HEALTH CARE SERVICE PROVIDER AGREEMENT

THIS Agreement is made by and between _____ (hereinafter referred to as "Provider"), a physician, group of physicians or similar provider of health care services or items, licensed to practice medicine and/or provide medical services in the state or states where services are provided and USA MANAGED CARE ORGANIZATION, INC. A TEXAS CORPORATION, (hereinafter referred to as "USA").

WITNESSETH:

WHEREAS, USA is a Preferred Provider Organization (PPO) engaged in the business of administrating quality health care services at an affordable price through its products {USA H & W Network, a group health and wellness program, USA Workers Injury Network (USA WIN), and USA Medicare (USA Senior Care)}, and Provider desires to provide services for the members (hereinafter referred to as "INSUREDS") of various group accident/health plans, work related injury/illness plans, motorist medical plans, Medicare Select plans, Medicare Advantage plans, Health Maintenance Organization plans, affiliated networks, self-insured employers, and foreign nationals (including citizens, employees, and embassy officials) with state governments which have entered into agreements with USA, (hereinafter referred to collectively as "INSURERS"); and

WHEREAS, USA has a network of contracted facilities, physicians, providers and other ancillary service providers (hereinafter referred to along with Provider as "Providers") available for use by the eligible INSUREDS of various plans contracted with USA, thereby making available to INSUREDS such Providers for health and medical care needs; and

WHEREAS, Providers shall be made available by USA as a convenience to INSUREDS for the purpose of allowing INSUREDS access to health and medical care; and

WHEREAS, Provider desires to contract with USA and its affiliates to provide services to INSUREDS and to accept as payment in full for such services the amounts set forth in the attached Exhibit B; and

WHEREAS, Provider agrees to conduct himself/herself ethically and in a manner that shall preserve and maintain the human dignity and integrity of all patients, and by their attitude and manner shall convey to the patient compassion and concern for the patient's problems. Provider shall dedicate himself/herself to alleviating those problems and providing comfort and care to those in need.

NOW, THEREFORE, in consideration of the mutual covenants herein contained and for good and valuable consideration, the legal adequacy of which is hereby acknowledged, the parties hereby agree as follows:

1. Services to be provided.

a) USA does hereby agree to add Provider to its network and Provider hereby agrees to comply with USA's policies for Provider participation including cooperation with USA's credentialing and recredentialing process and to provide INSUREDS with medical/surgical care in their medical specialty(ies) and exercise their best medical judgment in the treatment of the eligible INSUREDS. Provider agrees to practice within the scope of his/her licensure. With respect to such services, Provider agrees to accept the rates set forth in Exhibit B and/or Exhibit B-NP/PA of this Agreement, as full compensation for such services. Provider agrees to provide 24 hours per day, 7 days per week call coverage. Attachment A sets out the specific provisions for USA Workers Injury Network and Provider agrees to comply with the terms, provisions and conditions of the applicable Attachment.

b) **HOSPITALIZATION-REFERRALS:** Provider agrees that when hospitalization is necessary, they will arrange for hospitalizing INSUREDS in participating USA facilities when consistent with good medical practice. A toll-free number will be provided on INSURED'S I.D. card to obtain the names and locations of such participating USA facilities.

Those physicians without clinical privileges agree that when hospitalization is necessary, they will refer INSUREDS to a USA contracted participating provider who can admit INSURED to a participating USA facility when consistent with good medical practice. A toll free number will be provided on INSURED'S I.D. card to obtain the names and locations of such participating USA Providers.

c) **SPECIALIST-REFERRALS:** Provider agrees to refer INSUREDS to a USA contracted participating specialist when necessary, and when consistent with good medical practice. Provider further agrees to use the services of other USA contracted ancillary service providers when necessary and when consistent with good medical practice. A toll-free number will be provided on INSURED'S I.D. card to obtain the names and locations of such specialists participating with USA.

