit the previously missing information along with a new, signed certification page. Failure to provide this information in a prompt manner will delay your enrollment into the Medicare program.

Section 1

- Enter the reason for submission.
- Enter the Medicare Identification Number, if issued, and the associated National Provider Identifier number if you voluntarily terminating or changing your Medicare enrollment information.
- Provide the effective date of termination if you are voluntarily terminating your Medicare enrollment.

Section 2

- Provide the Tax Identification Number (EIN) and proof of the tax identification number (i.e., IRS CP 575) on the 855B in Section 2. Note: the legal business name must match the tax identification number.

Section 3

- Provide a response (check the appropriate box) to the Final Adverse Legal Actions/Convictions question. Your application will be considered incomplete if the information is missing or you enter not applicable in Section 3.
- List all final adverse actions, if any, in Section 3 and submit associated documentation.

Section 4

- The practice location must be the actual physical location of the practice or facility where the applicant furnishes services.
- Enter the Medicare Identification Number, if issued, and the associated National Provider Identifier number that you have assigned to organizational entity.
- If the special payment address in Section 4B is for a billing agency, complete Section 8 and submit the billing agreement.
- Add, change, or delete boxes are not marked and dates are not listed.

Section 5

- Provide a response (check the appropriate box) to the Final Adverse Legal Actions/Convictions question. Your application will be considered incomplete if the information is missing or you enter not applicable in Section 3.
- List all final adverse legal actions, if any, in Section 3 and submit associated documentation.
- Add, change, or delete boxes are not marked and dates are not listed.

Section 6

- Provide a response (check the appropriate box) to the Final Adverse Legal Actions/Convictions question. Your application will be considered incomplete if the information is missing or you enter not applicable in Section 3.
- List all final adverse legal actions, if any, in Section 3 and submit associated documentation.
- List all Board members regardless of whether for or not-for-profit.
- List all Managing and Owning individuals.
- Add, change, or delete boxes are not marked and dates are not listed.

Section 13

- The contact person listed in this Section should be available to assist with clarifications and additional information.

Section 15

- Applicants must be signed and dated by the appropriate individuals. If an applicant is submitting an initial application or an application in response to a contractor's revalidation request, the Authorized Official signs and dates this section.
- Authorized Official can also sign and date this section if submitting a change of Medicare information.

Section 16

- In lieu of the Authorized Official, the Delegated Authorized Official can sign and date this section.

Section 17

- Submit all supporting documentation at the time of filing, including copies of professional school degrees or certificates, professional licenses, and/or evidence of qualifying course work.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Authorization

☐ Revision to Current Authorization
(e.g. account or bank changes)

☐ Check here if EFT payment is being made to the Home Office of Chain
(Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

☐ Change of Ownership, and/or

☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address

Account Holder's City	Account Holder's State	Account Holder's Zip Code

Tax Identification Number: (designate ☐ SSN or ☐ EIN)

☐☐☐☐☐☐☐☐☐☐☐☐☐

Medicare Identification Number (if issued)

☐☐☐☐☐☐☐☐☐☐☐☐☐

National Provider Identifier (NPI)

☐☐☐☐☐☐☐☐☐☐

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town	Financial Institution State
Financial Institution Telephone Number	**Financial Institution Contact Person**

Financial Institution Routing Transit Number (nine digit)

☐☐☐☐☐☐☐☐☐

Depositor Account Number	Type of Account (check one)
☐☐☐☐☐☐☐☐☐☐☐☐☐	☐ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	**Contact Person's E-mail Address**

PART V: AUTHORIZATION

I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMS may assign its rights and obligations under this agreement to CMS' designated fee-for-service contractor. CMS may change its designated contractor at CMS' discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CMS has received written notification from me of its termination in such time and such manner as to afford CMS and the Financial Institution a reasonable opportunity to act on it. CMS will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMS an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Note: Must be original signature in black or blue ink.)*	Date

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Per 42 CFR 424.510(e)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request; and (2) submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

DO NOT MAIL THIS FORM TO THIS ADDRESS.
MAILING YOUR APPLICATION TO THIS ADDRESS WILL SIGNIFICANTLY DELAY PROCESSING.

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II: PROVIDER OR SUPPLIER INFORMATION

Line 1: Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.

Line 2: Enter the chain organization's name or the home office legal business name if different from the chain organization name.

Line 3: Enter the account holder's street address.

Line 4: Enter the account holder's city, state, and zip code.

Line 5: Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

Line 6: If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

Line 7: Enter the 10 digit NPI number. The NPI is required to process this form.

PART III: FINANCIAL INSTITUTION INFORMATION

Line 8: Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds). Note: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.

Line 9: Enter the city or town where your financial institution is located. Enter the state where your financial institution is located.

Line 10: Enter the bank or financial institutional telephone number and contact person's name.

Line 11: Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.

Line 12: Enter the depositor's account number, including applicable leading zeros. Select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV: CONTACT PERSON

Line 13: Enter the name and title of a contact person who can answer questions about the information submitted on this CMS-588 form.

Line 14: Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

Line 15: By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions with the effective date of the EFT authorization. You must notify CMS regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CMS-855 Medicare enrollment application which the Medicare contractor has on file. Include a telephone number where the Authorized Representative or Delegated Official can be contacted.

Mail this form with the original signature in black or blue ink (no facsimile signatures can be accepted) to the Medicare contractor that services your geographical area. An EFT authorization form must be submitted for each Medicare contractor to whom you submit claims for Medicare payment. To locate the mailing address for your fee-for-service contractor, go to: *www.cms.gov/MedicareProviderSupEnroll.*

Pomperaug District Department of Health
800 Main Street, South • Suite 124 • Southbury, Connecticut 06488
(203) 264-9616 • Woodbury (203) 266-4785 • Oxford (203) 888-6891
Fax: (203) 262-1960 • Website: www.pomperaughealthdistrict.org

January 6, 2012

NGS
Attn: Revaluation
P.O. Box 50437
Indianapolis, IN 46250-0437

RE: NPI #[redacted] – Attestation for Government Entities

To Whom It may Concern:

This letter is to attest that The Pomperaug District Department of Health will be legally and financially responsible for Medicare payments received and in the event that there is any outstanding debt owed to CMS.

As the Director of Health, I have authority to legally and financially bind the Pomperaug District Department of Health to the laws, regulations, and program instructions of Medicare. By Connecticut State Statute, I am also the Secretary and Treasurer for Pomperaug District Department of Health.

If you have any questions, please do not hesitate to call me at 203-264-9616.

Yours truly,

Neal Lustig, M.P.H.
Director of Health

[redacted]

Appendix M - 8

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

J. Robert Galvin, M.D., M.P.H.
Commissioner

M. Jodi Rel
Governor

February 8, 2007

Mr. Neal Lustig, MPH, RS
Director of Health
Pomperaug Health District
800 Main Street, Suite 130
Southbury, CT 06488

Dear Mr. Lustig:

This is to certify that the Pomperaug Health District has been properly organized in accordance with Sections 19a-241 to 19a-245 of the General Statutes of Connecticut, as amended, so that it is constituted as an official governmental health district and comes under the definition of municipalities insofar as the municipal employees' retirement program is concerned.

As an official governmental agency receiving its entire support from the towns of Oxford, Southbury, Woodbury and from the State of Connecticut, the Pomperaug Health District therefore has tax-exempt status and is eligible for prices on materials in the same way as municipalities.

Sincerely,

J. Robert Galvin, MD, MPH
Commissioner

JRG/ljs

PHONE: (860) 509-7101 FAX: (860) 509-7111
410 CAPITOL AVENUE - MS#13COM, P.O. BOX 340308, HARTFORD, CONNECTICUT 06134-0308

Department of the Treasury
Internal Revenue Service

08011320 L

Date of This Notice

07-17-86

If you inquire about your account, please refer to this number or attach a copy of this notice.

Employer Identification Number

▶ [redacted]

POMPERAUG DISTRICT DEPARTMENT OF
HEALTH
ATTN THEODORE J WITEK JR TOWN HALL
501 MAIN ST S
SOUTHBURY CT 06488

NOTICE OF NEW EMPLOYER IDENTIFICATION NUMBER ASSIGNED

Thank you for your Form SS-4, Application for Employer Identification Number. The number assigned to you is shown above. This number will be used to identify your business account and related tax returns and documents, even if you do not have employees.

Please keep a copy of this number in your permanent records. Use this number and your name, exactly as shown above, on all Federal tax forms that require this information, and refer to the number on all tax payments and tax-related correspondence or documents.

If your business is a partnership which must obtain prior approval for its tax year, the tax year you entered in Block 3 of your Form SS-4 does not establish a tax year. For guidance in determining if you must request prior approval and the method of doing so, see IRS Publication 538, Accounting Periods and Methods, available at most IRS offices.

For Exempt Organizations, please see the message on the reverse side.

Thank you for your cooperation.

575 B 941E

Form 5372 (Rev. 5-86)

Subject: Pay.Gov Payment Confirmation
Date: Thursday, November 3, 2011 11:33:18 AM ET
From: paygovadmin@mail.doc.twai.gov
To: pomphealth@earthlink.net

THIS IS AN AUTOMATED MESSAGE. PLEASE DO NOT REPLY.

Transaction Summary

Application Name: Medicare Application Fee
Pay.gov Tracking ID: 254S2QT7
Agency Tracking ID: 20111103000001245
Transaction Type: Sale
Transaction Date: Nov 3, 2011 11:33:18 AM

Account Holder Name: Neal Lustig
Transaction Amount: $505.00
Billing Address: 5 Pheasant Lane
City: Madison
State/Province: CT
Zip/Postal Code: 06443
Country: USA
Card Type: MasterCard
Card Number: **********7411

Medicare Application Fee Factsheet

Statutory Requirement. Section 6401(a) of the ***Affordable Care Act*** requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The statute specifies the amount of the application fee and the formula to be used for annual updates based on changes in the Consumer Price Index.

Application Fee Amount & Who Pays. The application fee in calendar year 2011 is $505.00. The fee is to be imposed on newly-enrolling and re-validating institutional providers and suppliers beginning March 25, 2011. The Centers for Medicare & Medicaid Services (CMS) has defined, "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S or associated Internet-based PECOS* enrollment application.

Fee Usage. According to the ***Affordable Care Act***, the application fee will be used to cover the cost of program integrity activities including provider screening associated with provider enrollment processes. The pre-enrollment screening of providers and suppliers is an essential tool in CMS' effort to fight fraud and abuse in the Medicare program and assure the cost effective use of taxpayer dollars. The end result of a more rigorous screening process will be the establishment of greater "front door" controls on the outflow of Medicare dollars. It well established that keeping questionable parties out of Federal programs is the most effective method of curbing losses due to fraud and abuse.

Payment Vehicle. In order to meet the requirements of the new law, CMS has partnered with the U.S. Department of Treasury to develop a process by which institutional providers and suppliers may submit their application fee electronically. The Treasury Department operates a secure web-based application called Pay.gov (www.pay.gov) which allows end users to fill out and submit forms online as well as make online payments to government agencies by credit card or by debit from their checking or savings account. Pay.gov is a secure system. It uses 128-bit SSL encryption to protect a user's transaction information while he/she is logged in to the system. In addition, any account numbers users set up in their profile are encrypted before being stored in the database. When users accesses their profile, any account numbers they entered will be masked on-screen; each account number in their profile will be displayed as a group of asterisks followed by the last four digits of the account number.

CMS's Use of Technology. CMS strongly encourages newly-enrolling and re-validating institutional providers and suppliers to use Pay.gov because of its security, convenience and simplicity. Upon paying the application fee, providers and suppliers will receive an electronic receipt which they can print right from the Pay.gov website. The new payment method eliminates possible confusion in the paper check submission and receipt notification process. Providers and suppliers will be able to make electronic payments of the new Medicare application fee using Pay.gov effective March 25, 2011. Look for future enhancements.

* Provider Enrollment, Chain and Ownership System

TransactRx - Tab

TransactRX

Provider Availability - Yes

Types of contracted immunization service available to Local Health Departments:

- Influenza vaccine
- Pneumococcal vaccine

TransactRX Contact Person:

Fabi Dominquez
Transact Customer Care
6635 West Happy Valley Road
Suite 104502
Glendale , Ar 85310
Phone: 866-522-3386

A) Provider Requirements:

- Public health department must:
  - have an NPI number
  - have a tax ID number
  - have liability insurance
  - medical license provided (medical advisor)
  - DEA Certificate
  - W-9
  - Existing Medicare # (?)

B) Application Process:

- Contact Fabi Dominquez
- She will send an agreement/applications (see samples)
- Fill out application and return it to Fabi Dominquez

Notes: TranasctRX is a sort of a electronic billing processor. They have a well designed web interface and provides Medicare Part D and Medicare Part B Comprehensive solutions with contracted payers. The Web interface is advanced enough to tell you immediately the coverage status of an individual, so they claim. They charge $1.50 per claim for medicare part B. They state that the LHD does not have to contract with NGS-Medicare or pay the fee ($523). They take care of that. They further state that they can assist the LHD in securing contracts with private insurers in CT., i.e. Connecticare, Anthem, Aetna. See appendices T-1, 2, 3 for additional info.

Appendix T-1

National Immunization Network Participation Instructions for Medical Providers

To enroll with TransactRx you will need to submit the following documents:

1. A list of all participating providers, their NPI, Pharmacy license number, Medicaid number, DEA number, and NPI. Copies of the following should be provided for each participating provider:
    a. DEA certificate
    b. Medical license
    c. Any applicable board certifications or accreditations
    d. Medicare and Medicaid #'s
    e. Date of birth
2. Tax ID
3. Malpractice insurance certificate
4. NPI number – copy of confirmation letter/email
5. PNT Provider Agreement - must be completed and signed
6. W-9

Any questions regarding these forms should be forward to Fabi Dominguez, Customer Care Supervisor, at 866-522-3386 or email fdominguez@pocnettech.com.

Subject: TransactRx Vaccine Manager

Date: Monday, June 25, 2012 3:24:17 PM ET

From: Michael Henderson

To: pomphealth@earthlink.net

Thank you for speaking with me earlier. Below I have provided a summary which highlights our programs benefits of which you may find beneficial.

TransactRx Vaccine Manager offers a **free web-based application** that allows users to ***verify eligibility***, ***benefits and file your claims electronically*** to the insurance companies.

Vaccines covered by **Medicare D** are; **all billable via TransactRx at no charge**.

- Zostovax
- Adacel (Syringe and Vial)
- Boostrix (Syringe and Vial)
- Ceftriaxone
- Cervarix (Syringe and Vial)
- Decavac (Syringe and Vial)
- Havrix
- Menactra (Syringe and Vial)
- Menomune
- Prolia
- Reclast
- Tetanus and Diphtheria
- Twinrix
- Vaqta
- Varivax

Vaccines covered by **Medicare B** are; all billable at just **$1.50 per submitted claim**

- Flu
- Pneumovax
- Afluvria
- Fluarix
- Flulaval
- Flumist
- Fluvirin
- Prevnar

We contract with Medicare so you don't have to! TransactRx has contracted with Medicare B and the majority of Medicare D plans nationally as a convenience to you. We have extended our contract to you for your claims processing. This alone is a cost savings of over $505.00 annually in Medicare credentialing cost associated in obtaining a Medicare PTAN provider billing number. This will also eliminate the need to roster bill or manually bill your claims to Medicare.
You may also process your **Medicaid, Commercial / Private Insurance** claims via our free web-based application.

- Medicaid Eligibility and Claim Submission: Varies by service and state, but very affordable
- Commercial Eligibility Verification and Claim Submission: $1.50/claim

Appendix T-3

PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT ("Agreement"), effective as of date of the last signature below ("Effective Date"), is made by and between POC Network Technologies, Inc. a Delaware corporation, dba TransactRx ("TransactRx"), with its principal offices located at 2332 Galiano Street, Suite 250, Coral Gables, FL 33134, and the entity listed below (the "Provider").

Full legal name: _____

Principal business address: _____

_____

State of incorporation: _____

WHEREAS, TransactRx is a provider of claims processing services, healthcare provider networks, web based software applications and revenue cycle management services for healthcare providers; and

WHEREAS, Provider desires to utilize one or more of the technologies and/or services provided by TransactRx as specified in the attached Service Riders ("TransactRx Services");

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

1. **License.** Subject to the terms of this Agreement, TransactRx hereby licenses to Provider a nonexclusive, nontransferable end user license for the term of this Agreement to utilize the necessary specifications and related materials for use with the TransactRx Services in Provider's business, and hereby licenses to Provider a nonexclusive, nontransferable license to use the TransactRx Services in compliance with this Agreement, any specifications and related materials furnished by TransactRx.
2. **Modification of Services.** TransactRx may, in its sole discretion, modify and/or update the TransactRx Services. In such event, TransactRx will provide to Provider, within a reasonable time, any additional specifications and related materials needed by Provider to allow implementation by Provider of such modified or updated services.
3. **Fees.** Provider agrees the Fees set forth in the attached executed Service Riders are due and payable within thirty (30) days of invoice date. TransactRx may modify the fees set forth in a Service Rider upon ninety (90) days written notice to Provider. If Provider fails to make payment with respect to any invoice by its due date, such invoice shall be deemed delinquent and a late charge equivalent to 1 ½% per month, or the maximum rate permitted by applicable law if less, of the unpaid balance shall be payable for each month, or portion thereof, during which the delinquency remains outstanding. TransactRx reserves the right to suspend use of the TransactRx Services at any time if past due invoices are not paid within 10 days following notice by TransactRx of such past due amounts, and all costs of collection, including reasonable attorneys' fees, shall be paid by Provider.
4. **Taxes or Charges.** Provider is responsible for payment of any taxes or charges imposed by any governmental or regulatory authority with respect to the delivery of products or services hereunder, excluding taxes on the net income of TransactRx, but including, without limitation, all sales and use taxes.
5. **Term and Termination.**
    a. This Agreement shall be effective as of the Effective Date appearing on the signature page hereof and shall continue in effect for a one (1) year term, and shall automatically renew for successive one-year terms unless either party provides written notice of non-renewal to the other party at least sixty (60) calendar days' prior to the end of the initial term or any renewal term.
    b. This entire Agreement may be terminated as follows:
        i. This Agreement will terminate automatically without notice with respect to Provider as of the date on which such Provider fails to maintain appropriate licensure, registration, certification, good standing, or insurance, as required under this Agreement and/or Law.
        ii. TransactRx may terminate this Agreement immediately upon written notice to Provider in the event of:

1. Breach of any representation, warranty or covenant of Provider in this Agreement;
2. The transfer of ownership of any of Provider's practice to a new owner, or if the right to control any aspect of Provider's operations is transferred to another person or entity;
3. Provider becomes insolvent, admits it is unable to pay its debts, an action is filed by or against Provider under the Federal Bankruptcy Act or any other Law or act regarding insolvency, reorganization, arrangement, or extension for the relief of debtors, including any assignment for the benefit of creditors, the appointment of a receiver or trustee for transfer or sale of a material portion of Provider's assets, or TransactRx's receipt of a writ of attachment, execution or garnishment;
4. Provider or Provider's employees act in an illegal, unethical, unscrupulous or immoral manner which adversely impacts the reputation of TransactRx, its Affiliates, or Payers; or
5. Provider engages in any fraudulent activity related to the terms of this Agreement.

c. Either Party may terminate this Agreement at any time for material breach by the other party by giving at least thirty (30) days' written notice to the other party, or such longer period as required by Law, which termination shall become effective at the end of such notice period if such breach is not cured to the satisfaction of the non-breaching party by such date.

d. In the event of termination or breach of this Agreement, in addition to all other rights and remedies TransactRx may have at Law, equity, or under this Agreement, TransactRx shall have the right, upon notice to Provider, to: (i) deduct from any amounts owing to Provider any amounts which Provider owes TransactRx; (ii) impose reasonable investigation, collection, audit, and/or similar fees with respect to any breach of this Agreement; (iii) suspend performance of any and/or all of TransactRx's obligations under or in connection with this Agreement, including, without limitation, TransactRx's obligation to process claims; and/or (iv) suspend Provider's performance of any and/or all of Provider's obligations under or in connection with this Agreement.

e. Upon termination of this Agreement, Provider shall return, at its expense, any Manuals, participation identification materials and other documents or materials supplied to Provider by TransactRx in connection with this Agreement, including all confidential and proprietary information of TransactRx.

f. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. The termination rights hereunder are in addition to any and all other rights and remedies that may be available to TransactRx under this Agreement.

6. Relationship of the Parties.

a. TransactRx and Provider are independent entities, and nothing in this Agreement shall be interpreted to create any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement. In the performance of the obligations of this Agreement, regarding any services rendered under this Agreement, by either party or its agents, servants, or employees, each party is at all times acting and performing as an independent contractor with respect to the other party, and no party shall have or exercise any control or direction over the method by which the other party shall perform such work or render or perform such services and functions. It is further expressly agreed that no work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative, or employee of, or joint venture with, or fiduciary of, the other party. No provision of this Agreement or any part of any Plan shall be construed to require any provider to dispense or administer any medication or specific type of medication to any Covered Individual if, in the provider's reasonable professional judgment, such medication should not be dispensed to such person.

b. This Agreement is non-exclusive, and Provider may contract with other third party entities so long as its ability to perform its obligations under this Agreement is not impaired. Nothing in this Agreement shall in any way restrict the ability of TransactRx or Provider to enter into any agreement of any kind relating to the subject matter of this Agreement.

7. **Indemnification**. All liability arising from the provision of any services rendered by Provider will be the sole responsibility of Provider. Provider will indemnify, defend, and hold harmless TransactRx, its designees, Payers, and their respective shareholders, officers, directors, employees, agents, and representatives from and against any and all liabilities, losses, awards, settlements, claims, injuries, damages, expenses, demands, penalties, or judgments of any kind

(including reasonable costs, expenses, and attorneys' fees) that may result or arise out of: (a) any actual or alleged malpractice, negligence, misconduct, or breach by Provider in the performance or omission of any act or responsibility assumed by Provider; (b) the provision of Provider services for the sale, compounding, dispensing, manufacturing, or use of a drug or device dispensed by Provider; or (c) the breach or alleged breach by Provider of any representation, warranty, or covenant of Provider as set forth in this Agreement.

8. **Representations and Warranties**.

   a. TransactRx represents and warrants to Provider that TransactRx will provide the TransactRx Services in accordance with the terms of this Agreement.

   b. TRANSACTRX MAKES NO EXPRESS WARRANTIES AS TO SUCH TRANSACTRX SERVICES, AND NO WARRANTIES ARE TO BE IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. IN NO EVENT SHALL TRANSACTRX, ITS SUBSIDIARIES OR AFFILIATES, OR ITS SUBCONTRACTORS, HAVE ANY LIABILITY WHATSOEVER TO PROVIDER ARISING OUT OF OR IN CONNECTION WITH SUPPLYING OR FAILING TO SUPPLY THE TRANSACTRX SERVICES.

9. **Limitation of Liability**.