2. Rates to be Paid to Provider.

a) Provider, when billing under the name(s) and tax identification number(s) provided to USA, is to be paid by INSURER according to the rates established in Exhibit B, not to exceed billed charges. The negotiated rates in Exhibit B represent the total amount to be received by Provider including any co-payments, co-insurance and/or deductibles paid by INSUREDS. INSURER shall pay the amount due to Provider for services rendered to INSURED, based on the provisions of the applicable plan and Provider agrees to look to INSURER for the payment of such covered services except for any amounts required to be paid by INSURED pursuant to Subparagraph 2(c). Payments will be made to Provider for medical services actually rendered and only after submission of a claim.

b) Provider agrees to provide services under this Agreement for the treatment and care of illnesses, injuries or conditions of INSUREDS. In the event a third party other than INSURER should have primary responsibility for payment of services provided an INSURED, Provider agrees to collect payment from such other source prior to requesting payment from INSURER. Any payment made by INSURER to Provider for obligations which are the primary responsibility of a third party shall be refunded to INSURER by Provider. By executing this Agreement, Provider waives all rights to collect, and/or pursue collection of any amounts in excess of the reimbursement listed in Exhibit B from any INSURERS who may have secondary responsibility.

c) Services rendered or items furnished INSUREDS by Provider which are not covered as a benefit under the applicable plan and all co-payments, co-insurances and/or deductibles, are to be paid by INSURED and Provider is responsible for collection of such payments.

d) Provider agrees and acknowledges that USA is administrating health care services on behalf of INSURERS under this Agreement. USA will not be responsible or liable for the cost of any services provided to INSUREDS by Provider or for the payment of any claim to Provider.

e) Provider agrees to participate in the Cost Containment Guidelines as set forth in Exhibit A.

3. Payment of Claim.

Payment of claims is subject to the terms and conditions of INSURED'S insurance plan. Payment by INSURER shall be limited to services provided to INSURED for which INSURED is eligible. Payment by INSURER shall be reduced by co-payments, co-insurance and/or deductibles. Provider agrees to bill at their usual and customary rate and further agree not to bill for the difference between Providers's usual and customary rates and the rates set forth on Exhibit B. INSURER shall make payments within thirty (30) days of receipt of claims, unless written notice of dispute or discrepancy is mailed to Provider within thirty (30) days. If claim is not paid within thirty (30) days on undisputed claims and ninety (90) days on disputed claims, Provider shall have the right to deny the negotiated rates set forth on Exhibit B and seek full billed charges.

4. Hold Harmless.

a) PPO INSUREDS

Provider agrees that INSURER is responsible for payment of Provider's compensation pursuant to this Agreement. Provider shall not request payment from any INSURED for any treatment or services provided to INSURED pursuant to the terms of the Agreement except as otherwise provided herein. Provider agrees to release and hold harmless INSURED, provided INSURER makes payment pursuant to the terms of this Agreement. Notwithstanding the foregoing, in the event INSURER fails to make payment within ninety (90) days of receipt of claim or if INSURER is declared insolvent or otherwise unable to make payment, Provider may bill INSURED for services rendered.

b) HMO INSUREDS

Provider hereby agrees that in no event, including but not limited to non-payment by INSURER, INSURER insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against INSURED, or persons other than INSURER acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges (non-covered services) or co-payments on INSURER'S behalf made in accordance with the terms of the applicable plan between INSURER and INSURED.

Provider further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of INSURED, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and INSURED or persons acting on their behalf. Any modifications, additions or deletions to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the Commissioner of Insurance has approved such changes.

5. Medical Records.

a) With the proper patient consent and in accordance with all local, state and federal laws governing confidentiality, Provider shall make available to USA, INSURER, or as applicable all federal, state and local agents, copies of all medical records for the purpose of maintaining a quality assurance program required by USA or INSURER for a period of the greater of five (5) years from the date of treatment or consultation or the number of years that medical records are required to be kept under applicable governing laws.

b) Provider shall furnish, upon request and without charge, all information reasonably required by USA to verify and substantiate its provision of medical services, the charges for such services, and the medical necessity for such services.

6. Pre-Certification and Certification.

It is the responsibility of Provider to verify with INSURER prior to the delivery of medical services in non-emergent situations and within forty-eight (48) hours or the next business day in emergency situations that any patient is an INSURED in good standing under the applicable plan and eligible for benefits, as well as to obtain information as to the extent and nature of INSURED'S benefits. Provider understands that it is his/her responsibility to verify eligibility and benefits, allowing Provider to determine, if/when pre-certification (pre-authorization) and certification (authorization) is required by the plan. Provider understands that an INSURED'S membership identification card is not a guarantee that the cardholder is an INSURED in good standing. INSURED'S I.D. card will display appropriate telephone numbers for benefit/eligibility verification.

Provider agrees and acknowledges that USA has contracted with various INSURERS. INSURERS have elected at their discretion to secure services {pre-certification (pre-authorization), certification (authorization), case management and utilization management} from the vendor of their choice. While the requirements of the plan, as well as each vendor may vary, Provider agrees, at a minimum to comply, free of charge, with the following:

Non-emergent and/or post-stabilization facility admissions after the provision of emergency care may require pre-certification/certification to be eligible for full benefits. Provider agrees to phone the appropriate number provided on INSURED'S identification card to determine whether pre-certification/certification is required. Provider agrees to notify the appropriate party prior to the delivery of medical services in non-emergent situations and within forty-eight (48) hours or the next business day in post-stabilization emergent situations. Provider should be prepared to provide the following information:

a) Patient's name, sex, and date of birth
b) INSURED'S name, address, social security number, and group/policy number
c) Name of INSURER
d) Pre-admission diagnosis(es)
e) Name, address, and telephone number of the physician
f) Date of service (admission or procedure date)
g) Treatment and or surgical procedures

Provider further understands that pre-certification and certification are a determination of medical necessity. Pre-certification/certification shall be granted when the intensity level of the treatment and the level of care are appropriate with respect to the severity of the illness. Medical services will be pre-certified/certified based on the information provided to the appropriate party at the time of notification. Pre-certification and certification are not verification of eligibility and/or benefits. To verify eligibility and/or benefits, Provider must phone the appropriate number listed on INSURED'S identification card.

In the case of an admission, if the medical condition of INSURED is such that he/she cannot be discharged from the facility on the last day certified, Provider must call the appropriate telephone number on INSURED'S identification card on or before the last day certified to determine whether additional days may be certified. Benefits may be reduced for additional days which are not certified.

In the case of an admission, where INSURED'S illness, injury or condition (e.g. coma) prohibits INSURED from cooperating with Provider to identify himself/herself as an INSURED having access to USA's network, Provider agrees to notify the appropriate party as soon as Provider is able to identify INSURED.

Emergent admissions may be payable if they **a)** are certified or **b)** meet the conditions of an emergency as defined below:

An emergency is:

1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- **(i)** placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- **(ii)** serious impairment to bodily functions; or
- **(iii)** serious dysfunction of any bodily organ or part; or
- **(iv)** a "mental health" emergency consisting of a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

2) With respect to a pregnant woman who is having contractions:

- **(i)** that there is inadequate time to effect a safe transfer to another hospital before delivery; or
- **(ii)** that transfer may pose a threat to the health or safety of the woman or the unborn child.

7. Change in Terms and Benefits.

It is agreed by the parties hereto that the benefits, terms and conditions of the various agreements between INSURER and INSURED of any plan may be changed during the term of this Agreement without notice. However, such changes will not affect this Agreement unless agreed to by Provider and USA.

8. Termination of Coverage of INSUREDS.

Coverage for each INSURED may be terminated by INSURED or INSURER. When an INSURED whose coverage has terminated receives services from Provider, Provider agrees to bill INSURED directly. INSURER shall not be liable to Provider for any bills incurred by an INSURED whose coverage has been terminated.

9. Duration.

The initial term of this Agreement shall be a period of one (1) year from the date of execution of this Agreement by USA. During that time, Provider agrees that the reimbursement listed in Exhibit B and/or Exhibit B-NP/PA will not be subject to increase. This Agreement shall automatically renew for successive one (1) year terms on the anniversary date of this Agreement and shall remain in force until termination as provided for in Section 10 (Termination) of this Agreement.