   A. NOTWITHSTANDING ANY OTHER TERM OF THIS AGREEMENT, IN NO EVENT SHALL TRANSACTRX BE LIABLE TO PROVIDER FOR SPECIAL, INDIRECT, INCIDENTAL, EXEMPLARY, CONSEQUENTIAL (INCLUDING BUT NOT LIMITED TO LOSS OF PROFITS) OR PUNITIVE DAMAGES ARISING FROM THE RELATIONSHIP OF THE PARTIES OR THE CONDUCT OF BUSINESS UNDER THIS AGREEMENT (EVEN IF TRANSACTRX HAS BEEN ADVISED OF OR HAS FORESEEN THE POSSIBILITY OF SUCH DAMAGES).

   b. IN ANY EVENT NEITHER PARTY'S AGGREGATE LIABILITY HEREUNDER FOR ANY AND ALL CLAIMS ARISING HEREUNDER OR AS A RESULT HEREOF SHALL EXCEED THE TOTAL AMOUNT OF NET FEES PAID BY PROVIDER FOR THE APPLICABLE TRANSACTRX SERVICES FOR THE IMMEDIATELY PRECEDING TWELVE MONTH PERIOD. THE FOREGOING LIMITATION OF LIABILITY REPRESENTS THE ALLOCATION OF RISK OF FAILURE BETWEEN THE PARTIES AS REFLECTED IN THE PRICING HEREUNDER AND IS AN ESSENTIAL ELEMENT OF THE BASIS OF THE BARGAIN BETWEEN THE PARTIES.

10. **Ownership.** Provider acknowledges and agrees that TransactRx claims and reserves all rights afforded to TransactRx under all applicable intellectual property laws in all TransactRx Services and TransactRx Materials, including without limitation TransactRx Confidential Information furnished to Provider or its Representatives in connection with this Agreement. The Agreement shall not affect any transfer of right, title, or interest in or to any such TransactRx Service or Confidential Information, and Provider agrees that it shall not assert any right, title, or interest in or to any such TransactRx Service or Confidential Information. Ownership rights to all data and information submitted to Data Processor or TransactRx in connection with this Agreement shall vest in TransactRx.

11. **Confidential Information.**

   a. Provider shall utilize reasonable security controls to protect the System which are no less stringent than those Provider uses to protect its own proprietary rights. Provider agrees that all data submitted to TransactRx for processing and all output provided by TransactRx shall be delivered and transported to and from Provider at its sole risk, cost and expense.

   b. Provider and TransactRx agree that all patient related data transmitted between Provider and TransactRx shall be treated as confidential so as to comply with all Laws regarding the confidentiality of healthcare records, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and amendments thereto, and/or is prudent in accordance with applicable industry standards. Provider agrees to execute any documents reasonably necessary for Provider, TransactRx and/or a Payer to comply with HIPAA. Provider agrees never to provide patients' information resulting from the use of TransactRx Services to others for Provider's pecuniary gain. Nothing herein is meant, however, or shall be construed, to limit the rights of TransactRx, or the rights of governmental authorities, to inspect and copy any accounting, administrative, or Covered Individual records maintained by Provider pursuant to the audit provisions of this Agreement.

   c. Provider agrees that all terms contained herein and within any other agreement between TransactRx and Provider, and all pricing, programs, services, business practices, and procedures of TransactRx and Payers are

confidential and/or proprietary. Provider agrees to maintain the confidential nature of such materials and not to disclose the terms and conditions contained herein or contained in any other agreement with TransactRx or any pricing, programs, services, business practices, or procedures of TransactRx or Payers, without the express written consent of TransactRx or the applicable Payer, unless such information is already publicly available due to no fault of Provider or such disclosure is required to comply with any Law.

d. Provider shall promptly notify TransactRx if it becomes aware of any use of confidential information or data that is not authorized by TransactRx. Provider acknowledges and agrees that any unauthorized disclosure or use of confidential and/or proprietary information or data obtained from or provided by TransactRx would cause TransactRx immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if Provider fails to comply with this Article 11, TransactRx is entitled to seek and obtain injunctive relief, monetary remedies, and/or such other damages as available by Law against Provider.

12. Force Majeure and Excusable Delay. Except as provided herein, neither party shall be liable for any Losses attributable to nonperformance arising out any "Event of Force Majeure". As used herein, "Event of Force Majeure" means an act beyond the control of a party, including without limitation, an act of any federal, state or local governmental authority, act of God, terrorism, loss of communication, delay of the other party or third parties, strike, riot, fire, flood, lightning, electrical power failure, natural disaster or other similar cause beyond the party's control. Each party shall give the other prompt notice of the occurrence of any Event of Force Majeure that is expected to cause delay hereunder, and the date of performance by any such party shall be extended for a period not exceeding the period of delay caused by the Event of Force Majeure identified in such notice. Notwithstanding any other provision in this Agreement and/or any applicable schedule(s) to the contrary, neither party shall be liable for any delay or failure in the performance of its obligations under this Agreement and/or applicable exhibits or schedule that directly results from any failure of the other party to perform its obligations as set forth in this Agreement and/or applicable exhibits or schedule. Neither party shall be responsible to the other for interruptions or cancellations arising from non-cooperation and/or non-participation of third party information suppliers.

13. General Provisions

a. Entire Agreement. This Agreement together with all schedules, attachments, exhibits, Manuals, and addenda attached hereto or incorporated herein, contains the entire Agreement between TransactRx and Provider, all of which are incorporated by reference as if fully set forth herein and referred to collectively as this "**Agreement**". Any prior oral or written agreements, promises, negotiations, or representations concerning the subject matter covered by this Agreement are terminated and of no force and effect except that all existing pricing schedules and addenda shall be incorporated into this Agreement, unless otherwise provided for in any attached Schedule to this Agreement. This Agreement will be effective and binding on the parties only if the duly authorized signatures of the parties are affixed hereto where indicated on the signature page. In the event there is a conflict between terms in this Agreement and any Service Riders or other addenda to this Agreement executed now or in the future the Service Rider or addenda terms will have priority over the terms in this Agreement.

b. Amendments/Modifications. This Agreement may be altered or amended only with the written consent of each party hereto; except that TransactRx may amend any term, part or provision of this Agreement, including, without limitation, any exhibits, Manuals, schedules, amendment or addenda, by giving written notice to Provider at least ten (10) calendar days (or such longer period required by Law) prior to the Effective Date of the amendment ("notice period"). Notwithstanding the foregoing, TransactRx may amend the Terms of Use as described in Exhibit E. If Provider objects to any such amendment(s), Provider may terminate this Agreement by giving TransactRx written notice of termination of this Agreement prior to the expiration of the notice period, which termination shall become effective thirty (30) days after the date of such notice of termination, or such other longer or shorter period required by Law. If Provider does not provide written notice of termination of this Agreement to TransactRx within the notice period, then Provider will be deemed to have accepted such amendment, and Provider agrees that such amendment(s) shall not require a separate signature in order to be effective.

c. Assignment. No part of this Agreement may be assigned by Provider without TransactRx's prior written consent, and any attempted assignment without such consent shall be void. Provider acknowledges and agrees that TransactRx, without consent, may assign all or any part of this Agreement and/or TransactRx's rights, privileges or duties under this Agreement to any direct or indirect parent, subsidiary, entity with substantially similar ownership or to a successor company.

d. Third Party Agreements/Subcontractors. TransactRx may subcontract all or any part of its obligations under this Agreement to a third party provided that such subcontractor agrees to perform the services as set forth

herein. Provider will be advised of such subcontracting relationships when necessary to enable Provider to perform its duties under this Agreement.

e. Choice of Law. This Agreement shall be construed, interpreted, and governed by the Laws of the State of Florida, without giving effect to its conflict of laws provisions. The operation of Provider or the professional practice of Provider shall in all respects be governed by the laws of the state wherein the Provider is located and where the practice of Provider is performed.

f. Notices. Any notice required to be given pursuant to this Agreement shall be in writing, postage prepaid, and shall be sent via facsimile transmission or by United States first class mail or by certified or registered mail to the parties at the addresses indicated on the first page of this Agreement (or such other addresses that the parties may hereafter designate).;provided however that any notice of dispute or termination by Provider must be sent by certified or registered mail to TransactRx at the address indicated on the first page of this Agreement, with a copy sent by certified or registered mail to the following (or such other address designated by written notice of TransactRx):

POC Network Technologies, Inc.
2332 Galiano Street, Suite 250
Coral Gables, FL 33134
Attn: Jack Guinan

g. Dispute Resolution. In the event that any dispute, claim or controversy arising out of or relating to this Agreement arises between Provider and TransactRx, except for disputes deemed by TransactRx to be related to termination without cause of this Agreement, both agree to meet and make a good faith effort to resolve the dispute. If such efforts are unsuccessful, either party may commence arbitration by filing an arbitration demand with the American Arbitration Association ("AAA") or American Health Lawyers Association ("AHLA") within thirty (30) calendar days of the meeting. The dispute will be resolved through arbitration to be conducted in Miami, Florida.

i. Any dispute subject to arbitration shall be settled by binding arbitration, strictly in accordance with this Agreement, except to the extent the dispute is required by Law to be resolved by a state or federal authority. The parties shall not have the right to participate as a member of any class of claimants pertaining to any dispute subject to arbitration hereunder, nor shall there be any authority for disputes arising hereunder to be arbitrated on a class action basis. Arbitration shall be limited only to disputes arising between Provider and TransactRx and cannot be consolidated or joined with claims of other persons who may have similar claims.

ii. The Commercial Arbitration Rules of the AAA or AHLA shall apply, using a three (3) member panel of arbitrators. Any dispute under $500,000 shall be handled by expedited procedures under the AAA or AHLA. The panel shall consist of one (1) arbitrator selected by Provider, one (1) arbitrator selected by TransactRx, and the third independent arbitrator shall be selected and agreed upon by the first two arbitrators. The parties may also use a single arbitrator, provided they mutually agree to do so and mutually agree on the choice of arbitrator. The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The cost of any arbitration proceeding under this Section shall be shared equally by the parties to such dispute unless otherwise ordered by the arbitrator(s). Judgment upon the award rendered by the arbitrator(s) may be entered and enforced in any court of competent jurisdiction. In the event the dispute is required by Law to be resolved by a state or federal authority, TransactRx and Provider agree to be bound by the findings of such state or federal authority.

iii. In the event that any dispute, claim or controversy arising out of or relating to this Agreement arises between Provider and Payer, Provider shall exhaust all internal Payer administrative appeal, grievance or other dispute resolution mechanisms prior to the submission of any unresolved disputes to a third party. If such dispute resolution efforts are unsuccessful, such dispute shall be resolved by binding arbitration, in accordance with the applicable Payer's dispute resolution procedures.

iv. This Dispute Resolution provision shall survive termination of this Agreement.

h. Lawful Interpretation. This Agreement will be interpreted and performed in compliance with all laws and regulations. If this Agreement or any part hereof is found not to be in compliance with any law or regulation, then the parties shall renegotiate this Agreement for the sole purpose of correcting the non-compliance.

i. Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

j. Waiver. Neither the waiver by either of the parties of a breach or a default of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasions, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach or default of any of the provisions of this Agreement. A waiver by either party of strict compliance with the terms of this Agreement shall only be effective if in writing and signed by both parties hereto, and shall not be effective with respect to any prior or subsequent failure by either party to comply with any term of this Agreement.

k. Binding Effect. Except as otherwise provided herein, this Agreement shall be binding upon and inure to the benefit of the parties, their agents, successors and permitted assigns unless otherwise set forth herein or agreed to in writing by the parties.

IN WITNESS WHEREOF, the respective authorized officers of the parties hereto have executed this Agreement as of the date indicated below, effective as of the Effective Date defined herein.

TRANSACTRX	**PROVIDER***:*
_____	_____
(Signature)	*(Signature)*
_____	_____
(Print Name)	*(Print Name)*
_____	_____
(Title)	*(Title)*
_____	_____
(Date)	(Date)

EXHIBIT A
Mass Immunizer Billing Services Rider
To Provider Agreement

This Mass Immunizer Billing Services Rider shall be considered an integral part of the Provider Agreement only if it is executed by Provider.

1. **Mass Immunizer Billing Services.** For the purposes of this Agreement, 'Mass immunizer Billing Services" include:

    a. Transaction Services. TransactRx shall provide the systems and related services required to enable Provider to submit real-time pharmacy claim and claim reversal transactions for certain vaccine products and administration fees from their existing pharmacy claims management system or from the TransactRx web portal to the TransactRx transaction processing platform for later submission to Participating and Non-Participating Payers as later defined in this Service Rider ('Transaction Services").

    b. Immunization Bill Coding. TransactRx will provide systems and services to ensure claims submitted via the Transaction Services meet the bill coding requirements established by Participating Payers and to include the appropriate billing codes in claims submitted to the Participating Payers.

    c. Billing Services.

        i. Electronic Submission. TransactRx will provide the systems and related services to create appropriately formatted claims from claims submitted through the Transaction Services and submit them electronically either directly or through appropriate clearinghouses to certain Payers.

        ii. Paper Claims. TransactRx will provide the systems and related services to print appropriately formatted paper claims from claims submitted through the Transaction Services and mail them to certain Payers.

    d. Claim Status and Remittance Advice Reporting. TransactRx will forward to Provider or will provide functionality to allow Provider to download any claim status reports or payment remittance advice reports that are transmitted from Payers through TransactRx.

2. Fees

    a. Pricing

        i. Service Location Setup Fee ~~$250.00 per Service Location (one-time fee)~~

        This fee is waived if Provider is enrolled in one of the TransactRx Networks

        ii. Transaction Fees

Accepted Claims	$ 1.50 per Validated Claim submitted to a Payer
Claim Reversals	$ 0.00
Rejected Claims	$ 0.00

    b. Invoicing. TransactRx will invoice Provider within 10 days after the last day of each month for all fees incurred during the month. Invoice will include a summary of transaction counts and other services provided during the billing period.

3. Provider Obligations

    a. Payer enrollment. Provider will perform any required enrollment, credentialing or registration process required by each Payer that Provider intends to submit claims to prior to utilizing the Transaction Services to submit claims to any Payer requiring these enrollment activities.

    b. Authorization. Provider shall comply with TransactRx procedures to secure any authorizations then required by TransactRx, applicable law, or industry practice in connection with the Transaction Services. **PROVIDER HEREBY APPOINTS TRANSACTRX AS ITS ATTORNEY-IN-FACT FOR THE LIMITED PURPOSE OF ENROLLING OR REGISTERING PROVIDER INTO A PAYER'S TRANSACTION PROCESSING SYSTEM AND OF SUBMITTING PROVIDER'S TRANSACTIONS AND/OR SIGNING PAPER TRANSACTIONS ON PROVIDER'S BEHALF TO THIRD-PARTY PAYERS OR**

PROCESSORS, WHERE PROVIDER'S SIGNATURE IS REQUIRED FOR ENROLLMENT, PROCESSING OR ADJUDICATION.

c. Electronic Format. All claims must be submitted electronically to TransactRx in NCPDP format (then most current version) or in such other manner and format as directed by TransactRx. Provider shall provide and maintain at its expense the equipment, software, and communications network transmission capabilities necessary to transmit claims to and receive processing and status messages from the TransactRx system.

d. Eligibility Verification. Provider agrees to determine the eligibility of each patient for whom a claim is submitted by requesting a current Payer identification card or by requesting patient's identification number and verifying eligibility using the Transaction Services or web application software based eligibility verification methods. Provider may not be paid for products and services provided to an individual whose eligibility was not correctly submitted to and verified by TransactRx.

e. Time for Submission. All claims shall be submitted promptly after rendering the service, and in no event later than thirty (30) calendar days after the date that the service is rendered (or such longer period required by applicable laws). Failure to timely submit a claim may result in non-payment of such claim.

f. Claim Reversals. All claims for services not received by a patient must be reversed through the TransactRx system. Unless otherwise notified in writing by TransactRx, Provider shall submit claim reversals within five (5) calendar days following the date the claim was originally submitted.

g. Compliance with Law. Provider acknowledges that various state and federal mandates and guidelines may apply with respect to this Agreement and the healthcare services provided under this Agreement. Provider represents and warrants that it is, and shall remain, in compliance with all applicable laws, including but not limited to all applicable Medicare laws, regulations, and CMS instructions, all laws applicable to individuals and entities receiving Federal funds and all other applicable Federal and State laws, regulations, and governmental issuances, including but not limited to those governing participation in the Medicare Advantage Program, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, all applicable Federal and State anti-kickback statutes, all State laws and regulations related to the administration of immunizations and vaccines and all Federal and State privacy and security requirements, including the privacy and security provisions contained in 42 CFR Section 403.812.

4. TransactRx Obligations.

a. Claim Submission.

i. TransactRx will forward any Validated Claim submitted by Provider through the Transaction Services to the payer identified in the claim within 30 days. A Validated Claim is a properly formatted NCPDP claim transaction received at the TransactRx System that has passed the current TransactRx content validation rules and the appropriate benefit eligibility of the patient referenced in the claim has been verified through the TransactRx System.

ii. For each transaction transmitted by Provider to the TransactRx System TransactRx will respond in real time via a properly formatted NCPDP claim response transaction including an indication of whether the claim is rejected or accepted for submission to the intended Payer at the TransactRx System. When available from data provided by the Payer or other sources TransactRx will include in the response the patient financial responsibility amount and the amount the Provider will be reimbursed for the product and service being rendered.

b. Provider Enrollment Assistance. TransactRx will use best efforts to provide assistance to Provider in obtaining information and documents required for the Provider to enroll or register with individual payers at the request of the Provider.

c. Payer List updates. TransactRx will publish and periodically update the list of Payers for which TransactRx is capable of submitting electronic or paper claims including any required payer identifiers.

d. Service Availability

i. TransactRx will provide Transaction Services to Provider at 99.6% uptime during "Normal Business Hours", defined as 7:00 AM until 12:00AM central standard time, measured on a monthly basis. In addition to Normal Business Hours, TransactRx will make Transaction Services generally available but will periodically administer maintenance to systems and require service outages outside of Normal

Business Hours. "Uptime" shall be defined as all periods of time that does not meet the definition of "downtime" set below.

ii. For the purposes of this section, "downtime" occurs when Provider's retail pharmacies are unable to transmit transactions related to Mass Immunizer Billing Services other than for reasons beyond TransactRx's reasonable control. It will not be considered downtime if

1. There is a general failure of slow down by a telecommunications carrier or other intermediary outside the control and management of TransactRx,
2. Provider's network or communications experiences a failure or slow down
3. The failure is due to any Provider software or hardware system not supplied by TransactRx
4. The cause is beyond TransactRx's reasonable control such as severe weather, earthquakes or natural disasters, strikes or other labor problems, wars or government restrictions.

5. **Disclaimer of Warranties. EXCEPT AS EXPRESSLY STATED HEREIN OR IN THE PROVIDER AGREEMENT TRANSACTRX PROVIDES THE MASS IMMUNIZER BILLING SERVICES "AS IS", AND EXPLICITLY DISCLAIMS ALL OTHER WARRANTIES, EXPRESSED, IMPLIED OR STATUTORY, INCLUDING, ANY WARRANTY OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR USE, WITH RESPECT TO ANY OF THE FOREGOING. NEITHER PARTY SHALL BE LIABLE FOR ANY INDIRECT OR CONSEQUENTIAL DAMAGES, OR FOR ANY OTHER SPECIAL DAMAGES SUCH AS, BUT NOT LIMTED TO, EXEMPLARY OR PUNITIVE DAMAGES, EVEN IF IT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES OCCURRING.**

6. **Termination**.

a. In the event this Agreement is terminated, Provider shall submit all claims for products and services administered before the date of termination within five (5) calendar days after the date of termination. Any rights to payment for any claim submitted after such time, whether or not the same would qualify as a claim, shall be deemed forfeited, and Provider agrees to hold TransactRx, affiliates, their subsidiaries, subcontractors, Payers, and each of their respective employees, shareholders, members, officers and directors and the patient receiving the service harmless for any expense associated therewith.

b. Upon termination of this Agreement, Provider shall return, at its expense, any Manuals, decals, participation identification materials and other documents or materials supplied to Provider by TransactRx in connection with this Agreement including all confidential and proprietary information of TransactRx.

c. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. The termination rights hereunder are in addition to any and all other rights and remedies that may be available to TransactRx under this Agreement.

7. **Vaccine Manager Terms of Use**. The following Terms of Use apply to Provider's use of the TransactRx Vaccine Manager website and any of its information, features, or services (all together referred to as "the Website and Services"). By using the Website and Services, Provider hereby agrees to the Agreement including these Terms of Use. Certain features of the Website and Services may be governed by additional terms of use. By agreeing to these Terms of Use, Provider hereby agrees to all applicable terms and restrictions including any additional terms of use described herein or later added.

a. Authority. Provider agrees that he/she is able, and has the authority, to accept the Terms of Use for the Website and Services and that he/she will use the Website and Services in a manner consistent with these Terms of Use. Further, Provider represents and warrants that only Provider will use the Website and Services.
b. Changes to the Terms of Use. TransactRx may update and change these Terms of Use from time to time without separate notice to Provider. Provider is responsible for reviewing these Terms of Use on a regular basis to ensure the ability to comply with them. By using or accessing the Website and Services after changes have been made to the Website and Services or to these Terms of Use, Provider is agreeing to accept those changes.
c. Protecting Information. Provider is responsible for ensuring that only Provider and authorized personnel have access to Provider's user ID(s) and password(s). Provider should keep any correspondence relating to the Website and Services (including, but not limited to, user ID, passwords, other registration information, e-mails, order information, or any other information) confidential and in a safe place. If other people have access to Provider's computer, handheld device, user ID or password, or other personal information, they may be able to

access information Provider has obtained from the Website and Services. TransactRx is not responsible for the security or privacy of any such information under these circumstances. Any information transmitted through the Website and Services will be solely the responsibility of the registered user whose ID and password was utilized to gain access. Provider agrees to notify TransactRx at the address in Section 13.10 if Provider becomes aware of or suspects any loss or unauthorized use of Provider's login information (user ID or password). TransactRx is not responsible for the security of Provider's internet access services provider, and Provider should review any applicable security and privacy policies carefully.

d. Use of the Website and Services.
    i. Provider agrees to use the Website and Services only for lawful purposes and in a manner consistent with their intended use, the Agreement and these Terms of Use. TransactRx may, at any time and without notice, prohibit access to the Website and Services to any individuals whom TransactRx determines are using the Website and Services in a way not permitted under these Terms of Use, who is restricting or prohibiting any other user from using or enjoying the Website and Services, or whose conduct might constitute a criminal offense, result in civil liability, or otherwise violate any applicable local, state, national or international law.
    ii. Examples of prohibited uses of the Website and Services include, but are not limited to: (a) sharing of personal medical/prescription information with an unauthorized third party; (b) placement on the Website and Services of any untrue, malicious, fraudulent, harassing, offensive or defamatory material, or any material that is irrelevant to a legitimate use of the Website and Services; (c) introduction of viruses, worms or other programming routines that are intended to disrupt or interfere with the operation of the Website and Services; (d) linking to or insertion of links to other sites of whatever character; (e) unauthorized changes to any data or information supplied by the Website and Services; (f) any activity that infringes on the copyright, patent, trademark or other rights of any other person or organization. Any unauthorized entry (commonly referred to as "hacking") into any portion of the Website and Services may constitute a crime under state and/or federal law and TransactRx will prosecute these violations to the fullest extent permitted by law. Anyone using this Website and Services in violation of these Terms of Use will be liable to TransactRx for damages of any nature whatsoever suffered by TransactRx or its Affiliates.

b. Permission to Print and Copy. The Website and Services contain copyrighted works, trademarks and other proprietary material owned by TransactRx or its information providers. If no restrictions are displayed, Provider may print, download, or make copies of materials from the Website and Services for Provider's own personal and non-commercial use only. Except as just provided, Provider may not copy, reproduce, publish, post, transmit, display, store, sublicense, transfer or distribute material or images from the Website and Services without written permission from TransactRx. In addition, Provider may not modify, alter, revise, paraphrase, omit, change, create derivative works, or modify or obliterate any copyright notice or other warning on any material or images from the Website and Services without written permission from TransactRx.

c. License. Provider may not assign, sublicense, transfer, pledge, lease, rent or share Provider's rights under these Terms of Use, unless otherwise agreed to in writing by TransactRx. Nothing contained on the Website and Services should be construed as granting, by implication, estoppel or otherwise, any license or right in and to TransactRx or its related parties' trademarks or copyrighted material of TransactRx or any third party without the express written permission of the applicable party.

d. Medical and Other Advice. TransactRx is not authorized to provide and does not engage in providing medical advice. Further, the information in the Website and Services is also not intended as and does not constitute financial or legal advice and Provider should consult an appropriate professional for specific advice tailored to Provider's situation.

e. Down Time. TransactRx takes commercially reasonable measures to ensure system availability without interruption, except for scheduled maintenance. However, service interruptions may occur and in no event will TransactRx be liable to Provider or to any other party for such service interruptions, whatever the cause or length.

f. Links to Other Websites. The Website and Services may occasionally provide links to other websites that might be of interest to users. Please note that when Provider clicks on one of these links Provider may be moving to another company's website. TransactRx cannot control the activities of any such company once Provider leaves TransactRx's Website. TransactRx encourages Provider to read the terms of use and privacy policies of these linked sites because they may differ from TransactRx's.

g. Jurisdiction. The Website and Services are intended only for access and use by United States residents, are presented solely as a service to visitors and subscribers located in the United States of America and its territories, and therefore may not comply with legal requirements of foreign countries.

h. Not Intended for Use by Minors. The Website and Services are not intended for, nor does TransactRx believe, they are appealing to, children under the age of 16. TransactRx will not knowingly collect information from visitors in this age group.