10. Termination.

Either party to this Agreement may elect to terminate this Agreement, without cause, at any time by giving one hundred eighty (180) days prior written notice to the other party. Said notice shall clearly explain the reason giving rise to termination to be considered in compliance with this Section.

USA may terminate this agreement at any time for immediate cause, which includes, but is not limited to:

a) The failure of Provider to maintain or obtain a license to practice medicine in the state where services are provided.

b) The failure of Provider to obtain and/or maintain hospital privileges at a hospital or ambulatory health care facility contracted with USA.

c) The cancellation of Provider's coverage or insurability under his/her professional liability insurance.

d) The conviction of Provider of a felony.

e) Death of Provider.

f) Unprofessional conduct by or on behalf of Provider as defined by the laws of the state where services are rendered.

g) Provider's filing of bankruptcy (whether voluntary or involuntary), declaration of insolvency, or the appointment of a receiver or conservator of his/her assets.

In the event this Agreement is terminated for immediate cause, termination shall be effective upon receipt of written notification.

USA may also terminate this Agreement for reasons other than immediate cause. Those reasons may include, but are not limited to, a breach of any provision contained in this Agreement, habitual neglect, or the continued failure of Provider to perform his/her professional duties. If termination is for reasons other than immediate cause, USA will notify Provider in writing, stating the reason for termination, and giving Provider sixty (60) days in which to cure.

If Provider has failed to effect a satisfactory cure within the sixty (60) day cure period, of all reasons stated in the notice of termination, termination shall be effective on the tenth (10th) day following the expiration of the sixty (60) day cure period.

11. Notice to INSURER of Termination of Agreement

In the event this Agreement is terminated by either party in accordance with the procedure set forth herein, USA will notify INSURER. Provider agrees to notify INSUREDS, prior to giving service, that this Agreement is no longer in effect.

12. Accuracy of Information.

Provider represents and warrants that all information provided to USA is true and accurate in all respects and acknowledges that USA is relying on the accuracy of such information in entering into and continuing the term of this Agreement. Provider shall promptly notify USA, without request, of any change in the information provided.

13. Independent Contractor.

a) In entering into and complying with this Agreement, USA is at all times performing as an independent contractor. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee, principal and agent, partnership, joint venture, or any relationship other than that of independent parties contracting with each other solely to carry out the provisions of this Agreement for the purposes recited herein.

b) Provider shall be responsible for the treatment and medical care provided to each INSURED that Provider treats.

14. Confidentiality.

Each party may, in the course of the relationship established by this Agreement, disclose to the other party in confidence non-public information concerning such party's earnings, volume of business, methods, systems, practices, plans, purchaser discounts and contract terms, or other confidential or commercially valuable proprietary information (collectively referred to as "Confidential Information"). Each party acknowledges that the disclosing party shall at all times be and remain the owner of all Confidential Information disclosed by such party, and that the party to whom Confidential Information is disclosed may use such Confidential Information only in furtherance of the purposes and obligations of this Agreement. The party to whom any Confidential Information is disclosed shall use its best efforts, consistent with the manner in which it protects its own Confidential Information, to preserve the confidentiality of any such Confidential Information which such party knows or reasonably should know that the other party deems to be Confidential Information.

The party to whom Confidential Information is disclosed shall not use said information to the disadvantage of or in competition against the disclosing party. It is understood by each party that any Confidential Information disclosed is non-public information which is of great value to the disclosing party and that a breach of the foregoing confidentiality provision would cause irreparable damage. In the event of such a breach, the injured party shall have the right to seek and obtain in any court of competent jurisdiction an injunction to restrain a violation or alleged violation by the other party of this covenant together with any damages that the party may suffer in the event of such a breach.