By executing this Service Rider Provider acknowledges that all provisions are an integral part of the TransactRx Provider Agreement executed by the Provider.

TRANSACTRX	**PROVIDER***:*
_____	_____
(Signature)	*(Signature)*
_____	_____
(Print Name)	*(Print Name)*
_____	_____
(Title)	*(Title)*
_____	_____
(Date)	(Date)

EXHIBIT B
National Immunization Network Rider
To Provider Agreement

This National Immunization Network Rider shall be considered an integral part of the Provider Agreement only if it is executed by Provider.

TransactRx owns and operates the National Immunization Network which is a healthcare provider network that contracts with Medicare, Medicare Advantage Plans, and commercial insurance Payers to reimburse participating providers at negotiated rates for certain influenza and pneumococcal vaccines administered to Covered Individuals of contracted Payers.

Provider desires to participate in the National Immunization Network to submit claims and receive payment for vaccines the Provider administers to Covered Individuals of contracted Payers.

1. Definitions

a. Claim. The term "Claim" shall mean the Provider request for payment in the format prescribed by TransactRx of amounts due Provider under this Agreement for providing Covered Services to Covered Individuals.

b. Co-payment or Co-pay. The terms "Co-payment" or "Co-pay" shall mean the payment due from a Covered Individual to the Provider at the time the Covered Service is provided, according to the Covered Individual's Plan or as otherwise required by a Payer, which shall be deducted from Provider's Reimbursement hereunder. Co-payments may include, but are not limited to, flat or percentage dollar amounts, coinsurance, deductible, and preferred or formulary incentives.

c. Covered Individual. The term "Covered Individual" shall mean an individual who is eligible, as determined by Payers, to receive Covered Services under a Plan.

d. Covered Service. The term "Covered Service" shall mean the administration of certain influenza or pneumococcal vaccines to a Covered Individual for which such Covered Individual is entitled to receive in accordance with and subject to the terms and conditions of the applicable Plan. TransactRx will periodically update publish the list of vaccines which are to be considered Covered Services.

e. HIPAA. The term "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any subsequent amendments or regulations promulgated thereunder.

f. Law. The term "Law" shall mean any federal, state, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, order, specified standards, instructions, or objective criteria contained in any applicable permit or approval, or other legislative or administrative action of the United States of America, or any state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

g. NDC. The term "NDC" shall mean the national drug code, which is an identifier published by the pharmaceutical industry for a prescription drug.

h. Network. The term "Network" shall mean a group of physicians, pharmacists and other licensed medical professionals that have agreed to participate in a national, state, Payer, or other network under this Agreement or obtained by acquisition or otherwise.

i. Payer. The term "Payer" shall mean any third party payer, including Medicare, Medicare Advantage Plan Sponsor or Commercial Insurer.

j. Plan. The term "Plan" shall mean a contract, endorsement, or other agreement or program and any changes or additions thereto as may be made or amended from time to time which, by its terms, provides coverage for health care or Provider services and/or supplies or otherwise provides access to health care or Provider services and/or supplies pursuant to agreed upon terms.

k. Provider Reimbursement. The term "provider Reimbursement" shall mean the total compensation payable to Provider for providing Covered Services to a Covered Individual. Such compensation shall be messaged to Provider via TransactRx's electronic Transaction Services, and as more fully described in the applicable Program Requirements.

l. Prior Authorization. The term "Prior Authorization" shall mean certain Covered Services, identified by

TransactRx's online system, that are not payable unless certain criteria are satisfied.

m. Program Requirements. The term "Program Requirements" shall mean those contracts, agreements and documents which set forth the rules, guidelines, policies and procedures of TransactRx and/or Payer, and may include, without limitation, Network participation requirements, credentialing, audit, drug utilization evaluation activities, prior authorization requirements, quality of care review, and/or grievance resolution procedures, as may be amended from time to time by TransactRx.

2. National Immunization Network Services

a. Enrollment Services. TransactRx will provide the necessary enrollment documents, authorization forms and other materials to Provider that are required to enable Provider to participate in the National Immunization Network and submit claims to contracted Payers. TransactRx will provide assistance to Provider to complete all required materials as requested by Provider.

b. Accept Claims. Upon completed enrollment of Provider in the Network TransactRx will accept Claims from the Provider submitted through one or more of the TransactRx online claim submission systems for contracted Payers. TransactRx will notify Provider as to Payers that the Provider is enabled to submit claims.

c. Claim Submission. Valid Claims accepted at TransactRx will be submitted to appropriate Payers according to the specific Payer specifications and submission requirements in a timely manner as more fully defined in this Service Rider.

d. Payment Processing. TransactRx will accept payments from Payers for Claims submitted on Provider's behalf to the Payers. TransactRx will process payer payments and remit payment to Providers on a periodic basis as further defined in Section 6 Provider Payments.

3. Fees

a. Pricing

i.	Enrollment and Credentialing Fee	~~$250.00 per Service Location (one-time fee)~~
ii.	Annual Re-Credentialing Fee	~~$250.00 per Service Location (annual fee)~~
iii.	Payment Processing Fees	
	ACH Payments	$ 0.00 per Provider Payment
	Paper Check Payments	$ 2.50 per check

b. Invoicing. These Fees will be either invoiced at the end of a billing period with the terms of the invoice being due on receipt or the TransactRx Fees will be deducted from payments being made by TransactRx to Provider.

4. Relationship of the Parties.

a. Independent Entities. TransactRx and Provider are independent entities, and nothing in this Agreement shall be interpreted to create any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement. In the performance of the obligations of this Agreement, regarding any services rendered under this Agreement, by either party or its agents, servants, or employees, each party is at all times acting and performing as an independent contractor with respect to the other party, and no party shall have or exercise any control or direction over the method by which the other party shall perform such work or render or perform such services and functions. It is further expressly agreed that no work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative, or employee of, or joint venture with, or fiduciary of, the other party. No provision of this Agreement or any part of any Plan shall be construed to require any provider to dispense or administer any medication or specific type of medication to any Covered Individual if, in the provider's reasonable professional judgment, such medication should not be dispensed to such person.

b. Relationship Between Provider And Covered Individuals. The relationship between Provider and Covered Individuals is that of healthcare provider and patient. Provider shall perform all professional and other services required to be provided under this Agreement and shall be free to exercise its own judgment on all questions of professional practice. Notwithstanding the foregoing, the term "Provider" may include one or more providers working under a single Tax ID Number and/or National Provider Identifier but all of who have been added to and validated through the TransactRx National Immunization Network.

c. Non-Exclusivity. This Agreement is non-exclusive, and Provider may contract with other third party entities so long as its ability to perform its obligations under this Agreement is not impaired. Nothing in this Agreement shall in any way restrict the ability of TransactRx or Provider to enter into any agreement of any kind relating to the subject matter of this Agreement.

5. Provider Participation Requirements.

a. Licensure and Other Requirements. Provider represents and warrants that it is, and will maintain, in good standing, all federal, state, and local licenses and certifications as required by Law. Provider further represents and warrants that it has any necessary license to and can legally dispense prescriptions and/or administer vaccines for Medicare and/or Medicaid programs; and that it is not subject to exclusion, suspension or debarment from the Medicare, Medicaid, or other government healthcare programs (as further described below). Provider further represents and warrants that it has, and will maintain, policies for general and professional liability insurance in such forms and amounts reasonable for the industry, which shall in no event be less than the amount required by Law. Provider agrees to immediately notify TransactRx in writing of any suspension, revocation, limitation, or disciplinary action taken by any State licensing or regulatory authority agency (including, without limitation the State Board of Medical Examiners or similar agency, the State Board of Pharmacy or similar agency, or Medicare or Medicaid) and of any suspensions, cancellations, or material changes of insurance coverage. Provider acknowledges that failure to maintain the appropriate license, certifications, and/or insurance policies will result in immediate termination of Provider from the Networks. Provider must provide TransactRx evidence of such licenses, certifications, and insurance policies upon request.

b. Ineligibility To Participate. Providers sanctioned by the General Services Administration, Office of Inspector General, or other applicable regulatory body, who are not eligible to participate in Medicare, Medicaid, or other Federal health care programs are not eligible to participate in any TransactRx Network. Provider warrants and represents that at the time of execution of this Agreement, neither it nor any of its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at http://www.arnet.gov/epls) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://www.dhhs.gov/progorg/oig). In the event Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose ineligible person status, Provider shall have an obligation to: (i) immediately notify TransactRx in writing of such ineligible person status, and (ii) within ten (10) calendar days of such notice, remove such individual, entity, or location that is responsible for, or involved with, Provider's business operations related to this Agreement. Excluded Providers may not submit claims for Covered Services under this Agreement.

c. Provider Certification. Provider hereby certifies that it has provided the required information below and acknowledges that it has reviewed the Provider Attestation in Attachment 1 to this Service Rider and represents and warrants that the answer to each and every item is correct, based on complete, current, correct, and not misleading information. Provider shall update the Provider Certification promptly upon any material changes in the information contained therein, and otherwise upon request of TransactRx, and shall immediately notify TransactRx of any information that would make any of the statements in the Provider Attestation inaccurate.

i. Required Information:

1. DEA License Number
2. Practice Address (Which must match the address on DEA registration)
3. State Medical License Number
4. NPI
5. Confirmation of Professional Liability Insurance

6. Provider Obligations.

a. Providing Covered Services. Provider will provide Covered Services to Covered Individuals subject to and in accordance with this Agreement, including but not limited to any exhibits, schedules or addenda hereto, the prescriber's directions, the Plan, the TransactRx System, applicable Law, and the standard of practice of the community in which Provider provides Covered Services and in a manner so as to assure the quality of such services in a culturally competent manner. Provider agrees that all Covered Services provided to Covered Individuals under this Agreement shall be provided by a qualified healthcare provider licensed and certified to provide the specific Covered Service

b. Compliance with Law. Provider acknowledges that various state and federal mandates and guidelines may apply with respect to this Agreement and the healthcare services provided under this Agreement. Provider

represents and warrants that it is, and shall remain, in compliance with all applicable laws, including but not limited to all applicable Medicare laws, regulations, and CMS instructions, all laws applicable to individuals and entities receiving Federal funds and all other applicable Federal and State laws, regulations, and governmental issuances, including but not limited to those governing participation in the Medicare Advantage Program, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, all applicable Federal and State anti-kickback statutes, all State laws and regulations related to the administration of immunizations and vaccines and all Federal and State privacy and security requirements, including the privacy and security provisions contained in 42 CFR Section 403.812.

c. Payer Contract Obligations. Provider acknowledges that this Agreement is entered into subject to TransactRx's contracts with Payers ("Payer Contracts"), and Provider agrees to abide by all provisions applicable to Provider under the Payer Contracts.

d. Service Availability. Provider shall provide Covered Services to all Covered Individuals pursuant to the terms of this Agreement during regular hours of operation of Provider and in the same manner, in accordance with the same standards, and with the same availability as that offered to other persons.

e. Eligibility Verification. Provider agrees to determine, as a condition precedent to providing Covered Services, the eligibility of each Covered Individual by requesting a current Payer identification card or by requesting Covered Individual's identification number and verifying eligibility using one of TransactRx's transaction based or web application software based eligibility verification methods. Provider may not be paid for Covered Services provided to an individual whose eligibility was not correctly submitted to and verified by TransactRx.

f. Claims Submission. In each instance when a Covered Service is provided to a Covered Individual, Provider must submit a Claim to TransactRx or its designee. Provider agrees to obtain written consent and release from each Covered Individual to permit Provider to submit the Claim for Covered Service for reimbursement to the Payer and to retain any such reimbursement as compensation for Provider's services rendered to Covered Individual. Each Claim submitted by Provider will constitute a representation and certification by Provider to TransactRx that the Covered Services were provided to the Covered Individual and that the information transmitted is accurate, complete and truthful.

g. Time for Submission. All Claims shall be submitted promptly after providing the Covered Service, and in no event later than thirty (30) calendar days after the date that Covered Service is rendered (or such longer period required by applicable Law). Failure to timely submit a Claim may result in non-payment of such Claim.

h. Claim Reversals. All Covered Services not received by a Covered Individual must be reversed through the online system. Unless otherwise notified in writing by TransactRx, Provider shall submit Claim reversals within five (5) calendar days following the date the Claim was originally submitted.

i. Prior Authorization. Unless otherwise instructed in writing by TransactRx, if Provider receives a system message that states "Prior Authorization Required" (or such other language to that affect) when submitting a Claim for a Covered Service, Provider shall comply with such Prior Authorization requirements and as permitted by the Plan, obtain additional information and contact the TransactRx or Payer (as applicable) prior authorization help desk to determine if the Plan Prior Authorization requirements have been satisfied.

j. TransactRx and Payer Programs. Provider agrees to provide Covered Services in accordance with any TransactRx and Payer programs and initiatives. This includes, but is not limited to, cooperating in good faith with, and participating in and complying with, any credentialing, utilization review, and quality assurance initiatives of TransactRx and/or Payers, as communicated to Provider, as may be amended from time to time.

k. Professional Judgment. Nothing in this Agreement is intended to limit Provider's professional judgment or violate applicable Law. Accordingly, notwithstanding anything to the contrary in this Agreement, Provider must exercise sound professional judgment at all times when providing Covered Services to Covered Individuals. Provider may refuse to provide Covered Services to a Covered Individual based on that professional judgment, which must be documented. Provider shall be solely responsible for its professional services rendered.

l. Covered Service Products. All drug products utilized in providing Covered Services to Covered Individuals must be in compliance with applicable federal and state requirements including those of the Federal Food and Drug Administration.

m. Grievance/Complaint Procedures. Provider agrees to cooperate fully with any applicable Covered Individual

grievance, complaint, or similar procedure, including but not limited to, informing Covered Individuals of applicable grievance and/or complaint rights. Further, Provider agrees to fully cooperate with, and provide information requested by TransactRx and/or Payers, to enable TransactRx and/or Payers to conduct and resolve grievances that may be raised by Covered Individuals, Payers, or other providers regarding the provision of Covered Services by Provider, and Provider shall comply with any final determinations made relating to any such grievances. Disputes of malpractice are outside the scope of this Agreement. This provision shall survive termination of this Agreement.

n. Appeals Procedures. Provider agrees to comply with any applicable Covered Individual appeal(s) procedures, including but not limited to, informing Covered Individuals of applicable Appeal rights. This provision shall survive termination of this Agreement.

o. Non-discrimination. Provider shall not discriminate or differentiate against any Covered Individual as a result of his or her enrollment in a particular plan, or because of race, color, creed, national origin, ancestry, religion, sex, sexual orientation, marital status, age, disability, payment source, state of health, need for health services, status as a Medicare or Medicaid beneficiary, or any other basis prohibited by Law.

p. Notification of Legal Action. Provider shall notify TransactRx or its designated agent of any legal or administrative claim made or action filed against Provider arising from this Agreement, by a Covered Individual, or otherwise which could affect the ability of Provider to carry out of this Agreement within ten (10) calendar days of receipt of such claim or action

q. Program Conditions and/or Requirements and Manual. Provider agrees to comply with the Program Conditions and/or Requirements and the Manual.

7. Provider Payment

a. Payment in Full. Provider will accept as payment in full for Covered Services rendered to Covered Individuals in accordance with this Agreement the amounts provided for in this Agreement, including the pricing Schedules hereto and any pricing Schedules, rate exhibits, amendments, or addenda entered into or agreed to by the parties prior to, on, or after the Effective Date of this Agreement (all of which are incorporated herein by this reference). Provider shall not be paid for products and/or services that are not Covered Services under the Plan the claim is submitted to. Claims will be paid at the reimbursement amount identified by the TransactRx System at the time of Claim submission.

b. Collection From Covered Individuals. Upon Covered Individual's receipt of each Covered Service, Provider shall collect and retain from the Covered Individual the Co-payment for the Covered Service. Provider shall have full responsibility for the collection of such Co-payment, as well as the collection of any other charge(s) designated as a Covered Individual's financial responsibility in accordance with the terms of the applicable Plan, and shall not seek to collect any Co-payment from TransactRx or Payers. Unless otherwise directed in writing by TransactRx, in no event shall Provider collect any greater amount than that indicated via the online system. Provider shall not discount, waive, reduce, or defer Covered Individual's Co-payment in whole or in part. Provider shall not: (a) balance-bill a Covered Individual for a Covered Service; (b) charge Covered Individuals any charges other than the Co-Payment or other Patient Financial Responsibility amount related to the Covered Service; and/or (c) charge a fee to Covered Individuals as a condition to be part of Provider's panel of patients.

c. Fee Schedule. Provider Reimbursement will be based on the then current fee schedule for the Provider's service location and provider type as published by the Covered Individual's applicable Plan.

d. Payment Processing Cycles.

i. TransactRx shall process or arrange to process all Claims submitted for payment that are accurate, complete, and otherwise in compliance with this Agreement within thirty (30) calendar days of receipt.

ii. Provided that sufficient payment has been received by TransactRx from Payer and provided the applicable Copayment has been collected by Provider, TransactRx will pay Provider for Covered Services provided to Covered Individuals in accordance with the payment rate information communicated to Provider through the TransactRx Platform or Vaccine Manager System, less the applicable Copayment

iii. TransactRx shall process all payments received from Payers in a timely fashion and will remit one payment to Provider on a bi-monthly schedule including all processed Payer payments received for

Covered Services rendered by Provider.

iv. Provider agrees not to seek reimbursement above and beyond the amount identified in this Agreement and communicated via the electronic claims system from TransactRx or the applicable Payer.

v. Provider acknowledges that TransactRx operates only as an intermediary between Payers and Provider with respect to payment. Payers have agreed with TransactRx to pay sufficient funds for claims submitted by Provider.

vi. TransactRx has no liability to Provider for nonpayment or for any delay in payment from a Payer and Provider shall look solely to the Payer for payment; provided that if a Payer has made payment to TransactRx as required under the agreement between the Payer and TransactRx, Provider shall look solely to TransactRx for payment of such amounts.

vii. To enable TransactRx to carry out the provisions of this Article 5, Provider hereby authorizes TransactRx as its limited agent for the purpose of receiving remittance advices, utilization reports, payments, and other information provided by Payers on behalf of Provider.

e. Overpayments and Authorized Deductions. Any amounts owed by Provider to TransactRx (including but not limited to transmission fees and overpayments from Claim reversals, errors, inaccurate submissions, or otherwise) shall become immediately due and owing and shall be paid by Provider to TransactRx upon request. Provider agrees not to attempt to affect any accord or satisfaction through a payment instrument or accompanying written communication and not to conditionally or restrictively endorse any payment instrument; and TransactRx shall not be bound by any such attempt or endorsement. In the event of non-payment by Provider or as otherwise authorized by this Agreement or at TransactRx's discretion, TransactRx may deduct or offset any overpayments or other amounts owed by Provider to TransactRx from any amounts otherwise payable to Provider. TransactRx further reserves the right, in its sole discretion, to require Provider to assign to TransactRx any collection rights Provider may have against any person.

f. Coordination of Benefits. Provider agrees to cooperate in good faith with TransactRx and Payers regarding coordination of benefits and to notify TransactRx promptly after receipt of information regarding any Covered Individual who may have a Claim involving coordination of benefits. Provider shall use its best efforts to secure information from Covered Individuals and other medical benefit plans to facilitate the coordination of benefits. When a Payer has been determined to be other than the primary payer, payment hereunder shall be based upon the provider Reimbursement, reduced by the amount paid for the Covered Service by the primary and other tertiary plans. Provider agrees to accept such amount as payment in full for the Covered Service. Notwithstanding the foregoing, this Section shall not be construed to require Provider to waive coinsurance, indemnity balances and deductibles in contravention of any Medicare rule or regulation, nor shall this Section be construed to supersede any other Medicare Law.

g. Subrogation. Provider agrees to cooperate with TransactRx regarding subrogation and to notify TransactRx promptly after receipt of information regarding any Covered Individual who may have a Claim involving subrogation.

h. Taxes. If any taxes, assessments, and/or similar fees ("taxes") are imposed on Provider by a governmental authority for the provision of Covered Services to Covered Individuals, Provider shall be responsible for such taxes and shall not pass such taxes on to Covered Individuals, Payers or TransactRx unless specifically required to do so under applicable Laws or expressly permitted to do so by TransactRx or Payer. In no event shall TransactRx be liable for any taxes or the determination of the amount of taxes.

i. Objection To Payment. Provider must promptly notify TransactRx in writing of any alleged error, miscalculation, discrepancy or basis for disputing the correctness or accuracy of any Claim (whether paid, denied, rejected, reversed, or otherwise) within one hundred eighty (180) calendar days after payment is due. Otherwise, Provider will be deemed to have confirmed the correctness and accuracy of the Claims processed and/or paid during that financial cycle. In no event will TransactRx have liability above or beyond the aggregate amount of Claims during such one hundred eighty (180) calendar day period. To request an adjustment to a Claim payment, Provider must timely submit to TransactRx sufficient documentation to evidence that the Claim was paid incorrectly. This objection and time limitation does not apply with respect to any overpayments that may be made to Provider.

j. Covered Individual Held Harmless. Prior to providing Covered Services to a Covered Individual, Provider will collect from each Covered Individual the applicable Copayment as required by this Agreement. Provider will in no event (including, but not limited to, non-payment by TransactRx or any Payer, TransactRx's or any Payer's

insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Covered Individual or other persons acting on their behalf. In the event of Payer's insolvency or other cessation of operations, Provider agrees that benefits to Medicare Risk Covered Individuals will continue through the period for which premium has been paid. This provision does not prohibit the collection of Copayments or charges for non-covered services or items; however, Provider shall not add additional charges to the Copayment for the provision of Covered Services under this Agreement. This provision will survive the termination of this Agreement and supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Covered Individual or someone acting on the Covered Individual's behalf.

k. Rebates. TransactRx, Payers, and/or their designees have and retain the right to submit all Claims for Covered Services for Covered Individuals to pharmaceutical companies in connection with rebate, discount or other similar programs. Unless otherwise agreed to in writing, Provider shall not submit any of the Claims for Covered Services for Covered Individuals to any pharmaceutical company for the purpose of receiving any rebates or discounts.

l. Payment of TransactRx Fees. TransactRx will charge Provider certain Transaction Fees, Processing, Enrollment and Credentialing Fees as identified in the Agreement and/or executed Service Riders. These TransactRx Fees will be either invoiced at the end of a billing period with the terms of the invoice being due on receipt or the TransactRx Fees will be deducted from payments being made by TransactRx to Provider.

8. Record Maintenance and Access.

a. Maintenance of Records. Provider agrees to maintain records as is required by TransactRx, by Law, or by appropriate regulatory authorities as such relate to Covered Services to be provided in accordance with this Agreement for a period of no less than ten (10) years (or such longer period required by Law) following the termination of this Agreement. Without limiting the generality of the foregoing, Provider shall maintain all Provider records and data relating to the provisions of Covered Services to Covered Individuals and its responsibilities under this Agreement in a manner consistent with appropriate Provider standards and Laws, including, without limitation, maintaining original prescription orders, patient signature logs, pharmaceutical purchase records, prescriber information, patient profiles, billing records, and payments received from, or on behalf of, Covered Individuals. With respect to re-written prescription, re-written prescriptions for Covered Services must contain all appropriate documentation which was on the original prescription. TransactRx may withhold, deny, or chargeback payments where records and logs are not maintained as required hereunder.

b. Access to Records. During the Term of this Agreement and for two (2) years thereafter, TransactRx, Payers, and any and all applicable governmental authorities, shall have access at all reasonable times to Provider's books, records and other papers which relate to this Agreement and/or Covered Services, including, without limitation, original prescription orders, patient signature logs, pharmaceutical purchase records, prescriber information, patient profiles, billing records, and payments received from, or on behalf of, Covered Individuals.

c. Survival of Termination. The provision of this Article 6 shall survive the termination of this Agreement.

9. Audits

a. Audit Procedures. TransactRx, a Payer, the Comptroller General of the United States ("Comptroller"), the Department of Health and Human Services ("DHHS"), the Centers for Medicare and Medicaid Services ("CMS"), and their respective duly authorized representatives or designees shall have the right, for the term of this Agreement and for ten (10) years thereafter (or such longer period required by Law) to review, audit, examine, and reproduce any of Provider's books, records, prescription files, and other documentation pertaining to Covered Services for Covered Individuals and/or Provider's compliance with this Agreement. TransactRx will provide Provider with fifteen (15) calendar days prior notice, or such lesser or greater time as is required by Law, of any onsite audit. In addition, Provider shall provide records or copies of records requested by TransactRx, a Payer, Comptroller, DHHS, CMS, or their third party authorized representatives or designees within ten (10) calendar days from the date of such written request or such shorter time required by Law. Provider agrees to fully cooperate in good faith with such audits, regardless of the form of such audit, including but not limited to, onsite audits and audits by mail, in-house desk audits, drug utilization reviews and detection of Claim submission errors. If TransactRx is denied admission to the Provider or if Provider does not timely present requested documentation and records, Provider may be assessed a reasonable audit fee or TransactRx may deem 100% of the Claims to be audited as noncompliant and due and owing to TransactRx. In addition, where based on a sampling of audited Claims, if TransactRx determines that Provider has engaged in fraud or abuse or has made common errors in the submission of Claims, TransactRx has the right to extrapolate for

purposes of determining the amount due and owing to TransactRx for noncompliant Claims to the extent not prohibited by Law.

b. Audit Discrepancies. Audits of Provider will be conducted to determine non-compliant or discrepant Claims, which include, but are not limited to, the following: Provider billed for brand, but dispensed generic; quantity dispensed does not reflect the prescription order, ethical use, exceeds or is not in accordance with the Covered Individual's Plan; missing (or not timely produced) hard copy prescriptions; reason not specified on prescription when refill too early message is over-ridden; inaccurate Prescriber Numbers submitted; NDC number billed not in accordance with NDC number administered; NDC number of product or number of units billed does not reflect Covered Service.

c. Audit Recovery. If it is determined by TransactRx or its designee that overpayments were made to Provider, any such overpayment shall become immediately due and owing and shall be paid by Provider to TransactRx upon notice to Provider. TransactRx may, at its sole discretion, deduct or offset such amount of any overpayments made to Provider from any amounts otherwise payable to Provider.

d. Provider Non-Compliance. If Provider is deemed non-compliant with this Agreement, certain penalties may apply, including, but not limited to, fees, interest, penalties, damages, or other charges imposed upon TransactRx by governmental entities, regulatory agencies, and/or Payers. TransactRx has the right to deduct any such amounts from any amounts payable to Provider. TransactRx may report its audit findings to Payers, appropriate governmental entities, and/or regulatory agencies.

e. Survival of Termination. The provisions of this Article 7 shall survive the termination of this Agreement.

10. **Insurance.** Provider, at its sole cost and expense, shall procure and maintain policies of general and professional liability insurance and such other insurance as shall be necessary to insure it and its employees against any claim or claims for damages arising out of, or related to, alleged personal injuries or death occasioned directly or indirectly in connection with the performance of Covered Services and activities of Provider, and/or the use of any facilities, equipment or supplies provided by Provider. Each of such policies shall be in amounts of at least one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) annual aggregate, or such greater amount required by Law. In additional, all health care professionals employed or under contract with Provider to provide Covered Services to Covered Individuals shall procure and maintain such insurance, unless such health care professionals are covered under Provider's insurance policies. Provider shall name as an additional insured TransactRx, its successors and assignees. Provider shall immediately notify TransactRx in writing of any suspension, cancellation, or material change of insurance coverage. Provider shall furnish TransactRx reasonable proof of such insurance as may be requested upon execution of this Agreement and/or at any reasonable time thereafter. Provider acknowledges and agrees that failure to maintain the appropriate insurance policies will result in immediate termination of this Agreement. This provision shall survive the termination of this Agreement.

11. **Indemnification**. All liability arising from the provision of Covered Services and any other services rendered by Provider will be the sole responsibility of Provider. Provider will indemnify, defend, and hold harmless TransactRx, its designees, Payers, and their respective shareholders, officers, directors, employees, agents, and representatives from and against any and all liabilities, losses, awards, settlements, claims, injuries, damages, expenses, demands, penalties, or judgments of any kind (including reasonable costs, expenses, and attorneys' fees) that may result or arise out of: (a) any actual or alleged malpractice, negligence, misconduct, or breach by Provider in the performance or omission of any act or responsibility assumed by Provider; (b) the provision of Provider services for the sale, compounding, dispensing, manufacturing, or use of a drug or device dispensed by Provider; or (c) the breach or alleged breach by Provider of any representation, warranty, or covenant of Provider as set forth in this Agreement.

12. **Disclaimer of Warranties.** EXCEPT AS EXPRESSLY STATED HEREIN OR IN THE PROVIDER AGREEMENT TRANSACTRX PROVIDES THE NATIONAL IMMUNIZATION NETWORK SERVICES "AS IS", AND EXPLICITLY DISCLAIMS ALL OTHER WARRANTIES, EXPRESSED, IMPLIED OR STATUTORY, INCLUDING, ANY WARRANTY OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR USE, WITH RESPECT TO ANY OF THE FOREGOING. NEITHER PARTY SHALL BE LIABLE FOR ANY INDIRECT OR CONSEQUENTIAL DAMAGES, OR FOR ANY OTHER SPECIAL DAMAGES SUCH AS, BUT NOT LIMTED TO, EXEMPLARY OR PUNITIVE DAMAGES, EVEN IF IT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES OCCURRING.
13. **Covered Individual Records**. Provider and TransactRx agree that all Covered Individual records shall be treated as confidential so as to comply with all Laws regarding the confidentiality of Covered Individual records, including, without limitation, the HIPAA and amendments thereto, and/or is prudent in accordance with applicable industry standards. Provider agrees to execute any documents reasonably necessary for Provider, TransactRx and/or a Payer to

comply with HIPAA. Provider agrees never to provide Covered Individuals' information to others for Provider's pecuniary gain. Nothing herein is meant, however, or shall be construed, to limit the rights of TransactRx, or the rights of governmental authorities, to inspect and copy any accounting, administrative, or Covered Individual records maintained by Provider pursuant to Article 7 of this Agreement.

14. **Termination**.

a. Automatic Termination. This Agreement will terminate automatically without notice with respect to Provider as of the date on which such Provider fails to maintain appropriate licensure, registration, certification, good standing, or insurance, as required under this Agreement and/or Law.

b. Immediate Termination Rights. TransactRx may terminate this Agreement immediately upon written notice to Provider in the event of:

i. Breach of any representation, warranty or covenant of Provider in this Agreement;

ii. The transfer of ownership of any of Provider's practice to a new owner, or if the right to control any aspect of Provider's operations is transferred to another person or entity;

iii. Provider becomes insolvent, admits it is unable to pay its debts, an action is filed by or against Provider under the Federal Bankruptcy Act or any other Law or act regarding insolvency, reorganization, arrangement, or extension for the relief of debtors, including any assignment for the benefit of creditors, the appointment of a receiver or trustee for transfer or sale of a material portion of Provider's assets, or TransactRx's receipt of a writ of attachment, execution or garnishment;

iv. Provider or Provider's employees act in an illegal, unethical, unscrupulous or immoral manner which adversely impacts the reputation of TransactRx, its Affiliates, or Payers;

v. TransactRx has reason to believe in its sole discretion that the health or safety of a Covered Individual(s) may be in jeopardy; or

vi. Provider engages in any fraudulent activity related to the terms of this Agreement.

c. Network Termination. TransactRx may terminate Provider from participating in any specific Network or provider program, including but not limited to any Network or provider program as it relates to a specific Plan or Payer, without cause upon a thirty (30) day written notice to Provider (or such longer period as required by Law).

d. Prescriber Identification Number. Unless prohibited by Law, and in accordance with the other provisions of this Agreement, TransactRx has the right to terminate this Agreement for cause if TransactRx determines in its sole discretion that Provider has submitted an unreasonable number of Claims with invalid prescriber identification and/or provider numbers ("Prescriber Number"). Prescriber Numbers shall be considered invalid when: (i) the Prescriber Number submitted by Provider with the Claim is not the Prescriber Number listed on the prescription by the Prescriber; or (ii) no Prescriber Number is provided on the prescription, and the Prescriber Number submitted by the Provider with the prescription Claim is not the "default" identification number provided by TransactRx; or (iii) the Prescriber Number submitted by the Provider with the prescription Claim does not correspond to the actual prescriber of the prescription. This provision of this Agreement does not prohibit Provider from submitting valid Prescriber Numbers that may be available to the Provider through its prescription claims processing system.

e. Termination Rights and Remedies.

i. In the event this Agreement is terminated, Provider shall submit all claims for products and services administered before the date of termination within five (5) calendar days after the date of termination. Any rights to payment for any claim submitted after such time, whether or not the same would qualify as a claim, shall be deemed forfeited, and Provider agrees to hold TransactRx, affiliates, their subsidiaries, subcontractors, Payers, and each of their respective employees, shareholders, members, officers and directors and the patient receiving the service harmless for any expense associated therewith.

ii. Upon termination of this Agreement, Provider shall return, at its expense, any Manuals, decals, participation identification materials and other documents or materials supplied to Provider by TransactRx in connection with this Agreement including all confidential and proprietary information

of TransactRx.

iii. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. The termination rights hereunder are in addition to any and all other rights and remedies that may be available to TransactRx under this Agreement.

15. **Federal Funds**. Provider acknowledges and agrees that claims data and information provided in connection with this Agreement is used for purposes of obtaining Federal funds. Provider agrees that it is bound by 45 CFR Part 76 and represents and warrants that it is not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration

16. **Headings**. The paragraph headings herein are for convenience purposes only and are not to be utilized in construction of the provisions of this Agreement.

By executing this Service Rider Provider acknowledges that all provisions are an integral part of the TransactRx Provider Agreement executed by the Provider.

TRANSACTRX	**PROVIDER***:*
_____	_____
(Signature)	*(Signature)*
_____	_____
(Print Name)	*(Print Name)*
_____	_____
(Title)	*(Title)*
_____	_____
(Date)	(Date)

Exhibit B, Attachment 1

A.	Provider license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction has never been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you ever been fined or received a letter of reprimand or is any such action pending or under review.
B.	Provider has never been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?
C.	Provider has not been denied clinical privileges, membership, contractual participation or employment by any health care related organization*, nor have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, nor is any such action pending or under review.
D.	Provider has never surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review.
E.	An application for clinical privileges, appointment, membership, employment or participation in any health care related organization* has never been withdrawn on your request prior to the organization's final action.
F.	Provider's membership or fellowship in any local, county, state, regional, national, or international professional organization has never been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, and no such action is pending or under review
G	Provider has never had board certification revoked.
H	Provider has never been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity.
I.	Provider has never been charged with a criminal violation (felony or misdemeanor).
J.	Provider does not presently use any illegal drugs.
K	Provider does not have, nor had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect Provider's current ability to practice, with or without reasonable accommodation.
L.	Provider is able to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance.
M.	Professional liability claims or lawsuits have never been closed and/or filed against Provider.
N.	Provider's professional liability insurance has never been terminated or denied, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged).

NPI - Tab

National Provider Identifier (NPI)

NPI Contact Person:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059
Phone: 1-800-465-3203 or TTY 1-800-692-2326
customerservice@npienumerator.com

Website: https://nppes.cms.hhs.gov/

What is an NPI number?

A **National Provider Identifier** or **NPI** is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers.

All individual Health Insurance Portability and Accountability Act (HIPAA) covered healthcare providers or organizations must obtain an NPI for use in all HIPAA standard transactions, even if a billing agency prepares the transaction. Once assigned, a provider's NPI is permanent and remains with the provider regardless of job or location changes.

Health care providers can apply for NPIs in one of three ways:

- Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into National Plan and Provider Enumeration System (NPPES).
    - A copy of this form is included in this manual. Please note that the instructions for completing the paper application are on page 5 of the paper application.
    - This form is also available for download from the CMS website (http://www.cms.gov; type CMS-10114 in the search box) or by request from the NPI Enumerator. Health care providers who wish to obtain a copy of this form from the NPI Enumerator may do so in any of these ways:
        - Phone: 1-800-465-3203 or TTY 1-800-692-2326
        - E-mail: customerservice@npienumerator.com
        - Mail: NPI EnumeratorP.O. Box 6059 Fargo, ND 58108-6059

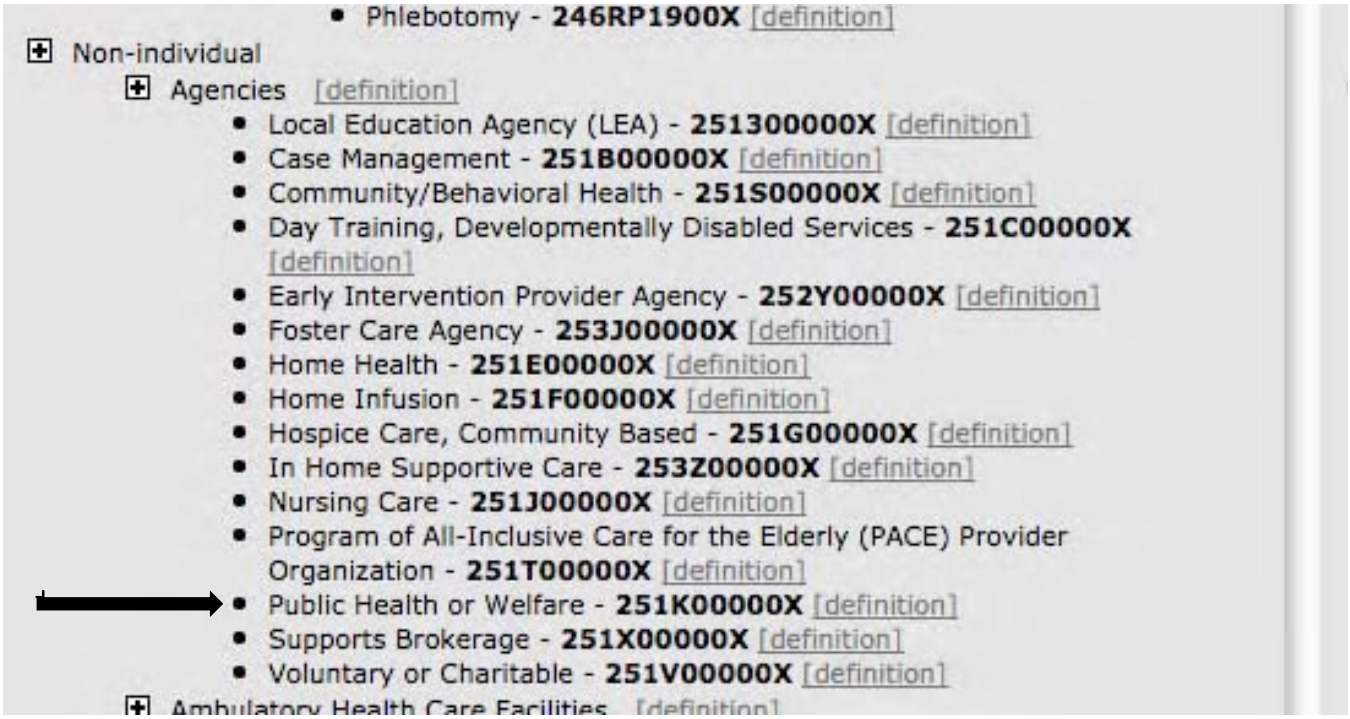
- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan and Provider Enumeration System (NPPES) and apply online. https://nppes.cms.hhs.gov/NPPES/Welcome.do
    - The instructions for completing the online form are included in this manual. These instructions list all the information you will need to complete the application. Please note that you will not be able to save your work if you quit before you have completed the application form.
    - You may wish to fill out the paper NPI Application/Update Form (CMS-10114) prior to completing the online application. A copy of this application is included in this manual.

- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.

Taxonomy Code

The NPI application asks for the provider's taxonomy code. Taxonomy codes are national 10-digit alpha-numeric codes that classify health care providers according to the primary services they render.

NPI Taxonomy Code for Local Health Departments:



Please note that if your department provides medical services, the taxonomy may be different.

The complete list of NPI taxonomy codes can be obtained at the following website: http://www.wpc-edi.com/reference

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0931

NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Use only blue or black ink. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form. Information submitted on this application (except for Social Security Number, IRS Individual Taxpayer Identification Number, and Date of Birth) may be made available on the internet.

SECTION 1 – BASIC INFORMATION

A. Reason For Submittal Of This Form (Check the appropriate box)

1. ❑ Initial Application
2. ❑ Change of Information (See instructions)
   NPI:_____
   - ❑ Add Information
   - ❑ Replace Information
3. ❑ Deactivation (See Instructions)
   NPI : _____
   Reason (Check one of the following)
   ❑ Death ❑ Business Dissolved
   ❑ Other, Specify: (See Instructions) _____
   _____
4. ❑ Reactivation (See Instructions)
   NPI : _____
   Reason: _____

B. Entity Type (Check only one box) (See Instructions)

1. ❑ An individual who renders health care. **(Complete Sections 2A, 3, 4A and 5 only)**
   - Is the individual a sole proprietor? (See Instructions) ❑ Yes ❑ No
2. ❑ An organization that renders health care. **(Complete Sections 2B, 3, 4B and 5 only)**
   - Is the organization a subpart? (See Instructions) ❑ Yes ❑ No
   - If yes, enter the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider:
     Parent Organization LBN:_____
     Parent Organization TIN: _____

SECTION 2 – IDENTIFYING INFORMATION

A. Individuals *(includes Sole Proprietorships and Incorporated Individuals)*

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last
5. Suffix (e.g., Jr., Sr.)		6. Credential (e.g., M.D., D.O.)	

Other Name Information (If applicable. Use additional sheets of paper if necessary)

7. Prefix (e.g.,Major, Mrs.)	8. First	9. Middle	10. Last
11. Suffix (e.g., Jr., Sr.)		12. Credential (e.g., M.D., D.O.)	

13. Type of other Name
❑ Former Name ❑ Professional Name ❑ Other, specify: _____

14. Date of Birth (mm/dd/yyyy)	15. State of Birth (U.S. only)	16. Country of Birth (If other than U.S.)

17. Gender
❑ Male ❑ Female

18. Social Security Number (SSN)	19. IRS Individual Taxpayer Identification Number (ITIN) (See Instructions)

B. Organizations *(includes Groups, Corporations and Partnerships)*

1. Name (Legal Business Name)	2. Employer Identification Number (EIN) (Do not report an SSN in this field.)

3. Other Name (Use additional sheets of paper if necessary)

4. Type of Other Name
❑ Former Legal Business Name ❑ D/B/A Name ❑ Other (Describe) _____

SECTION 3 – BUSINESS ADDRESSES AND OTHER INFORMATION

A. Business Mailing Address Information *(Do not report your residential address unless it is also your Business Mailing Address.)*

1. Business Mailing Address Line 1 (Street Number and Name or P.O. Box)

2. Business Mailing Address Line 2 (Address Information; e.g., Suite Number)

3. Business City	4. Business State	5. ZIP+4 or Foreign Postal Code

6. Business Country Name (if outside U.S.)

7. Business Telephone Number (Include Area Code & Extension)	8. Business Fax Number (Include Area Code)

B. Business Practice Location Information *(Do not report your residential address unless it is also your Business Practice Location.)*

1. Business Primary Practice Location Address Line 1 (Street Number and Name – P.O. Boxes Not Acceptable)

2. Business Primary Practice Location Address Line 2 (Address Information; e.g., Suite Number)

3. Business City	4. Business State	5. ZIP+4 or Foreign Postal Code

6. Business Country Name (if outside U.S.)

7. Business Telephone Number (Include Area Code & Extension) (Required)	8. Business Fax Number (Include Area Code)

C. Other Provider Identification Numbers *(Use additional sheets of paper if necessary) Do not include SSN, ITIN, or EIN in this section.*

Issuer	Identification Number	State *(If applicable)*	Issuer (For Other Number Type Only)
Medicare UPIN	_____	_____	
Medicare OSCAR/Certification	_____	_____	
Medicare PIN	_____	_____	
Medicare NSC	_____	_____	
Medicaid	_____	_____ (State is required if Medicaid number is furnished.)	
Other, Specify:	_____	_____	_____

D. Provider Taxonomy Code *(Provider Type/Specialty. Enter one or more codes)* and License Number Information

Do not include SSN, ITIN, or EIN in this section.