15. Disputes.

USA agrees to attempt resolution of any dispute that may arise between Provider and INSURER from services delivered by Provider to an INSURED of INSURER. USA will act as a mediator between Provider and INSURER to resolve the dispute. Provider agrees to cooperate with USA acting as mediator, and INSURER in resolving the dispute. Cooperation includes providing any documentation requested by USA. If the mediation does not result in the resolution of the dispute, USA agrees to notify the parties in writing, and the parties may then seek any other means of resolution of the dispute.

If there is a dispute between the parties concerning the interpretation, performance or lack of performance of any term, condition or provision of this Agreement, the parties agree that they will submit the dispute to mediation with a third party neutral prior to filing a lawsuit. If the mediation does not result in a resolution of the dispute, then the parties may file suit to resolve the dispute. The parties agree that jurisdiction for any lawsuit filed by either party to enforce or interpret any provision, term or condition of this Agreement shall be brought in a court of competent jurisdiction in the State of Texas, and that venue for that suit shall be in Travis County, Texas. The prevailing party in any lawsuit brought pursuant to this paragraph shall be entitled to recover its reasonable attorney's fees and costs from the non-prevailing party.

16. Responsibility of the Parties.

Each party agrees it shall not be responsible for any claims, losses, damages, liabilities, costs, expenses or obligations arising out of or resulting from the negligent or willful misconduct of the other party, its officers, employees or agents in the performance of services pursuant to this Agreement.

17. Notices.
All notices, requests, or correspondence required under this Agreement shall be in writing, and delivered by United States mail to:

a) If to USA:

USA MANAGED CARE ORGANIZATION, INC.
1250 South Capital of Texas Highway
Building 3, Suite 500
Austin, Texas 78746
Attention: Provider Relations
E-mail Address: info@usamco.com

b) If to Provider:

_____
_____
_____
Attention: _____
E-mail Address: _____

Either party may change the address to which communications are to be sent by giving written notice. All communications will be directed to Provider at the most current address on file with USA.

18. Attorney's Fees.
If it shall become necessary for either USA or Provider to employ an attorney to enforce or defend its rights under this Agreement, the non-prevailing party in any arbitration, legal action, or proceeding shall reimburse the prevailing party for its reasonable attorney's fees and costs of suit in addition to any other relief to which such party is entitled.

19. Partial Invalidity.
If any part, clause or provision of this Agreement is held to be void by a court of competent jurisdiction, the remaining provisions of this Agreement shall not be affected and shall be given such construction, if possible, as to permit those remaining provisions to comply with the minimum requirements of any applicable law and the intent of the parties hereto.

20. Waiver.
A party's waiver of a breach of any term of this Agreement shall not constitute a waiver of any subsequent breach of the same or another term contained in the Agreement. A party's subsequent acceptance of performance by the other party shall not be construed as a waiver of a preceding breach of this Agreement other than failure to perform the particular duties so accepted.

21. Controlling Law.
This Agreement and all questions relating to its validity, interpretation, performance and enforcement shall be governed by and construed in accordance with the laws of the state where services are being provided.

22. Conformity with Federal and State Statutes.
The Parties intend that the terms, conditions and provisions of this Agreement be and remain in compliance with the Medicare laws of the United States and any rules and regulations promulgated pursuant to that law or the laws of any state of the United States that are applicable to this Agreement. Therefore, if any term, provision or condition contained in this Agreement, is in conflict with the Medicare laws, rules and regulations, or any state laws, rules or regulations that are applicable to this Agreement, the conflicting term, provision or condition is modified, added, changed or amended without further action of the Parties so that this entire Agreement is consistent with and complies with Medicare laws, rules and regulations, and applicable state laws, rules and regulations. USA agrees to give Provider notice in writing of any change, modification, addition or deletion to this Agreement that is necessary for this Agreement to comply with applicable laws, rules and regulations. The Parties agree that notice of a change constitutes an amendment to this Agreement without the necessity of signatures of the parties, and is effective on the date of the notice.

23. Entire Agreement.
This Agreement, Attachment A, Exhibits A and B, and the Provider Application contain the entire understanding between the parties hereto with respect to the subject matter hereof and supersedes all prior Agreements and understandings, expressed or implied, oral or written. Notwithstanding provisions in section 34 (Network Products or Services), any material change to this Agreement's language or rates must be in writing and signed by duly authorized officers or representatives of Provider and USA.