Information on provider taxonomy codes is available at *www.wpc-edi.com/taxonomy*. Please see instructions if you plan to submit more than one taxonomy code for a Type 2 (organization) entity.

1. **Primary** Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

2. License Number (See Instructions)	3. State where issued

4. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

5. License Number (See Instructions)	6. State where issued

7. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

8. License Number (See Instructions)	9. State where issued

PENALTIES FOR FALSIFYING INFORMATION ON THE NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

SECTION 4 – CERTIFICATION STATEMENT

I, the undersigned, certify to the following:

- This form is being completed by, or on behalf of, a health care provider as defined at 45 CFR 160.103.
- I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator of this fact immediately.
- I authorize the NPI Enumerator to verify the information contained herein. I agree to notify the NPI Enumerator of any changes in this form within 30 days of the effective date of the change.
- I have read and understand the Penalties for Falsifying Information on the NPI Application/Update Form as printed in this application. I am aware that falsifying information will result in fines and/or imprisonment.
- I have read and understand the Privacy Act Statement.

A. Individual Practitioner's Signature

1. Applicant's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	2. Date (mm/dd/yyyy)

B. Authorized Official's Information and Signature for the Organization

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last

5. Suffix (e.g., Jr., Sr.)	6. Credential (e.g., M.D., D.O.)

7. Title/Position	8. Telephone Number (Area Code & Extension)

9. Authorized Official's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	10. Date (mm/dd/yyyy)

SECTION 5 – CONTACT PERSON

A. Contact Person's Information

❑ Check here if you are the same person identified in 2A or 4B.

If you checked the box, complete only items 8 and 9 in this section (Section 5).

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last

5. Suffix (e.g., Jr., Sr.)	6. Credential (e.g., M.D., D.O.)

7. Title/Position	8. E-Mail Address	9. Telephone Number

For the most efficient and fast receipt of your NPI, please use the web-based NPI process at the following address: *https://nppes.cms.hhs.gov.* NPI web is a quick and easy way for you to get your NPI.

Or send the completed signed application to:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0931. The time required to complete this information collection is estimated to average 20 minutes per response for new applications and 10 minutes for changes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. **Do not send the applications to this address.**

PRIVACY ACT STATEMENT

Section 1173 of the Social Security Act authorizes the adoption of a standard unique health identifier for all health care providers who conduct electronically any standard transaction adopted under 45 CFR 162. The purpose of collecting this information is to assign a standard unique health identifier, the National Provider Identifier (NPI), to each health care provider for use on standard transactions. The NPI will simplify the administrative processing of certain health information. Further, it will improve the efficiency and effectiveness of standard transactions in the Medicare and Medicaid programs and other Federal health programs and private health programs. The information collected will be entered into a new system of records called the National Provider System (NPS), HHS/HCFA/OIS No. 09-70-0008. In accordance with the NPPES Data Dissemination Notice (CMS-6060), published May 30, 2007, certain information that you furnish will be publicly disclosed. The NPPES Data Dissemination Notice can be found at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf.

Failure to provide complete and accurate information may cause the application to be returned and delay processing. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you furnished on the form. (See the instructions for completing the NPI application/update form to find the information that is voluntary or mandatory.)

Information may be disclosed under specific circumstances to:

1. The entity that contracts with HHS to perform the enumeration functions, and its agents, and the NPS for the purpose of uniquely identifying and assigning NPIs to providers.
2. Entities implementing or maintaining systems and data files necessary for compliance with standards promulgated to comply with title XI, part C, of the Social Security Act.
3. A congressional office, from the record of an individual, in response to an inquiry from the congressional office made at the request of that individual.
4. Another Federal agency for use in processing research and statistical data directly related to the administration of its programs.
5. The Department of Justice, to a court or other tribunal, or to another party before such tribunal, when
   (a) HHS, or any component thereof, or
   (b) Any HHS employee in his or her official capacity; or
   (c) Any HHS employee in his or her individual capacity, where the Department of Justice (or HHS, where it is authorized to do so) has agreed to represent the employee; or
   (d) The United States or any agency thereof where HHS determines that the litigation is likely to affect HHS or any of its components is party to litigation or has an interest in such litigation, and HHS determines that the use of such records by the Department of Justice, the tribunal, or the other party is relevant and necessary to the litigation and would help in the effective representation of the governmental party or interest, provided, however, that in each case HHS determines that such disclosure is compatible with the purpose for which the records were collected.
6. An individual or organization for a research, demonstration, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or for the purposes of determining, evaluating and/or assessing cost, effectiveness, and/or the quality of health care services provided.
7. An Agency contractor for the purpose of collating, analyzing, aggregating or otherwise refining or processing records in this system, or for developing, modifying and/or manipulating automated data processing (ADP) software. Data would also be disclosed to contractors incidental to consultation, programming, operation, user assistance, or maintenance for ADP or telecommunications systems containing or supporting records in the system.
8. An agency of a State Government, or established by State law, for purposes of determining, evaluating and/or assessing cost, effectiveness, and/or quality of health care services provided in the State.
9. Another Federal or State agency
   (a) As necessary to enable such agency to fulfill a requirement of a Federal statute or regulation, or a State statute or regulation that implements a program funded in whole or in part with Federal funds.
   (b) For the purpose of identifying health care providers for debt collection under the provisions of the Debt Collection Information Act of 1996 and the Balanced Budget Act.

INSTRUCTIONS FOR COMPLETING THE NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Use only blue or black ink. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form. **Please note: Social Security Number (SSN) or IRS Individual Taxpayer Identification Number (ITIN) information should only be listed in block 18 or block 19 of this form. DO NOT report SSN or ITIN information in any other section of this application form.**

This application is to be completed by, or on behalf of, a health care provider or a subpart seeking to obtain an NPI. (See 45 CFR 162.408 and 162.410 (a) (1).

SECTION 1 – BASIC INFORMATION

This section is to identify the reason for submittal of this form and the type of entity seeking to obtain an NPI.

A. Reason for Submittal of this Form

This section identifies the reason the health care provider is submitting this form. *(Required)*

1. **Initial Application**
   If applying for a NPI for the first time check box #1, and complete appropriate sections as indicated in Section 1B for your entity type.
2. **Change of Information**
   If changing information, check box #2, write your NPI in the space provided, and provide the add/replace information within the appropriate section. If you are adding information, please check the 'Add Information' box and fill out the appropriate section(s) with the information you are adding. If you are replacing information, please check the 'Replace Information' box and fill out the appropriate section(s) with the replaced information. See the instructions in Section 4, then sign and date the certification statement in Section 4A or 4B. All changes must be reported to the NPI Enumerator within 30 days of the change. It is not necessary to complete sections that are not being changed; however, please ensure that your NPI is legible and correct. Complete Section 5 so that we may contact you in the event of problems processing this form. Please note that some changes, such as a change to a health care provider's date of birth, require a photocopy of the health care provider's U.S. driver's license or birth certificate to be submitted along with the form for verification purposes.
3. **Deactivation**
   If you are deactivating the NPI, check box #3. Record the NPI you want to deactivate, indicate the reason for deactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary. Please note that deactivations due to death must be completed and signed in Section 4 by the Power of Attorney or Executor of the Will. In addition, a copy of the death certificate or obituary must accompany the completed signed form.
4. **Reactivation**
   If you are reactivating the NPI, check box #4. Record the NPI you want to reactivate, provide the reason for reactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary.

B. Entity Type

Check only one box (*Required* for initial applications)

Entity Type 1: Individuals who render health care or furnish health care to patients; e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists. Incorporated individuals may obtain NPIs for themselves (Entity Type 1 Individual) if they are health care providers and may obtain NPIs for their corporations (Entity Type 2 Organization). A sole proprietorship is an Entity Type 1 (Individual). (A sole proprietorship is a form of business in which one person owns all the assets of the business and is solely liable for all the debts of the business in an individual capacity. Therefore, sole proprietorships are not organization health care providers.) Note that sole proprietorships may obtain only one NPI. Sole proprietorships must report their SSNs (not EINs even if they have EINs). Virtually any health care provider could be a sole proprietorship, including most of the examples listed in Entity Type 2.

Entity Type 2: Organizations that render health care or furnish health care supplies to patients; e.g., hospitals, home health agencies, ambulance companies, group practices, health maintenance organizations, durable medical equipment suppliers, pharmacies. Solely owned corporations that are health care providers obtain NPIs as Entity Type 2. If the organization is a subpart, check yes and furnish the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider.(A subpart is a component of an organization health care provider. A subpart may be a different location or may furnish a different type of health care than the organization health care provider. For ease of reference, we refer to that organization health care provider as the "parent".)

SECTION 2 – IDENTIFYING INFORMATION

A. Individual *(includes Sole Proprietorships and Incorporated Individuals)*

NOTE: An individual may obtain only one NPI, regardless of the number of taxonomies (specialties), licenses, or business practice locations he/she may possess. SSN or ITIN information should only be listed in block 18 or block 19, respectively, of this form. DO NOT report SSN and ITIN information in any other section of this form.

A sole proprietorship is an individual.

Name Information

1–6. Provide your full legal name. (Required first and last name) Do not use initials or abbreviations. If you furnish your social security number in block 18, this name must match the name on file with the Social Security Administration (SSA). In addition, the date of birth must match that on file with SSA. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

Other name information *(Use additional sheets of paper if necessary)*

7–12. If you have used another name, including a maiden name, supply that "Other Name" in this area. (Optional) You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

13. Mark the check box to indicate the type of "Other Name" you used. (Required if 7-12 are completed)

14–16. Provide the date *(Required)*, State *(Required)*, and country *(Required, if other than U.S.)* of your birth. Do not use abbreviations other than United States (U.S.).

17. Indicate your gender. *(Required)*

18. Furnish your Social Security Number (SSN) for purposes of unique identification. *(Optional)* If you furnish your SSN, this name must match the name and date of birth on file with the Social Security Administration (SSA). If you do not furnish your SSN, processing of your application may be delayed because of the difficulty of verifying your identity via other means; you may also have difficulty establishing your proper identity with insurers from which you receive payments. If you are not eligible for an SSN, see item #19. **If you do not furnish your SSN, you must furnish 2 proofs of identity with this application form: passport, birth certificate, a photocopy of your U.S. driver's license, State issued identification, or information requested in item #19.**

19. If you do not qualify for an SSN, furnish your IRS Individual Taxpayer Identification Number (ITIN) along with a photocopy of your U.S. driver's license, State issued ID, birth certificate or passport. **You may not report an ITIN if you have an SSN. Do not enter an Employer Identification Number (EIN) in the ITIN field. Note: Your passport, birth certificate, photocopy of the U.S. driver's license or State issued identification must accompany your ITIN. If you do not furnish the information requested in blocks 18 or 19, you must furnish 2 proofs of identity with this application form: passport, birth certificate, a photocopy of your U.S. driver's license or State issued identification.**
    Examples of individuals who need ITINs include:
    - Non-resident alien filing a U.S. tax return and not eligible for an SSN;
    - U.S. resident alien *(based on days present in the United States)* filing a U.S. tax return and not eligible for an SSN;
    - Dependent or spouse of a U.S. citizen/resident alien; and
    - Dependent or spouse of a non-resident alien visa holder.

B. Organizations *(includes Groups, Corporations and Partnerships)*

1–2. Provide your organization's or group's name *(legal business name used to file tax returns with the IRS)* and Employer Identification Number *(assigned by the IRS) (Required)*

3. If your organization or group uses or previously used another name, supply that "Other Name" in this area. *(Optional)* Use additional sheets of paper if necessary.

4. Mark the check box to indicate the type of "Other Name" used by your organization. *(D/B/A Name=Doing Business As Name.) (Required if 3 is completed.)*

NOTE: A sole proprietorship does not complete this section; he/she completes Section A.

SECTION 3 – ADDRESSES AND OTHER INFORMATION

A. Business Mailing Address Information *(Required)*

This information will assist us in contacting you with any questions we may have regarding your application for an NPI or with other information regarding NPI. You must provide an address and telephone number where we can contact you directly to resolve any issues that may arise during our review of your application. Do not report your residential address in this section unless it is also your business mailing address.

B. Business Practice Location Information *(Required)*

Provide information on the address of your primary practice location. If you have more than one practice location, select one as the "primary" location. Do not furnish information about additional locations on additional sheets of paper. Do not report your residential address in this section unless it is also your business practice location.

C. Other Provider Identification Numbers *(Optional)*

To assist health plans in matching your NPI to your existing health plan assigned identification number(s), you may wish to list the provider identification number(s) you currently use that were assigned to you by health plans. If you do not have such numbers, you are not required to obtain them in order to be assigned an NPI. Organizations should only furnish other provider identification numbers that belong to the organization; do not list identification numbers that belong to health care providers who are individuals who work for the Organizations. DO NOT report SSN, ITIN, or EIN information in this section of the form.

D. Provider Taxonomy Code *(Provider Type/Specialty) (Required)*

Provide your 10-digit taxonomy code. You must select a primary taxonomy code in order to facilitate aggregate reporting of providers by classification/specialization. If you need additional taxonomy codes to describe your type/classification/specialization, you may select additional codes. Information on taxonomy codes is available at www.wpc-edi.com/taxonomy.

Furnish the provider's health care license, registration, or certificate number(s) (if applicable). If issued by a State, show the State that issued the license/certificate. The following individual practitioners are required to submit a license number *(If you are one of the following and do not have a license or certificate, you must enclose a letter to the Enumerator explaining why not)*:

Certified Registered Nurse Anesthetist	Clinical Psychologist	Nurse Practitioner	Physician/Osteopath
Chiropractor	Dentist	Optometrist	Podiatrist
Clinical Nurse Specialist	Licensed Nurse	Pharmacist	Registered Nurse

You may use the same license, registration, or certification number for multiple taxonomies; e.g., if you are a physician with several different specialties.

NOTE: A health care provider that is an organization, such as a hospital, may obtain an NPI for itself and for any subparts that it determines need to be assigned NPIs. In some cases, the subparts have Provider Taxonomy Codes that may be different from that of the hospital and of each other, and each subpart may require separate licensing by the State (e.g., General Acute Care Hospital and Psychiatric Unit). If the organization provider chooses to include these multiple Provider Taxonomy Codes in a request for a single NPI, and later determines that the subparts should have been assigned their own NPIs with their associated Provider Taxonomy Codes, the organization provider must delete from its NPPES record any Provider Taxonomy Codes that belong to the subparts who will be obtaining their own NPIs. The organization provider must do this by initiating the Change of Information option on this form.

SECTION 4 – CERTIFICATION STATEMENT *(Required)*

This section is intended for the applicant to attest that he/she is aware of the requirements that must be met and maintained in order to obtain and retain an NPI. This section also requires the signature and date of signature of the "Individual" who is the type 1 provider, or the "Authorized Official" of the type 2 organization who can legally bind the provider to the laws and regulations relating to the NPI. See below to determine who within the provider qualifies as an Authorized Official. Review these requirements carefully.

Authorized Official's Information and Signature for the Organization

By his/her signature, the authorized official binds the provider/supplier to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied a National Provider Identifier if any requirements are not met. This section is intended for organizations; not health care providers who are individuals. All signatures must be original. Stamps, faxed or photocopied signatures are unacceptable. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

An authorized official is an appointed official with the legal authority to make changes and/or updates to the provider's status (e.g., change of address, etc.) and to commit the provider to fully abide by the laws and regulations relating to the National Provider Identifier. The authorized official must be a general partner, chairman of the board, chief financial officer, chief executive officer, direct owner of 5 percent or more of the provider being enumerated, or must hold a position of similar status and authority within the provider.

Only the authorized official(s) has the authority to sign the application on behalf of the provider.

By signing this application for the National Provider Identifier, the authorized official agrees to immediately notify the NPI Enumerator if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the NPI Enumerator of any changes to the information contained in this form within 30 days of the effective date of the change.

SECTION 5 – CONTACT PERSON *(If the contact person is the same person identified in 2A or 4B, complete items 8 & 9 in this section.) (Required)*

To assist in the timely processing of the NPI application, provide the name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application. The contact person can be the health care provider. The contact person will receive the NPI notification once the health care provider has been assigned an NPI. Please note that if a contact person is not provided, all questions about this application will be directed to the health care provider named in Section 2 or the authorized official named in Section 4, as appropriate. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

NPPES

National Plan & Provider Enumeration System

NPI Application Instructions

Note: Use of **Back** and **Forward** browser buttons could result in loss of all the information entered. Users should use the Next and Previous buttons provided on the application to navigate between the pages of the application.

Step 1: Before you begin, make sure you have the following information.
This information will be required to complete the NPI Application Form.
You will not be able to save your work if you quit before you have completed the application form.

- **Information Required for Individual Providers**
  - Provider Name
  - SSN (or ITIN if not eligible for SSN) [2]
  - Provider Date of Birth
  - Country of Birth
  - State of Birth*(if Country of Birth is U.S.)*
  - Provider Gender
  - Mailing Address
  - Practice Location Address and Phone Number
  - Taxonomy (Provider Type) [4]
  - State License Information [1]
  - Contact Person Name
  - Contact Person Phone Number and E-mail
- **Information Required for Organizations**
  - Organization Name
  - Employer Identification Number (EIN) [3]
  - Name of Authorized Official for the Organization
  - Phone Number of Authorized Official for the Organization
  - Organization Mailing Address
  - Practice Location Address and Phone Number
  - Taxonomy (Provider Type) [4]
  - Contact Person Name
  - Contact Person Phone Number and E-mail

[1] *(required for certain taxonomies only)*

[2] *(SSN or ITIN information should only be reported in the SSN or ITIN field)*

[3] *Do not report an SSN or IRS ITIN in the EIN field*

[4] *Provider Taxonomy codes can be obtained from http://www.wpc-edi.com/codes/taxonomy*

Online Help is available from each page of the Application / Update Form by clicking "Help" at the top right of the page.

If you need additional help or have any questions concerning your application, contact the NPI Enumerator.

NPI Enumerator Contact Information

By phone:	By e-mail at:	By mail at:
1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)	customerservice@npienumerator.com	NPI Enumerator PO Box 6059 Fargo, ND 58108-6059

Step 2: Read the information below.
You must agree to the terms below when you submit your application:

I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator immediately.

I authorize the NPI Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.

I understand that the information provided in this application may be used by other agencies in accordance with privacy regulations.

I have read and understand the Privacy Act Statement.

I have read and understand the ***Penalties for Falsifying Information*** *on the NPI Application / Update Form as stated in this application. I am aware that falsifying information will result in fines and/or imprisonment.*

Penalties for Falsifying Information on the NPI Application / Update Form:
18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Step 3: Begin online application. ☐ Begin Application Form

CAQH - Tab

Council for Affordable Quality Healthcare (CAQH) – Universal Provider Datasource (UPD)

Website: www.caqh.org

What is CAQH?

The **Council for Affordable Quality Healthcare (CAQH)** is a non-profit alliance of health plans and trade associations, working to simplify healthcare administration through industry collaboration on public-private initiatives. CAQH strives to be a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.

CAQH members work together to create and refine initiatives for streamlining healthcare administration. Aetna, America's Health Insurance Plans, AultCare, the Blue Cross Blue Shield Association, Blue Cross Blue Shield of Michigan, BlueCross BlueShield of North Carolina, BlueCross BlueShield of Tennessee, CareFirst BlueCross BlueShield, Cigna, Horizon Blue Cross Blue Shield of New Jersey, Kaiser Permanente, UnitedHealth Group, and WellPoint are among the health plans and trade associations that contribute to CAQH solutions.

Through one of its initiatives, **Universal Provider Datasource (UPD),** CAQH aims to reduce administrative burden for providers and health plans

What is UPD?

Built around a single electronic form and secure database, UPD enables healthcare providers to submit, store, update and access their most critical information for credentialing, claims processing, quality assurance and member services, such as directories and referrals. Health plans authorized by providers participating in UPD can electronically download the information into their systems. This standard form meets the data-collection needs of health plans, hospitals and other healthcare organizations.

To become a participating provider:

1. Check the CAQH website to see if there is already an existing account for the applicant
    a. Do not skip this step – if there are duplicate provider accounts, it will delay the credentialing process.
    b. If YES, you will have an 8 digit provider ID #. You can provide this 8 digit provider ID# to the insurance company so they can access your information through UPD for the credentialing process
2. If there is not an existing account (no provider ID #), you will need to do the following:
    a. contact the insurance company that you wish to become a provider for. Ask them to add you to the CAQH provider list. Note: you only have to contact one

insurance company to get into the CAQH system. Once you have obtained your 8 digit provider number, the other insurance companies will have access to your information.

b. The insurance company will tell you what information they need to do this – it may vary from company to company. You may need to complete an application. The insurance company will determine if you meet their criteria as a provider.
c. The insurance company will add your information to the CAQH system. An 8 digit Provider # will be generated by CAQH.
d. CAQH will mail you your 8 digit provider number.

3. Once you have your 8 digit CAQH provider number:
    a. Go to www.caqh.org
    b. Enter your 8 digit provider number to register online (you will need to make up a user name & password)
    c. Log in
    d. Complete application online

ANTHEM - Tab

Anthem Wellpoint

Provider Availability - Yes

Types of contracted immunization service available to Local Health Departments:

- Influenza vaccine
- Pneumococcal vaccine

Note: Anthem Wellpoint is looking to expand coverage to other vaccines on a national level. They are currently working on establishing a fee schedule.

Anthem WellPoint Contact Person:

Heather Schell
Provider Network Manager – Enterprise Ancillary Contracting
Anthem Blue Cross and Blue Shield
3000 Goff Falls Road
Manchester, NH 03111
Phone: 603-695-7911
Fax: 603-695-7942
heather.schell@anthem.com

A) Provider Requirements:

- Public health department must:
  - have an NPI number
  - have a Tax ID number (W-9 form required)
  - have liability insurance (general $1,000,000 / $3,000,000; professional $1,000,000 / $3,000,000)
  - have a state license (for either the health department or the medical director)
  - have CMS certification (Medicare #; must be a Medicare provider)
- Must operate clinics in accordance with current CDC guidelines and suggested protocols, in addition to any product specifications.
- Formal credentialing not required
- Medical Director does not have to be contracted with Anthem Blue Cross and Blue Shield

B) Application Process:

- Contact Heather Schell
- She will send an application.
  - Application is generic for all providers (sample application provided)
- Complete application and submit to Heather Schell

- Heather will draw up contract – it is a standard contract. No negotiations.
    - Application process takes a minimum of 45 days to implement
- Contracts are typically evergreen without an end date. There is no need to “renew”

CONFIDENTIAL/PROPRIETARY

Anthem Blue Cross and Blue Shield Facility / Provider Application – for Connecticut, Maine and New Hampshire

INSTRUCTIONS

Please complete and return this application along with all required documentation as indicated on pages 3 and 4. If credentialing of a facility/entity is required (Home Health, Hospice, Infusion Therapy, Skilled Nursing, Sub Acute), this will be completed by our credentialing department and extends the time needed to finalize participation with the facility. Original paper copies must be submitted, as original signatures are required.

Mail original application and all corresponding information to:

Anthem Blue Cross and Blue Shield
Attention: Heather Schell
3000 Goffs Falls Road
Manchester, NH 03111

DEMOGRAPHIC INFORMATION

Facility/Provider Name (as it appears on the W-9):		NPI:	
DBA Name or Legal Name:			
Parent Company:			
Facility Address:		Suite Number:	
City:	County:	State:	Zip:
Telephone Number:	Fax Number:		

BILLING INFORMATION

Billing Address (If different from above address):	Contact Name:		
City:	County:	State:	Zip:
Telephone Number:	Fax Number:		

STAFF INFORMATION

Director/Administrator:	Telephone Number:
Medical Director:	Telephone Number:
Contact Person for Contract Administration:	Telephone Number:
Contact Title:	Contact E-mail:

CONTRACTING STATES (check the state(s) that you desire to contract with)

Connecticut		Maine		New Hampshire	

PROVIDER TYPE (check all that apply)

Ambulance		Infusion Therapy – Ambulatory Suite	
Dialysis		Infusion Therapy - Home	
Durable Medical Equipment		Laboratory – Genetics, Pathology, Specialty	
Flu Clinic		Orthotics / Prosthetics	
Home Health Agency		Skilled Nursing Facility	
Home Hospice Agency		Sub Acute Facility / TBI / Acute Rehabilitation	
Hospice - Inpatient		Sleep Study	
Independent Diagnostic Testing Facility / Imaging		Other (list here)	

ADDITIONAL SERVICE LOCATION (1)

Address:		Suite Number:	
City:	County:	State:	Zip:
Telephone Number:	Fax Number:	NPI:	
Contact Name:	Contact Title:		

ADDITIONAL SERVICE LOCATION (2)

Address:		Suite Number:	
City:	County:	State:	Zip:
Telephone Number:	Fax Number:	NPI:	
Contact Name:	Contact Title:		

SERVICE DETAILS

Taxonomy Code:
Please provide a detailed description of the services that you provide.
List the specific code ranges that you bill (e.g. HCPCS S9208-S9279, Rev codes 800-809, CPT-4 codes 97597-97799).
Website:

CLAIM SUBMISSION (check the appropriate submission method and format)

Submission Method:	Electronic		Paper		Both	
Submission Format:	HCFA 1500 / CMS 1500		UB-92 / UB-04			

MEDICARE/MEDICAID PARTICIPATION

Medicare Certified:	Yes		No		
Medicare Number		Medicare Effective Date			
Is the provider currently under investigation by any government agency?		Yes		No	
Has the provider had any conditional federal deficiencies with the past 5 years?		Yes		No	
Has the provider ever been expelled or suspended from receiving payment under the Medicare or Medicaid program?		Yes		No	
If you answered yes to any of the three questions above, please explain the details on a separate page and include the CMS 2567 form if applicable.					
Medicaid Participating Provider:	Yes		No		
Medicaid Number:					

CONNECTICUT PROVIDERS ONLY

Do you hold participation with Empire Blue Cross Blue Shield?	Yes		No	

CONFIDENTIAL/PROPRIETARY

Facility Application

INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Current copies of the following documents MUST be submitted with this application:

- State License
- CMS (State/Medicare) Site visit HCFA 2567 (if not accredited)
- Certification letter from Medicare and Medicaid (if applicable)
- Facility Accreditation Certificate (s)
- Professional Liability Coverage Face Sheet
- W-9

DEMOGRAPHIC INFORMATION

Facility Name: NPI:			
Federal Tax ID Number:	Facility Type:		
DBA Name or Legal Name:			
Address:		Suite Number:	
City:	County:	State:	Zip:
Telephone Number:	Fax Number:		
Contact Name:	Contact Title:		

BILLING INFORMATION

Billing Address (If different from above address):	Contact Name:		
City:	County:	State:	Zip:
Telephone Number:	Fax Number:		

LICENSURE

State License Number:	Issue Date:	Expiration Date:

CMS SURVEY

Date of last survey:	Medicare Number:	Medicaid Number:

ACCREDITATION

Accrediting Agency:	Expiration Date:
Type of Accreditation obtained:	

PROFESSIONAL LIABILITY

Liability Carrier:	Coverage Limits:
Policy Number:	Expiration Date:
If Self-Insured, please supply documentation describing your self-insurance program.	

CONFIDENTIAL/PROPRIETARY

ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If you answer "yes," please provide full details on separate sheet

A. Has your malpractice insurance ever been terminated or revoked except with your consent or request?
Yes ☐ No ☐

B. Are you currently under investigation by any government agency?
Yes ☐ No ☐

C. Have you been expelled or suspended from receiving payment under Medicare or Medicaid?
Yes ☐ No ☐

D. Has your accreditation status ever been reduced, terminated, suspended or revoked?
Yes ☐ No ☐

E. Is your malpractice insurance provided through a self-insurance trust or program? Yes ☐ No ☐

If yes, an officer of the company (i.e. President, Vice-President, Chief Financial Officer or Chief Operating Officer) must sign the following attestation. On behalf of the applicant I represent and warrant the following with respect to the self-insurance program maintained by the applicant, or which provides professional liability insurance for the applicant:

1. The self insurance program is adequately funded to provide the minimum required limits of liability as required by Plan, and;
2. The self-insurance program has an actuarially validated reserve adequate for incurred claims, for incurred but not reported claims, and future claims based on past experience, and;
3. The self insurance program has a designated third party administrator or other appropriately licensed claims professional or attorney serving the program, and;
4. The self insurance program has a designated medical malpractice defense firm, or more than one designated medical malpractice defense firm, and;
5. The self insurance maintains excess insurance/reinsurance above the self funded level, if the self-insured level alone is insufficient to meet Plan's required limits, and;
6. The self insurance program maintains evidence of a surety bond or letter of credit as collateral to the self-insured limit, or a captive, self management of a large retention through a trust, and;
7. The self insurance maintains a total value of the program that at a minimum meets the required limit of liability as set forth by Plan?
8. I have confirmed the foregoing with my auditor or the actuary for the self-insurance fund.

Attest: _____

Name: _____

Title: _____

NOTE: The Plan reserves the right to request documentation from the applicant to confirm the information maintained in this attestation.

I hereby affirm that the information submitted in this application is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of privileges, employment or participating practitioner agreement.

A photocopy of this document shall be as effective as the original.

_____ _____

Preparer's Name Here Title

_____ _____

Signature Date

(Stamped Signature Is Not Acceptable)

ANTHEM BLUE CROSS AND BLUE SHIELD
ANCILLARY PROVIDER AGREEMENT FOR IMMUNIZATION SERVICES

Participation Attachment
for
Connecticut

A. Ancillary Provider shall be a Network/Participating Provider in:

- HMO (includes group HMO and POS products such as: BlueCare Health Benefit Plans; BlueCard POS Health Benefit Plans; New England Health Plans Health Benefit Plans;

  and If Applicable, Empire Blue Cross and Blue Shield of New York non-gatekeeper HMO/POS Health Benefit Plans- Direct HMO, Direct POS & Direct Share℠ POS)

- PPO (includes PPO, EPO and CDHP products such as: Century Preferred Health Benefit Plans; State Preferred Health Benefit Plans; PPO BlueCard PPO Health Benefit Plans; Federal Employee Program Health Benefit Plans; National Accounts Health Benefits Plans; and If Applicable, UniCare Life and Health Insurance Company PPO Health Benefit Plans)

- Traditional/Standard (includes traditional & standard products)

- Individual/direct pay (includes individual/direct pay products)

- Other: Anthem Blue Cross and Blue Shield Health Benefit Plans for which Hospital is a Network/Participating Provider

- Medicare HMO (includes group HMO and POS products, such as: If Applicable MediBlue℠ HMO Health Benefit Plans)

- Medicare PPO (includes PPO products such as: If Applicable MediBlue℠ PPO Health Benefit Plans)

B. Throughout the term of the Agreement, Ancillary Provider shall provide the following Covered Services to Covered Persons/Members:

1. Immunization Services – means influenza and/or pneumonia immunizations/vaccinations provided by Ancillary Provider to Covered Persons/Members at scheduled "on site" clinics as well as at public clinics that Ancillary Provider might conduct in conjunction with a community business, shopping center or retail store.

2. Ancillary Provider's administering clinics must have written policies and procedures for the operation of Immunization Services clinics, and Ancillary Provider must operate such clinics in accordance with current Center for Disease Control (CDC) guidelines and suggested protocols, in addition to any product specifications.

3. Ancillary Provider agrees that any nursing services required to be performed under the terms of this Agreement shall be performed by health care providers who, at a minimum, maintain a registered nurse license (RN), in good standing, in the state in which the services are being rendered. Nursing services may also be performed by licensed practical nurses (LPNs) under the direction of an RN, or other appropriately licensed supervisor, pursuant to Section 2.16 of this Agreement.

4. Ancillary Provider shall provide Immunization Services information materials to Covered Persons/Members prior to administration, and shall not bill Covered Person/Member, Anthem, or Plan for such excess dosage or unused services.

5. Ancillary Provider will ensure that appropriate emergency procedures and supplies are available for an emergency situation at clinics where Immunization Services are being administered until such time as emergency support services arrive.

6. Ancillary Provider shall be responsible for coordination, delivery, administration and billing of all Immunization Services provided to Covered Persons/Members performed by or on behalf of Ancillary Provider. Ancillary Provider shall instruct all of its subcontracted providers, if any, of this requirement. Any Claims received and/or paid by Anthem to Ancillary Provider*'s* subcontracted provider shall be considered an incorrect payment and Ancillary Provider shall be subject to Section 2.10. Offsets, Payment Corrections and Right of Recovery of the Agreement for any such incorrect payments

Amendment
to
ANTHEM BLUE CROSS AND BLUE SHIELD
ANCILLARY PROVIDER AGREEMENT FOR IMMUNIZATION SERVICES

THIS AMENDMENT is made and entered into as of September 1, 2011 (the "Effective Date") between **ANTHEM HEALTH PLANS, INC.** doing business as Anthem Blue Cross and Blue Shield ("Anthem") for itself and as agent for each of its Affiliates and **CONTRACTED PROVIDER** (defined herein).

WHEREAS, Ancillary Provider and Anthem ("Parties") have entered into an Agreement for immunization services; and

WHEREAS, the Parties desire to amend the Agreement in certain respects as herein set forth below;

NOW THEREFORE, in consideration of the mutual covenants and obligations set forth within and other good and valuable consideration, the receipt of which is hereby acknowledged, the Parties agree that the Agreement as referenced above shall be amended as follows:

I. **The Plan Payment Schedule shall be deleted and replaced with the attached Plan PaymentSchedule.**

No other changes to the Agreement are made by this Amendment and, in all other aspects, the Agreement, including all attachments and any amendments, shall remain in full force and effect. In the event of a conflict between this Amendment and the Agreement, including all attachments and any prior amendments, this Amendment shall prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

[redacted]

Date: 10/5/2010

ANTHEM HEALTH PLANS, INC.
for itself and as agent for Affiliates

By: L. Kathryn Norman

L. Kathryn Norman
Vice President
Provider Engagement and Contracting

Date: 11/15/10

Contracted Provider
Tax Identification Number: [redacted]

RECEIVED
NOV 0 8 2010
Ancillary Contracting Dept.

ANTHEM BLUE CROSS AND BLUE SHIELD
ANCILLARY PROVIDER AGREEMENT FOR IMMUNIZATION SERVICES

Plan Payment Schedule

I. Payment

Ancillary Provider agrees to accept the Anthem Rate as payment in full for Covered Services provided to Covered Person / Members the lesser of Ancillary Provider's charges or Anthem Rate as specified in this Plan Payment Schedule. Some or all of the Anthem Rate may be paid by Covered Person / Members in the form of Cost Shares.

Drug Schedule:

1. Medicare Drugs

The Anthem Rate for drugs is 100% of the published fee in the "ASP Drug Pricing File" as published by Medicare. In the event there are multiple fees published for a procedure code, the lowest fee that is published will be utilized. Anthem will update the Anthem Rate for Medicare drugs each quarter for Medicare changes effective no later than thirty-one (31) days after the Medicare quarterly update becomes effective. The update shall take place automatically and it does not require any notice or disclosure to Ancillary Provider or any contract amendment.

2. Drugs without a published fee on the Medicare "ASP Drug Pricing File"

The Anthem Rate for the drugs that are not priced by Medicare will be determined by the Plan. Any update shall take place automatically and it does not require any notice or disclosure to Ancillary Provider or any contract amendment.

Ancillary Provider must bill using industry standard codes specific for Influenza virus and Pneumococcal vaccines. Payment will be made only for Influenza virus and Pneumococcal vaccines and the administration codes listed in this Agreement. All other codes will deny as provider liable under the terms of this Agreement.

Anthem Administration Schedule		
Immunization Service *	**Code**	**Rate**
Administration of influenza virus vaccine	G0008	$13.00
Administration of pneumococcal vaccine	G0009	$13.00

* The pricing associated with the above immunization services shall include, but not be limited to, all services and supplies for the preparation and administration of immunizations/vaccinations, vaccine, educational materials, wages and travel time and expenses of Ancillary Provider's personnel, and cleanup and removal of waste materials.

II. Claim Form Requirements

STATE	CLAIM FORM
Connecticut	CMS 1500
New Hampshire	CMS 1500
Maine	CMS 1500

Note: Payment is made only for Covered Services subject to the terms, limitations and exclusions of the Covered Person/Members Health Benefit Plan and any applicable referral and pre-certification requirements.

CONNECTICARE - Tab

Connecticare

Provider Availability - Yes

Types of contracted immunization service available to Local Health Departments:

- Influenza vaccine
- Pneumococcal vaccine

Connecticare Contact Person:

Angie Karal
Sr. Provider Contracting Specialist, Network Operations
ConnectiCare, Inc. & Affiliates
175 Scott Swamp RoadPO Box 4050
Farmington, CT 06034-4050
Phone: 860-674-2061
Fax: 860-674-2849
akaral@connecticare.com

A) Provider Requirements:

- Public health department must:
  - have an NPI number
  - have a tax ID number
  - have a taxonomy number
  - have liability insurance
  - have a professional license need clarification
- Formal credentialing not required
- Medical Director does not have to be contracted with Connecticare

B) Application Process:

- Contact Angie Karal
- She will send an application.
  - Application is generic for all providers (sample application provided)
- Fill out application and return it to Angie Karal along with W-9 Form.
- Contracting process takes at least 4 weeks

ConnectiCare, Inc. & Affiliates
One of America's highest-rated health plans

Health Delivery Organization Profile

Organization Name:_____

♥ Credentialing sign off required

Type of Organization:

☐ Ambulatory Surgery Center♥	☐ a) Free standing	☐ b) Office Based	☐ Birthing Center♥
☐ Dialysis Center ♥	☐ Endoscopy Center ♥	☐ Home Health Agency ♥	☐ Hospice ♥
☐ Hospital ♥	☐ IV Infusion Facility ♥	☐ Skilled Nursing/Acute Rehab♥	
☐ Durable Medical Equipment	☐ Outpatient PT/ST/OT Therapy	☐ Walk-In/Urgent Care	
☐ Durable Medical Equipment	☐ Other	☐ Group number	

Primary Practice Address:

Street: _____ City: _____

State:_____Zip:_____County:_____

Phone Number: (_____)_____Fax Number: (_____) _____

Federal Tax ID #:_____Medicare Provider #: _____ NPI #:_____Taxonomy #_____

Medicare Legacy #_____ASC# (For ambulatory surgical centers only)_____

Name of Administrator: _____ E Mail Address: _____

Phone Number: (____)_____Fax Number: (_____) _____

Business Contact:_____ E Mail Address: _____

Phone Number: (_____)_____Fax Number: (_____)_____

Payment address: _____

Mailing address:_____

Parent Corporation or affiliation:_____Federal Tax ID #:_____

License Information:

State	License Type	License Number/ Facility Operating Certificate	Date of Issue	Date of Expiration

New York only: Permanent Facility Identifier Number:_____ NY Surcharge Provider? ☐ Yes ☐ No

For office use only: Tracking #_____N.O. Reviewer_____

Contract effective date_____ Pay Class_____ Designated Service Code:_____ Contract signed: Yes No

☐ (IL) H.S.A. Apply ☐ Yes ☐ No

Secondary Service Codes

1: 2: 3: 4: 5:

6: 7: 8: 9: 10:

OSI Analyst:_____ Date OSI Sent to N.O.:_____ Provider ID#:_____

Date Accept Letter Sent:_____ Date N.O. Sent to File Room_____Date File Room Rec'd:_____

Accreditation Information

Accrediting Body	Accreditation Status	Expiration date (mm/dd/yy)

If the organization is not accredited, does the organization have plans to apply for accreditation? ☐ Yes ☐ No ☐ N/A

Please explain:_____

***Non Accredited Skilled Nursing Facilities, Home Health Agencies or Ambi Surg Centers are required to submit the most recent annual State or Medicare survey in lieu of accreditation. Please attach to avoid delay in processing.**

Does your organization provide services at locations other than the primary address? ☐ Yes ☐ No ☐ N/A

♥ **If yes, please complete a Service Location Addendum for <u>each site</u>.**

Are all patient service locations / satellite sites accredited? ☐ Yes ☐ No ☐ N/A

Access and Availability

Please indicate the number of providers at this service location: _____

Please list hours of operation: ☐ 24 hours/day/ 7 days/week

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Does your organization provide:

- Translator or interpreter services? ☐ Yes ☐ No ☐ N/A
- Wheelchair accessibility? ☐ Yes ☐ No ☐ N/A
- Behavioral Health Consultations 24 hrs/ day for inpatient clients? ☐ Yes ☐ No ☐ N/A

♥ If no, please explain the process to assist clients with these identified needs:_____

_____

Timely submission of this information is requested at your earliest convenience.
Please return this form, W-9, and proof of Professional Liability Coverage via mail or fax to:

Network Operations
ConnectiCare, Inc. & Affiliates
175 Scott Swamp Rd.
Farmington, CT 06032-3124
Fax (860) 674-2849

_____ _____
Authorized Signature Date

_____ _____
Print Name/Title Phone

ADDENDUM

This form may be duplicated as needed

ADDITIONAL SERVICE LOCATIONS

Type of organization:

☐ Walk In/ Urgent Care	☐ Home Health Agency	☐ Outpatient PT/ST/OT
☐ Freestanding Ambulatory Surgery	☐ Freestanding Dialysis Center	☐ Freestanding Radiology Center
☐ Other		

Name of Organization:_____

Practice Address:

Street _____

City _____ State_____ Zip_____ County_____

Telephone #: (_____)_____Fax #: (_____)_____

Name of Administrator:_____

Phone Number: (_____)_____ Fax Number: (_____)_____

Medical Director:_____

Federal Tax Id #:_____Medicare Provider #:_____

Please list hours of operations: ☐ 24 hours/day/ 7 days/week

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

- Wheelchair accessibility? ☐ Yes ☐ No ☐ N/A
- Please indicate the number of providers at this service location: _____

Note: Please complete the following section only if differs from the information previously supplied on pages 1&2

State	License Type	License Number/ Facility Operating Certificate	Date of Issue	Date of Expiration

New York only: Permanent Facility Identifier Number:_____ NY Surcharge Provider? ☐ Yes ☐ No

Accreditation Information

Accrediting Body	Accreditation Status	Expiration date (mm/dd/yy)

For office use only: Addendum Information: Pay Class_____ Designated Service Code:_____

Secondary Service Codes

1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
11:	12:	13:	14:	15:
16:	17:	18:	19:	20:
21:	22:	23:	24:	25:

ANCILLARY SERVICES AGREEMENT

This Ancillary Services Agreement ("Agreement") is made and entered into by and between ConnectiCare, Inc., on behalf of itself and its Affiliates (as defined below) (hereinafter "CCI"), and **Pomperaug District Department of Health** (hereinafter "Provider"), to become effective on this **1st day of October 2008** ("Effective Date") provided that Provider has been credentialed and approved by CCI or its designee.

WHEREAS, CCI contracts for itself and on behalf of its Affiliates with employers, labor unions, administrators and other entities and individuals to insure, administer or arrange health insurance benefits and services and contracts with health care providers to render services to individuals entitled to receive health care services from or through a Plan (as defined below); and

WHEREAS, CCI has signed a contract with the Centers for Medicare and Medicaid Services ("CMS") under which CCI will arrange for the provision of health care services to Medicare beneficiaries under CCI's Medicare Advantage ("MA") Plan; and

WHEREAS, Provider wishes to contract with CCI to provide ancillary health care services to such individuals on the terms and conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements and undertakings herein and intending to be legally bound hereby, the parties agree as follows:

ARTICLE 1. PROVISION OF SERVICES

1.1. **Provision of Covered Services by Provider.** Provider shall provide to Members services and equipment, which are Covered Services under Member's Plans ("Provider Services"). Such Provider Services shall be comprised generally of all of the services and equipment available from Provider which are Covered Services ordered by the physician treating the Member or rendered to a Member in an Emergency. Provider shall provide services which are within the scope of the respective Provider's license and certification to practice. Nothwithstanding the Effective Date, Provider may not provide any Covered Services to Members unless and until Provider has been fully credentialed and approved by CCI or its designee. Provider acknowledges and agrees that credentialing and approval by CCI or its designee is a condition precedent to providing Covered Services to members and performing services under this Agreement and that this Agreement shall be void, as if the Agreement had not been entered into, upon written notice by CCI that Provider has not been approved by CCI. It is understood and agreed that CCI, or when applicable, the Payer shall have the final authority to determine whether any Provider Services provided by Provider are Covered Services in accordance with the applicable Plan. Provider shall also accept and treat as patients all Members without regard to the health status or health care needs of such Members, and shall protect the rights of such Members as patients. Provider shall not differentiate or discriminate in the treatment, or in the access to treatment, of Members on the basis of race, gender, creed, ancestry, lawful occupation,

age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Covered Services required, status as Members, or any other grounds prohibited by law or this Agreement.

Provider agrees to participate in CCI's Medicare Advantage Plan through and until December 31, 2008 ("Initial MA Term") and such participation under this Agreement, including Appendix C shall automatically renew for each calendar year thereafter. After the Initial MA Term, Provider may elect not to renew its participation in CCI's Medicare Advantage Plan by providing written notice to CCI no later than one hundred and twenty (120) days prior to the end of the Initial MA Term or any renewal term thereafter. Provider agrees to provide Covered Services to Medicare Members in accordance with this Agreement and Appendix C, Medicare Advantage Addendum, which is attached hereto and incorporated herein. For services rendered to Medicare Members in accordance with this Agreement, the provisions of the Medicare Advantage Addendum shall prevail over any provision in this Agreement, which may conflict or appear inconsistent with any provision in the Addendum. In the event the contract between CCI and CMS is terminated or not renewed, Appendix C, Medicare Advantage Addendum, may be terminated by CCI in its sole discretion effective upon termination of the effective date thereof within ten (10) business days of notice of termination given by either CCI or CMS.

1.2. **Provider Information.** Provider shall provide CCI a complete listing of all Providers' offices, which shall include office addresses, office hours, telephone and facsimile numbers. Provider shall notify CCI in writing within ten (10) business days of any change in this information.

1.3. **Representations**

1.3.1. **Provider Representation.** Provider represents that (a) it has and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies; (b) Provider complies and shall remain compliant with all applicable federal and state laws and regulations related to this Agreement and the services provided hereunder, including, but not limited to, laws and regulations related to fraud, abuse, self-referrals, false claims, prohibition of kickbacks, discrimination, disabilities, and confidentiality; and (c) this Agreement has been executed by its duly authorized representative.

1.3.2. **Qualified Personnel.** Provider also represents that he/she credentials its employees and shall ensure that all personnel employed by, associated or contracted with Provider who treat Members are appropriately licensed, certified, and supervised (when required by state law). Provider must obtain prior approval of CCI before utilizing any subcontractors to provide Covered Services to Members. If Provider contracts with other providers or facilities who agree to

provide Covered Services to Members with the expectation of receiving payment directly or indirectly from CCI, such providers or facilities shall agree to abide by the provisions of this Agreement.

1.4. **Standard of Performance.** In performing services and otherwise meeting its duties and obligations hereunder, Provider and shall each ensure that its employees and contractors observe high standards of professional and business ethics observed by like professionals in the same or similar business, including, but not limited to, following the requirements, rules and regulations applicable to Provider, respecting the privacy of CCI, its customers and Members, acting with integrity, and creating a workplace atmosphere free of discrimination and harassment.

ARTICLE 2. COMPENSATION

2.1. **Compensation of Provider.** CCI shall pay Provider in accordance with the Compensation Schedule attached hereto as Appendix B and Appendix D and made a part hereof for services provided to Members under a Plan. CCI shall, or when it is not the applicable Payer shall notify each Payer to, pay Provider for Covered Services rendered to Members in accordance with Appendix B and Appendix D. The Fee Schedule will set forth the maximum fees payable by CCI or the applicable Payer for Covered Services rendered by Provider. The Fee Schedule may be changed with notice by CCI at anytime in accordance with the Amendment section provided that CCI will not make such change more than once per calendar year unless otherwise mutually agreed to by Provider and CCI. Samples of the current Fee Schedules are available to Provider upon request at any time. Such payment shall be made within forty-five (45) days of CCI's or the applicable Payer's receipt of a complete claim containing all information required under CCI's Rules and provided such claim does not require further investigation by CCI or the applicable Payer. Provider's compensation for Covered Services rendered to Members shall be the lower of the rates in the Provider's Fee Schedule, or the Provider's billed charge minus any applicable Copayments, Coinsurance, or Deductibles.

For purposes of CCI Deductible and indemnity type plans Provider agrees to accept as payment in full the lesser of billed charges or the applicable contracted amount as set forth in this Agreement. For all claims for which the amount paid represents the lower billed charged amount, the parties agree that CCI shall make a deferred settlement payment to Provider which represents the difference between the lesser of payment and the contracted amount set forth in the Agreement.The additional payment shall be made quarterly by CCI, in the aggregate for all such claims, including interest, if any, in accordance with applicable state requirements. The payment for a calendar quarter shall be remitted by CCI within 45 days of the close of that calendar quarter.

Provider shall notify CCI of any overpayments or payments made in error within ten (10) business days of becoming aware of such overpayments or erroneous payments, and shall within thirty (30) days of notice by CCI return or arrange for the return of any such overpayment or payment made in error to CCI or the Member, as applicable.

2.2. **Billing of Members.** Provider shall collect any applicable Copayments, Coinsurance or Deductibles for certain Covered Services as required under the applicable Plans. Copayments shall be collected at the time Covered Services are rendered and may not be waived by Provider except where specifically permitted by applicable law. Provider may bill Members for non-Covered Services only if the Member's Plan provides and/or CCI confirms that the services are not covered and the Member was advised in writing that the services are not covered and the Member agreed to accept financial responsibility for such services. Nothing in this section is intended to restrict or prohibit Provider from billing individuals who were not Members at the time services were rendered.

2.3. **Coordination of Benefits.** CCI, or the applicable Payer, will pay for Covered Services in accordance with the terms of this Agreement and the applicable Plan, including its coordination of benefit rules. In no event shall amounts billed and retained by Provider under coordination of benefits for Covered Services exceed the Provider's usual and customary billed charges for such services.

2.4. **Claims Submission.** Provider shall submit claims to CCI or the applicable Payer for Covered Services rendered to Members by Provider. CCI or the applicable Payer must receive claims within one hundred eighty (180) days of the Member's receipt of such Covered Services. Claims submitted after the one hundred eighty (180) day period will not be reimbursed by CCI and Provider shall not bill any other person or entity for Covered Services, including, but not limited to, Member or the applicable Payer. Claims shall include detail and descriptive medical and Member data on HCFA 1500 forms and in accordance with CCI Rules.

2.5. **Member Hold Harmless.** If the applicable Payer is an HMO or health care center, Provider agrees that in no event, including, but not limited to, non-payment by the HMO or health care center, because the Provider has failed to comply with the terms or conditions of this Agreement, insolvency of the HMO or health care center or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons (other than HMO or health care center) acting on a Member's behalf for Covered Services. This provision shall not prohibit collection of Deductibles, Coinsurance, or Copayments or costs for non-covered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's Plan. Provider further agrees that this provision shall survive termination of this Agreement regardless of the cause giving rise to termination, shall be construed for the benefit of Members, and supersedes any contrary oral or written agreement now existing or hereafter entered into between Provider and a Member or persons acting on a Member's behalf.

Pursuant to section 20-7f of the Connecticut General Statutes, it is an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee (Member), other than a copayment or deductible, for Covered Services, or to

report to a credit reporting agency an enrollee's failure to pay a bill for medical services when a health care center (HMO) has primary responsibility for payment of such services.

ARTICLE 3. COMPLIANCE WITH CCI RULES

3.1 **Compliance with Rules, Policies, Procedures.** Provider shall comply fully with CCI Rules that CCI has established or will establish, including, but not limited to those regarding: (a) quality improvement/management; (b) utilization review, including, but not limited to, precertification of elective admissions and procedures, and referral process or protocols; (c) claims payment review; (d) Member grievances; (e) provider credentialing; and (f) claims submission. Provider acknowledges and agrees that failure to comply with CCI's Rules, will relieve CCI, or applicable Payer, and Members from any financial liability for the applicable portion of the Provider Services, and could lead to sanctions including, without limitation, termination of this Agreement. CCI may at any time modify any policies and procedures. CCI will provide thirty (30) days notice of any changes in CCI Rules that could reasonably be expected, in CCI's determination, to have a material adverse impact on Provider's reimbursement, Covered Services, or administration of Provider's practice.

3.2 **Utilization Review.** CCI utilizes systems of utilization review/quality improvement/peer review consistent with applicable federal and state laws, Health Employer Data Information ("HEDIS") and any other relevant accreditation standards. Provider shall cooperate reasonably with CCI in the implementation and ongoing maintenance by CCI of utilization review mechanisms established to monitor the Medical Necessity of services provided by Provider. In connection therewith, Provider shall permit duly authorized CCI personnel to have reasonable access to its facilities and/or employees.

3.3. **Member Grievances and Appeals.** Provider agrees to comply with CCI's appeals and grievance process as set forth in CCI's Rules or the applicable Plan. CCI shall have final authority to determine the resolution of appeals and grievances of Members or any Provider. In addition, the parties agree to cooperate with each other during the course of investigation, including, but not limited to, providing CCI with the requested information necessary to resolve such complaints.

3.4. **Reporting**. Provider shall maintain and provide any other records related to the services provided herein as CCI may reasonably request for regulatory compliance purposes and shall cooperate with CCI in all fiscal and medical audits, and any other monitoring required by regulatory or accreditation agencies, including but not limited to, HEDIS and the National Committee for Quality Assurance ("NCQA"). Any record required by CCI pursuant to this Agreement or a regulatory or accreditation agency shall, at the expense of Provider, be delivered to CCI within five (5) business days of its request. Any books, records and other papers required to be maintained pursuant to this Agreement shall be maintained for a period of (5) five years following termination of this Agreement or for the period required by applicable law, whichever is longer. This right to audit shall apply

to CCI, Payers, accreditation agencies and regulatory agencies with jurisdiction over CCI or the subject matter of this Agreement.

3.5. **Assignment of Benefits and Consents to Disclose Medical Information.** Provider shall obtain from all Members to whom services are provided: (a) signed assignments of benefits authorizing payment for services to be made directly to provider, and (b) consents to the release of medical information to CCI, Payers, and their agents and representatives in accordance with applicable laws.

3.6. **Accreditation and Review Activities.** Provider shall provide to CCI copies of signed and completed application forms and other requested information within five (5) business days after CCI's request and prior to Provider becoming a Participating Provider.

3.7. **Compliance with CCI Credentialing and Monitoring Systems.** In accordance with CCI Rules, Provider will cooperate with CCI's credentialing and recredentialing activities, including, but not limited to, site visits. During such site visits Provider shall make medical records available for review as required to meet CCI Rules and NCQA standards.

3.8. **Notice of Adverse Actions.** Provider shall notify CCI immediately of: i) any final action taken to limit, remove, suspend, or otherwise restrict Provider's license or certification required to render Provider Services to Members; ii) any litigation brought against Provider related to the provision of health care services regardless of whether a final judgment has been reached; iii) any actions taken or investigations initiated by any government agency involving Provider; or iv) any ownership interest or position with another health maintenance organization or health plan. Provider shall provide this information and related circumstances to the extent permitted by applicable law and peer review privileges. All notices required by this section shall be provided to CCI no later than ten (10) days that Provider acquires knowledge of the occurrence of an event requiring notice.

3.9. **Encounter Data.** Provider shall make best efforts to submit claims electronically and to participate in CCI's electronic data interface (EDI) program. Provider shall report such claims/encounter data to CCI in standard HCFA 1500 or UB92 format as defined in the Physician & Provider Manual. CCI reserves the right to use this data for business and research purposes, as permitted by applicable law, but in no instances shall CCI disclose this information to any third person or entity, except to the extent required by applicable law.

ARTICLE 4. INSURANCE

4.1 **Provider's Insurance.** During the entire term of the Agreement Provider shall maintain throughout the term of this Agreement professional liability insurance and comprehensive general liability insurance in an amount of no less than one million dollars ($1,000,000)

per occurrence and three million dollars ($3,000,000) in the annual aggregate. Provider shall provide CCI thirty (30) days prior written notice of voluntary cancellation, modification, or termination of such insurance coverage.

ARTICLE 5. RECORDS AND REPORTS

5.1 **Access to Information.** Provider agrees that CCI, on behalf of itself and on behalf of its Affiliates, shall have access to all data and information obtained, created, or collected by Provider related to Members ("Information"). Provider shall not enter into any contract or arrangement whereby CCI or its Affiliates do not have access to the Information in electronic or other form or would be required to pay any access, transaction or other fee to obtain such Information in electronic written or other form. Provider shall not directly or indirectly provide information to any competitor of CCI or its Affiliates. Any and all Information and data provided to Provider by CCI or at CCI's direction shall remain the sole and exclusive property of CCI and shall not be disclosed by Provider to any third party.

5.2 **Provision of Medical Records and Confidentiality.** Provider and CCI, agree that all Member medical records shall be treated as confidential and the use, maintenance and disclosure of such medical records shall comply with all applicable state and federal laws governing the security and privacy of medical records. CCI is authorized, pursuant to its enrollment forms, Membership Agreements and applicable law, to obtain medical records from Provider. To the extent permitted by applicable law, CCI shall have the right, upon request, to inspect at reasonable times all medical and billing records maintained by Provider pertaining to Member. CCI shall also have the right to audit such information for Plan administration purposes and such rights shall be extended to Payers upon request.

5.3 **Proprietary and Confidential Information.** Provider acknowledges that this Agreement and all documents and materials referenced herein including, but not limited to, CCI Rules, information related to reimbursement rates, encounter data, membership lists, Physician and Provider Manual, medical management or quality assurance programs, constitute confidential and proprietary information of CCI; the unauthorized use or disclosure of which would result in irreparable harm to CCI. Provider shall maintain such information in confidence and shall not disclose such information to any person, except as may be required by applicable law. Provider shall not use such information and shall, at the request of CCI, return or destroy such information and any copies or extracts thereof to CCI, upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Provider may disclose to a Member that inquires the compensation methodology under this Agreement.

5.4. **Member Communication.** Notwithstanding anything contained in this Agreement to the contrary, Provider or any person rendering services to Members may freely communicate

any information relevant to treatment, including alternative treatment options, regardless of coverage limitations of a Member's Plan.

ARTICLE 6. TERM AND TERMINATION

6.1. **Term.** Notwithstanding the Initial MA Term as defined in Section 1.1 herein, The "Initial Term" of this Agreement shall be for one (1) year commencing on the Effective Date. Unless earlier terminated as described herein, this Agreement shall automatically renew for successive one (1) year terms.

6.2 **Termination Without Cause.** Following the Initial Term, either party may terminate this Agreement at any time by providing written notice to the other party, at least ninety (90) days in advance of such termination.

6.3 **Termination for Breach.** This Agreement may be terminated at any time by either party upon at least sixty (60) days prior written notice of such termination to the other party upon default or breach by such party of one or more of its obligations hereunder, unless such default or breach is cured within sixty (60) days of the notice of termination.

6.4. **Immediate Termination or Suspension of Provider.** CCI may terminate Provider's "participating" status with CCI immediately upon written notice to Provider for the following reasons:

(a) CCI reasonably determines, in its sole discretion, that continuation of said Provider's status may cause harm to Members;

(b) Provider's arrest, conviction, indictment or charge with any felony charge related to moral turpitude or the practice of medicine;

(c) CCI determines that Provider has provided false and/or misleading information relating to billing, services rendered, the credentialing or recredentialing process or to other matters relating to this Agreement;

(d) Provider fails to meet or to continue to meet, any of CCI's credentialing and recredentialing criteria as may be revised from time to time;

(e) Provider's insurance required hereunder is terminated, canceled or materially decreased;

(f) Suspension or loss of Provider's license to operate in the State of Connecticut; or

(g) Suspension or exclusion from the Medicare or Medicaid program or any other federal or state health care program; or

6.5. **Obligations following Termination**. Following the effective date of any termination of this Agreement, Provider shall comply with the following obligations. This provision shall supersede any oral or written contrary agreements now existing or hereafter entered into between Provider and a Member or persons acting on a Member's behalf and shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1. **Upon Termination.** Upon termination of this Agreement for any reason, other than termination by CCI in accordance with 6.4 above, Provider shall remain obligated to provide Covered Services to (a) any Member who is an inpatient at any Hospital as of the effective date of termination until such Member's discharge and (b) to any Member under a course of treatment until such course of treatment is completed or CCI's orderly transition of such Member's care to another provider; or for six (6) months following termination of the Agreement, whichever is less. The terms of this Agreement shall apply to such services.

6.5.2. **Upon Insolvency or Cessation of Operations.** If this Agreement terminates as a result of insolvency or cessation of operations by CCI or a CCI Affiliate that is an HMO or health care center, and as to Members of such HMO or health care center that becomes insolvent or ceases operations, then in addition to other obligations set forth in this section, Provider shall continue to provide Covered Services to: (a) all Members for the duration of the period for which premiums on behalf of the Members were paid; to CCI or a CCI Affiliate; or (b) all Members confined as inpatients in Hospital on the date of insolvency or other cessation of operations until their medically appropriate discharge, whichever time is greater. This provision shall be construed for the benefit of Members.

6.5.3. **Transition/Obligation to Cooperate.** Upon notice of termination of this Agreement, Provider shall cooperate fully with CCI and comply with CCI procedures, if any, in the transfer of Members to other providers.

ARTICLE 7. RELATIONSHIP OF THE PARTIES

7.1. **Independent Entities.** None of the provisions of this Agreement are intended to create nor shall any be designed or construed to create any relationship among or between the parties other than that of independent entities contracting with each other solely for effecting the provisions of this Agreement. The relationship of Provider and CCI is that of independent contractors and none of the parties hereto, nor any of their respective employees and agents shall be construed to be the agent, employee, or representative of the other. Provider and CCI shall in no event be liable for the activities of the other, or their respective agents and employees, including without limitation, any liabilities, losses, damages, injunctions, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c)

the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Provider acknowledges that all patient care and related decisions are the sole responsibility of the Provider and that CCI's medical management procedures, protocols and policies do not dictate or control Provider's clinical decisions with respect to the medical care or treatment of Members.

7.2. **Indemnification**. Provider shall indemnify and hold harmless CCI, its employees, officers, directors, and Affiliates, against any expenses and liabilities, including, but not limited to, judgments, settlements, reasonable counsel fees, costs and associated charges, arising solely out of Provider's delivery or failure to deliver medical care to Members. Provider shall not be required to indemnify and hold harmless CCI, it employees, officers, directors, and Affiliates for any liabilities or expenses arising solely from CCI's management decisions, utilization review decisions or other policies, guidelines and procedures of CCI.

7.3. **Use of Name.** Provider consents to the use of its name and other identifying and descriptive material in provider directories and in other materials and marketing literature of CCI in all formats, including, but not limited to electronic media. Provider shall not use CCI's name, logos, trademarks or service marks in marketing materials or otherwise, except as provided in this Agreement without CCI's prior written consent which shall not be unreasonably withheld.

ARTICLE 8. CCI's OBLIGATIONS

8.1. **Eligibility.** CCI or its designee shall maintain a toll-free telephone system or other electronic means for Provider to verify a patient's status as a member on a twenty four (24) hour basis, except when CCI conducts routine system maintenance and system upgrades.

8.2. **Administrative Responsibilities.** CCI shall provide Provider with an explanation of benefits; administrative requirements; a Physician and Provider Manual; a listing of Providers, hospitals and ancillary providers in CCI's network and timely notification of significant changes to this information. CCI shall perform all utilization review, case management, credentialing and other plan related services unless otherwise delegated to another entity who has executed a separate delegation agreement with CCI.

8.3. **Provider Relation Services.** CCI will maintain a dedicated provider relation telephone line, a provider grievance process and access to CCI's Medical Directors, as appropriate. CCI shall also provide Provider with a provider identification number that Provider shall record on all billing forms for claims submitted to CCI, Payer, or its designee, for payment.

ARTICLE 9. GENERAL PROVISIONS

9.1. **Member Rights and Benefits**. Notwithstanding any other provision in this Agreement, nothing in this Agreement contract shall be construed to modify the rights and benefits contained in the Member's Plan. Provider agrees that this provision shall survive termination of this Agreement regardless of the cause giving rise to termination, shall be construed for the benefit of Members and supersedes any contrary oral or written agreement now existing or hereafter entered into between Provider and a Member or persons acting on a Member's behalf.

9.2. **Entire Agreement.** This Agreement (including any attached schedules and appendices) constitutes the complete agreement between the parties regarding the subject hereof and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein.

9.3. **Waiver.** The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by the party to be charged.

9.4. **Amendments.** CCI may amend this Agreement by providing written notice to Provider no less than ninety (90) days prior to the effective date of such amendment. If Provider does not agree to such amendment, Provider must provide written notice to CCI of its intent to terminate this Agreement no less than thirty (30) days after receipt of such amendment. In limited circumstances, CCI may determine that Provider may object to the amendment and continue to participate under this Agreement without such amendment. Notwithstanding, CCI may amend this Agreement upon written notice to Provider if such amendment is required in order to comply with applicable law or regulations, or any order or directive of any governmental agency.

9.5. **Assignment.** This Agreement, being intended to secure the services of Provider, shall not be assigned, subcontracted, delegated or transferred by Provider in any manner. CCI may assign, delegate, or transfer this Agreement in whole or in part to any Affiliate, existing now or in the future, or to any entity which succeeds to the applicable portion of its business through a sale, merger or other transaction, provided that such entity assumes the obligations of CCI hereunder.

9.6. **Governing Law.** This Agreement shall be governed in all respects by the laws of the State of Connecticut.

9.7. **Severability.** Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality, or enforceability of any other provision of this Agreement.

9.8. **Inconsistencies.** If any term or provision of this Agreement is inconsistent with a term or provision of a Plan, then as to individuals entitled to receive Covered Services through said Plan; the term or provision of the Plan shall prevail.

9.9. **Headings.** The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provision of this Agreement.

9.10. **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Such notice, when sent pursuant to this section, shall be deemed received by the recipient within three (3) days after such notice is sent or sooner if the sender has proof that the recipient received the notice prior to such three (3) day period.

To Provider at: **Principal Address unless otherwise noted**

[redacted]

To CCI at:

ConnectiCare, Inc.
Network Operations
175 Scott Swamp Road
P.O. Box 4050
Farmington, Connecticut 06034-4050
Attention: Vice President Network Operations

9.11. **Discrimination.** Provider shall not discriminate against any Member on the basis of CCI membership, source of payment, color, race, sex, age, national origin, religion, place of residence, health status, health care needs, HIV status, physical, mental or developmental disability or handicap, sexual orientation, marital status or type of illness or condition in rendering services pursuant to this Agreement. Provider shall cooperate and comply with the American With Disabilities Act ("ADA") and any CCI policy and procedure promulgated pursuant to the ADA to assure that Covered Services are readily accessible and usable by Members with disabilities as required by the ADA. Provider shall treat Members in the same manner and in accordance with the same standards and priority as they treat their other patients. Provider will provide services in a manner to support positive Provider-patient relationships, striving for a high level of patient satisfaction.

9.12. **Dispute Resolution**. Any disputes or claims between CCI and Provider, other than matters relating to medical malpractice, arising out of or relating to the interpretation or application of this Agreement or breach thereof shall be resolved by direct negotiation between CCI and Provider. Such direct negotiation shall be completed upon forty-five

(45) days of notice to the other party of such dispute or claim. If the parties cannot resolve such dispute or claim upon the completion of the forty-five (45) day period, then the parties shall submit such claim or dispute to binding arbitration for resolution. An arbitrator mutually agreed upon by the parties and conducted in accordance with the rules and procedures of the American Health Lawyers Association arbitration process shall conduct the binding arbitration. No party shall bring any legal proceedings until the parties have exhausted the dispute resolution requirements set forth on this agreement.

9.13. **Fair Contract.** The parties agree and acknowledge that the terms, provisions and structure of this Agreement, including but not limited to provisions pertaining to risk sharing, if any, and monetary compensation, are the result of arms-length bargaining freely engaged in between sophisticated persons, and were not the product of the exercise of unequal bargaining power or duress and do not constitute a contract of adhesion. The parties further represent and acknowledge that each were represented by experienced legal counsel and others familiar with managed care provider agreements, and relied on the advice of said persons in entering into this Agreement. The parties further agree and acknowledge that this Agreement is the product of mutual negotiation such that neither party may claim that the other was the drafter against whom ambiguities in the terms or provisions hereof, if any, must be resolved.

ARTICLE 10. DEFINITIONS

10.1. **Affiliate.** An "Affiliate", with respect to CCI, means any corporation, partnership or other legal entity directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with, CCI.

10.2. **CCI Rules.** "CCI Rules" means those rules, regulations, policies, procedures and standards established by CCI and as may be set forth in the Physician and Provider Manual. CCI Rules may be added or modified by CCI from time to time. Upon such addition or modification, CCI shall provide notice to Participating Provider of such change.

10.3. **Coinsurance.** "Coinsurance" means the percentage of the lesser of: (a) the rates established under this Agreement; or (b) the Participating Provider's reasonable and customary billed charges, which a Member is required to pay for Covered Services under a Plan.

10.4. **Copayment.** "Copayment" means a charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services.

10.5. **Covered Services.** "Covered Services" means those Medically Necessary services which a Member is entitled to receive under the terms and conditions of the applicable Plan and as set forth in the applicable Plan.

10.6. **Deductible.** "Deductible" means an amount that a Member must pay for Covered Services during a specified period in accordance with the Member's Plan before benefits will be paid.

10.7. **Emergency.** "Emergency" means, unless otherwise defined under the applicable Plan, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of medical treatment to result in: (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.

10.8. **Emergency Medical Condition (Emergency).** For purposes of the MA Plan, an "Emergency Medical Condition" or "Emergency" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (2)serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

10.9. **Medically Necessary.** "Medically Necessary" means, unless otherwise defined under the applicable Plan, those health care services, which are determined by CCI to be required therapeutic treatments for an illness or injury. Medically Necessary does not include experimental or investigational services and supplies, custodial services, supportive care or rest cures, or services and supplies provided for the convenience of the patient, the patient's family, or the provider.

10.10. **Member.** "Member" means an individual covered by or enrolled in a Plan.

10.11. **Participating Provider.** "Participating Provider" means any Provider, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with CCI, directly or through an IPA, PHO or group, or other entity, to provide Covered Services to Members and has been credentialed by CCI or its designee.

10.12. **Payer.** "Payer" means an employer, insurer, health maintenance organization, labor union, government entity, organization or other person or entity, which has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.

10.13. **Plan.** "Plan" means any health benefit product or plan issued, administered, or serviced by CCI or one of its Affiliates.

10.14. **Primary Care Provider.** "Primary Care Provider" or "PCP" means a provider whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated a Primary Care Provider by CCI, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such Participating Provider, if the applicable Plan provided for a Primary Care Provider.

10.15. **Provider.** "Provider" means a duly licensed and qualified Doctor of Medicine, or Osteopathy or a duly licensed and qualified health care professional who is under contract.

10.16. **Urgently Needed Services.** For purposes of the MA Plan, "Urgently Needed Services" shall mean those Covered Services provided when a MA Member is temporarily absent from the MA Plan's service area (or, under unusual and extraordinary circumstances, provided when the MA Member is in the service area but Participating Providers are temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required; (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the services through Participating Providers.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement, intending to be bound hereby.

CONNECTICARE, INC.

By: _____

Printed Name: Kathleen A. Madden

Title: Vice President, Network Operations

Date: _____

APPENDIX A

SCOPE OF SERVICES:

The scope of services covered under this Agreement shall include those Flu Clinic services that are (a) covered under the terms of the Plan and (b) authorized in advance (if applicable) by CCI or its designee.

APPENDIX B

COMPENSATON FOR ANCILLARY COVERED SERVICES
(For all Plans except Medicare Advantage Plans Members)

Payment for Influenza vaccinations rendered to eligible Members shall be $28.00 per vaccination. Valid CPT Codes: 90655, 90656, 90657, 90658.

In instances when billing solely for the Administration, payment shall be $19.00. Valid CPT Code: 90471

APPENDIX C

MEDICARE ADVANTAGE ADDENDUM

The provisions of this Addendum apply to health care services rendered by Provider to Medicare Advantage ("MA") Members covered under a Plan pursuant to CCI's MA Contract ("MA Contract") with CMS. In addition to Provider's obligations under the Agreement, Provider agrees to abide by all applicable provisions of CCI's contract with CMS and to fulfill Provider's obligations hereunder in a manner consistent with CCI's obligations under such contract. With respect to MA Members, the provisions of this Addendum shall prevail over any provision in the Agreement which may conflict or appear inconsistent with any provision in this Addendum.

1. Patient Confidentiality; Accuracy of Records. Provider shall be bound by any patient confidentiality provisions set forth in CCI's policies and procedures, as well as federal and state laws and regulations and the provisions of the MA Contract regarding confidentiality and disclosure of medical records or other health or enrollment information pertaining to MA Members. Without limiting the generality of the foregoing, Provider agrees to: (i) safeguard the privacy of all MA Member medical records and ensure that copies of or information from such records are released only to authorized individuals; (ii) release such records only in accordance with applicable federal or state laws or pursuant to court orders or subpoenas; (iii) maintain all such records in an accurate and timely manner; and (iv) ensure timely access by MA Members to records and information that pertain to them.

2. Hold Harmless. Provider acknowledges and agrees that in no event, including but not limited to the insolvency of CCI, breach of the Agreement and/or non-payment for services by CCI, shall Provider bill or seek compensation from or assert any legal action against MA Members or persons acting on behalf of MA Members for payment of any fees that are the legal obligation of CCI.

3. Prompt Payment. In the event that Provider performs the function of claims payment, Provider shall approve, pay or deny within the time period specified by 42 CFR § 422.520(a).

4. Compliance. Provider shall comply with all applicable Medicare laws and regulations and applicable CMS instructions, and with CCI's policies and procedures.

5. Audits/Access. Provider shall permit audits and inspection by the United States Department of Health and Human Services, the Comptroller General of the United States, CMS and/or their designees regarding any pertinent contracts, books, documents, papers and records (collectively, "Books and Records") involving or relating to Provider's provision of services to MA Members. All such Books and Records shall be made available by Provider for a period of ten (10) years from the termination of the applicable MA Contract or ten (10) years from the date of completion of any audit or in certain instances described in applicable Medicare Advantage regulations, for periods in excess of ten (10) years, if appropriate.

6. Accountability. Provider acknowledges that CCI oversees and is accountable to CMS for any functions and responsibilities set forth in the regulations governing the Medicare Advantage Program. Provider further acknowledges and agrees that pursuant to the Medicare Advantage regulations, CCI or its designees will monitor Provider's performance hereunder and that CCI and/or CMS shall have the right to terminate the Agreement and Provider's participation in the Medicare Advantage Contract if Provider does not perform satisfactorily hereunder.

7. Delegation. Any delegation of functions hereunder shall be in accordance with applicable delegation requirements set forth in the Medicare Advantage regulations.

8. Reporting Requirements; Policies and Procedures. Provider is required to comply with reporting requirements in 422.516, 422.310, 422.504(a) (8). Provider acknowledges that CCI is required by CMS to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality, and such other matters as CMS may require from time to time, including Risk Adjustment Data (as defined below). Provider agrees, and to submit, upon request, all data necessary for CCI to fulfill these obligations and within the timeframes specified by CCI to meet CMS requirements. Provider agrees to certify as to the accuracy, completeness and truthfulness of all such data, including such Risk Adjustment Data. For purposes of the Agreement, Risk Adjustment Data shall include documentation provided to CCI by Provider, which summarizes all relevant information which pertains to any occasion where a Member receives Covered Services, including all data necessary to characterize the context and purpose of each encounter between a Member and Hospital, suppliers, physicians, practitioners or other provider. Risk Adjustment Data shall comply with applicable CMS standards in effect from time to time, and shall be on such forms and provided with such frequency as CCI may require.

9. Continued Care. Provider agrees that: (i) Covered Services provided to MA Members hereunder shall continue for all MA Members for the duration of the MA Contract period for which CMS payments have been made to CCI; and (ii) in the event of CCI insolvency or termination of the MA Contract for any reason, Covered Services shall continue until the date of discharge for any MA Member confined in an inpatient facility on the effective date of insolvency or termination.

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APPENDIX D
Medicare Advantage Schedule of Payments
(For Medicare Advantage Plan Members)

Payment for Influenza vaccinations rendered to eligible Members shall be $28.00 per vaccination. Valid CPT Codes: 90655, 90656, 90657, 90658.

In instances when billing solely for the Administration, payment shall be $19.00. Valid CPT Code: G0008

AETNA - Tab

Aetna

Provider Availability - Yes

Types of contracted immunization service available to Local Health Departments:

- Influenza vaccine
- Pneumococcal vaccine

Aetna Contact Person:

Marianna Pellici, Contract Negotiator
Aetna
151 Farmington Avenue
Marianna Pellici RWAB
Hartford, CT 06156
Phone: 877-251-3133
Fax: 860-262-9141
PelliciM@aetna.com

A) Provider Requirements

- Public health department must have a medical director who is a participating provider to establish a contract with Aetna. This person can be a physician or a nurse practitioner.
  - The doctor or nurse practitioner is the servicing provider.
  - The doctor's or nurse practitioner's name must be on the bill along with the health department' name, Tax Identification Number (TIN#) and the health department location
  - See Section C for if the medical director is NOT a participating provider with Aetna
- Health Department must also have the following:
  - Tax Payer ID#
  - NPI number
  - Tax identification number (W-9 form required)

B) Application Process **6/26/12 need to confirm this process – have call in to Marianna; 6/28/12 sent email; Marianna on vacation until 7/9/12**

- Contact Contract Negotiator (Marianna Pellici); 877-251-3133
- Process will take 1-2 months
- Must request a provider application at www.Aetna.com
  - http://www.aetna.com/healthcare-professionals/join-aetna-network/how-to-apply.html
- Complete the application

- Application and credentialing reviewed by a committee on a twice per month basis

C) Application Process if Medical Director is NOT a Participating Provider

- Contact Contract Negotiator (Marianna Pellici); 877-251-3133
- The medical director must:
  - Fill out the Aetna provider application (http://www.aetna.com/healthcare-professionals/join-aetna-network/how-to-apply.html)
    - How long it takes to become a provider is dependent upon the credentialing and application process
    - Application and credentialing are reviewed by a committee twice per month
  - Go through the credentialing process
- **Credentialing process:**
  - Check the CAQH Universal Provider Datasource (UPD) to see if there is already an existing account for the applicant
    - www.CAQH.org
    - 888-599-1771
    - Do not skip this step – if there are duplicate provider accounts, it will delay the credentialing process
    - If YES, you will have an 8 digit provider ID #. You can provide this 8 digit provider ID# to Aetna so they can access your information through CAQH/UPD for the credentialing process
  - If there is NOT an existing account (no provider ID #), you will need to do the following:
    - Contact Aetna Credentialing Customer Service, 800-353-1232. Ask them to add you to the CAQH/UPD provider list.
    - Aetna will require that you complete a provider application. (http://www.aetna.com/healthcare-professionals/join-aetna-network/how-to-apply.html) Aetna will determine if you meet their criteria as a provider.
    - If you are approved, Aetna will add your information to the CAQH/UPD system. An 8 digit Provider # will be generated by CAQH/UPD.
    - CAQH/UPD will mail you your 8 digit provider number
  - Once you have your 8 digit CAQH provider number:
    - Go to www.caqh.org
    - Enter your 8 digit provider number to register online (you will need to make up a user name & password)
    - Log in
    - Complete UPD application online

- You will be able to designate which insurance companies have access to your credentialing information.

D) Concurrent to the application and credentialing process:

- Contract negotiator will put a contract together (sample provided). It is a “carve out” contract which lists specifically which vaccination codes will be allowed by the contract. See sample contract.
- Once the provider is credentialed and the application is approved, Aetna assigns an effective date for the contract and the doctor/nurse practitioner is linked to the contract.

The Pomperaug Health District
Effective Date: 03/15/2012

MEDICARE PROVIDER AMENDMENT

Provider agrees to comply with all applicable Medicare laws, rules and regulations, including, without limitation, instructions issued by the Centers for Medicare and Medicaid Services ("CMS"). Specifically, the following provisions are now part of the Agreement:

1. Provider agrees to provide Covered Services to those persons who meet all eligibility requirements of the federal Medicare program and who have enrolled in Company's Medicare Plans ("Medicare Members").

2. Provider agrees to comply with all Medicare laws, rules and regulations, as well as Company requirements designed to ensure Company's compliance with such laws, rules and regulations, including, without limitation, laws, rules and regulations relating to the protection of Medicare Member privacy and confidentiality and the accuracy of Medicare Member health records. Provider agrees that all services and other activities performed by Provider under the Agreement will be consistent and comply with Company's obligations under its contract(s) with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Plans. Upon request, Provider shall immediately provide to Company any information required by Company to meet its reporting obligations to CMS, including, where applicable, physician incentive plan information. Provider agrees to allow CMS and Company to monitor Provider's performance under this Agreement on an ongoing basis, in accordance with Medicare laws, rules and regulations.

3. Provider acknowledges and agrees that all provisions of this Amendment and of the Agreement shall apply equally to any employees, independent contractors and subcontractors of Provider who provide or may provide Covered Services to Medicare Members, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with this Amendment and the Agreement and all applicable laws and regulations, and perform all requirements applicable to Medicare programs.

4. Company agrees to pay Provider for Covered Services rendered to Medicare Members within forty-five (45) calendar days of actual receipt by Company of a Clean Claim. Payments for non-capitated Covered Services rendered to Medicare Members are subject to any and all valid and applicable Medicare laws related to claims payment. With respect to Medicare Members, Provider acknowledges that compensation under the Agreement for such Members constitutes receipt of federal funds.

   Provider shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Medicare Members for which Provider is financially responsible pursuant to the Agreement.

5. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

6. Provider agrees to cooperate with and participate in internal and external review procedures necessary to process Medicare appeals and grievances.

7. For purposes of this Section 7, "risk adjustment data" shall have the meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time. Company is required to obtain risk adjustment data from Provider for Medicare Members, and Provider agrees to provide complete and accurate risk adjustment data to Company for Medicare Members that conforms to all standards and requirements set

forth in applicable laws, rules and regulations and/or CMS instructions that apply to risk adjustment data. Provider certifies, based on best knowledge, information and belief, that any risk adjustment data that Provider submits to Company for Medicare Members is accurate, complete and truthful. Provider agrees to immediately notify Company if any risk adjustment data that was submitted to Company for Medicare Members is erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable laws, rules and regulations and CMS instructions.

Provider further agrees to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Company for Medicare Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations and/or CMS instructions, and allows any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (1) confirm that the appropriate diagnoses codes and level of specificity are documented ; (2) verify the date of service is documented and within the risk adjustment data collection period; and (3) confirm that the appropriate provider's signature and credentials are present ("Medical Records").

Provider agrees to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of risk adjustment data ("Audit Data"). Provider agrees to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that CMS conducts a review that includes the validation of risk adjustment data submitted by Provider, Company will submit to Provider a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

8. With respect to any Plan offered by Company to Medicare Members, Provider agrees to provide Company and federal, state and local governmental authorities having jurisdiction, or their designees, upon request, access to all books, records and other papers (including, but not limited to, medical and financial records and contracts) and information relating to the Agreement and to those Covered Services rendered by Provider and its employees, independent contractors and subcontractors to Medicare Members ("Information and Records"), and that this right of inspection, evaluation and audit will continue for the longer of: (i) a period of ten (10) years from the end of the contract period of any government contract of Company, (ii) the date that the U.S. Department of Health and Human Services (HHS), the Comptroller General or their designees complete an audit, or (iii) the period required under applicable laws, rules or regulations. With respect to any Plan offered by Company to Medicare Members, Provider also agrees to maintain Information and Records for the longer of: (i) ten (10) years from the end of the contract period of any government contract of Company, (ii) the date HHS, the Comptroller General or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 7 shall survive the termination of the Agreement, regardless of the cause of the termination.

9. Provider agrees to comply with the following, as applicable and as amended from time to time: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, HIPAA administrative simplification rules at 45 C.F.R. parts 160, 162, and 164, the Americans with Disabilities Act, Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. §§ 3729 *et. seq.*), and the anti-kickback statute (section 1128B(b) of the Social Security Act), and any other laws applicable to recipients of Federal funds.

10. In no event, including without limitation, non-payment by Company, insolvency of Company or breach of the Agreement or this Amendment, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Medicare Member or persons (other than the Company) acting on a Medicare Member's behalf for services covered by the Agreement. This provision shall not prohibit collection of deductibles, coinsurance or copayments from Medicare Members in accordance with the terms of the Medicare Member's agreement with Company.

Provider further agrees that: (a) this provision shall survive termination of the Agreement and this Amendment regardless of the cause giving rise to termination and shall be construed for the benefit of Medicare Members, and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Medicare Member or persons acting on a Medicare Member's behalf.
No modification of this provision shall be effective without the prior written approval of the appropriate state and/or federal regulatory entities.

11. In the event of Company's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to (i) Medicare Members through the period for which premium has been paid to Company, and (ii) those Medicare Members who are confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge.

12. Provider acknowledges that Company may only delegate activities or functions to Provider in a manner consistent with Medicare laws, rules and regulations. Provider acknowledges and agrees that if any of Company's activities or responsibilities under Company's contract with CMS to offer Medicare Plans is delegated by Company to Provider, such activity or responsibility may be revoked if CMS or Company determines that Provider has not performed satisfactorily.

Capitalized terms not otherwise defined herein shall have the meaning given such terms in the Agreement. All terms of the Agreement not amended herein remain in full force and effect. If the terms of this Amendment conflict with any term of Agreement, the terms of this Amendment shall prevail.

The Pomperaug Health District
Effective Date: 03/15/2012

PROVIDER
SERVICES AND COMPENSATION SCHEDULE

COMPENSATION:

Payment Details:

For Gatekeeper and Non-Gatekeeper products:

Service	Billing Codes	Rates
Flu Virus Vacc-split 3 Yr & Above	**CPT4 Codes:** 90658	100% of Aetna Market Fee Schedule
Pneumococcal Vaccine	**CPT4 Codes:** 90732	100% of Aetna Market Fee Schedule
Flu Vaccine, Nasal	**CPT4 Codes:** 90660	100% of Aetna Market Fee Schedule
Flu Virus Vacc-split 6-35 Mo	**CPT4 Codes:** 90657	100% of Aetna Market Fee Schedule
Immunization Admin, Single	**CPT4 Codes:** 90471	100% of Aetna Market Fee Schedule
Immunization Admin, 2+	**CPT4 Codes:** 90472	100% of Aetna Market Fee Schedule
Flu Vaccine No Preserv, Id	**CPT4 Codes:** 90654	100% of Aetna Market Fee Schedule
Flu Vacc Prsv Free Inc Antig	**CPT4 Codes:** 90662	100% of Aetna Market Fee Schedule
All Services not otherwise identified		Not Reimbursed

For Government Programs products:

Service	Billing Codes	Rates
Flu Virus Vacc-split 3 Yr & Above	**CPT4 Codes:** 90658	100% of Medicare Physician Fee Schedule
Pneumococcal Vaccine	**CPT4 Codes:** 90732	100% of Medicare Physician Fee Schedule
Flu Vaccine, Nasal	**CPT4 Codes:** 90660	100% of Medicare Physician Fee Schedule
Flu Virus Vacc-split 6-35 Mo	**CPT4 Codes:** 90657	100% of Medicare Physician Fee Schedule
Immunization Admin, Single	**CPT4 Codes:** 90471	100% of Medicare Physician Fee Schedule

Immunization Admin, 2+	**CPT4 Codes:** 90472	100% of Medicare Physician Fee Schedule
Flu Vaccine No Preserv, Id	**CPT4 Codes:** 90654	100% of Medicare Physician Fee Schedule
Flu Vacc Prsv Free Inc Antig	**CPT4 Codes:** 90662	100% of Medicare Physician Fee Schedule
Admin Influenza Virus Vac	**HCPC Codes:** G0008	100% of Medicare Physician Fee Schedule
Admin Pneumococcal Vaccine	**HCPC Codes:** G0009	100% of Medicare Physician Fee Schedule
Afluria Vacc, 3 Yrs & >, Im	**HCPC Codes:** Q2035	100% of Medicare Physician Fee Schedule
Fluvirin Vacc, 3 Yrs & >, Im	**HCPC Codes:** Q2037	100% of Medicare Physician Fee Schedule
Fluzone Vacc, 3 Yrs & >, Im	**HCPC Codes:** Q2038	100% of Medicare Physician Fee Schedule
All Services not otherwise identified		Not Reimbursed

SERVICES:

Provider will provide services that are within the scope of and appropriate to the Provider's license and certification to practice.

COMPENSATION TERMS AND CONDITIONS:

Definitions

"Aetna Market Fee Schedule" (AMFS) – A fee schedule that is based upon the contracted location where service is performed.

"Service Groupings" – A grouping of codes (e.g., HCPCS, CPT4, ICD-9 (ICD-10 or successor standard)) that are considered similar services and are contracted at one rate under the Services and Compensation Schedule.

Medicare Physician Fee Schedule (MFS)- A fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 60 days of the final rates and/or codes being

published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Aetna payment policies apply to services paid based upon the Medicare Physician Fee Schedule

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full. Company will pay the lesser of the contracted rate or eligible billed charges.

b) Payment for services of Mid-level Practitioners (Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Registered Nurses) may be less than Physician services based on Company's then current payment policy.

c) Payment for services of Clinical Psychologists, Psychiatric Nurses and any other Licensed Master Level Practitioner (Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may be less than Company's then current payment methodology for Behavioral Health physician services.

Billing

d) Provider must designate the codes set forth in this Compensation Schedule when billing.

e) When Provider is compensated on a fee for services basis and if a Government Official imposes a financial adjustment or penalty on Company based on a determination that there is insufficient information or documentation to support an International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM" (ICD-10 or successor standard)) diagnosis submitted by Provider to Company for a Medicare Member ("Diagnosis"), Company may recoup the total amount that Company paid to Provider for the Current Procedural Terminology (CPT) codes associated with the Diagnosis for the dates of service in question, for which that Diagnosis was listed.

Coding

f) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new codes. Such updates may include changes to Service Groupings. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

UNITEDHEALTHCARE - Tab

UnitedHealthCare

Provider Availability - No

Types of contracted immunization service available to Local Health Departments:

None

UnitedHealthCare Contact Person:

Lisa Taylor
Director, Nertwork Management
UnitedHealthCare
185 Asylum Street, 19A
Hartford, CT 06103
Phone: 860-702-5862
Fax: 855-707-2485
lisa a taylor@uhc.com

CIGNA - Tab

CIGNA

Provider Availability - No

Types of contracted immunization service available to Local Health Departments:

None

CIGNA Contact Person:

Joe Wankerl
Provider Contract Manager
Phone: 860-226-1974
joseph.wankerl@cigna.com