Non-material changes can be communicated via notifications. If neither party disapproves of a notification in writing within thirty (30) days, such notice will be considered accepted and binding. No other third party, including but not limited to any INSUREDS and INSURERS, shall be required to consent or receive notice of any such amendment or notice in order for the amendment or notice to be effective and binding upon the parties to this Agreement.

24. Title Not to Affect Interpretation.

The paragraph and subparagraph headings in this Agreement are for convenience only and they form no part of this Agreement and shall not affect its interpretation.

25. Peer Review.

Provider acknowledges USA's commitment to quality assurance and is willing to participate in peer review programs. USA agrees to compensate Provider one hundred dollars ($100.00) for peer review participation.

26. Force Majeure.

Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption in the discharge of its responsibility, either directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or supplies, vandalism, strikes or other work interruptions by employees, or any similar or dissimilar cause beyond the reasonable control of either party.

27. Survival.

In the event this Agreement is terminated as set forth herein, Sections 4, 14, 16, 18, 21, 27, 28 and 33 shall survive the termination of this Agreement.

28. Termination Responsibilities.

In accordance with Section 10 (Termination) or any termination of this Agreement, or any product herein said termination shall have no effect upon the rights or obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Provider agrees to accept, as payment in full, the rates in Exhibit B for services rendered to an INSURED who is inpatient upon the effective date of such termination or undergoing a course of treatment, until INSURED is discharged or safely transferred to a participating USA facility, or completes said course of treatment.

29. Discrimination.

Provider agrees to provide services for INSUREDS within the normal scope of Provider's medical practice. These services shall be accessible to INSUREDS, and made available to them, without limitation or discrimination, to the same extent as they are made available to other patients of Provider, and in accordance with accepted medical and professional practices and standards applicable to Provider's other patients.

30. Network Recognition.

USA maintains a current contracted carrier/payor (INSURER) list indicating clients who have directly contracted with USA for use of USA's network and services. INSURERS shall identify USA's network with USA's name or logo on the INSURED's identification card or explanation of benefits.

31. Insurance.

Providers shall, throughout the duration of this Agreement, maintain and provide USA with evidence of malpractice insurance, professional liability insurance, a program of self-insurance, an escrow account or other equivalent means to demonstrate Providers' ability to insure against, protect, or pay malpractice claims in an amount which is the greater of that which is required by the state in which services are rendered, that amount which is required by Facility to maintain active clinical privileges or one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in the aggregate.

32. Licensure.

Provider shall, throughout the duration of this Agreement, be required to maintain any and all licenses and certificates as may be required by the state in which Provider provides services.

33. Claim Disputes.

Provider may, for a period of ninety (90) days from the receipt of payment of a claim, review the payment and provide to INSURER written notice of any perceived underpayment. INSURER shall reimburse Provider the amount of the underpayment within thirty (30) days provided documentation substantiates the payment error. After the ninety (90) day period has expired, payment of that claim is final and may not be disputed for any reason.

34. Network Products or Services.

USA advises Provider that from time to time it may develop other products or services that will benefit participating network providers. The parties agree that if USA develops a new network product or service that network product or service may be added to this Agreement by amendment to this Agreement. The procedure for amending this Agreement to add a new product or service is as follows: USA will notify each Provider that it is offering a new network product or service. The notice will be accompanied by a proposed Amendment to this Agreement which shall set out the description of the product or service and the terms and conditions of the product or service, including fees payable to Provider for the product or service. On the thirtieth (30^{th}) day after the date of the notice, the Amendment shall become an amendment to this Agreement and shall be binding on USA and Provider unless within the thirty (30) day period Provider notifies USA in writing, signed by an authorized representative and dated, that it does not accept the Amendment and does not want to participate in the additional product or service. If a Provider notifies USA that it does not accept the Amendment, then Provider is not bound by the terms of the Amendment, and may not participate in the additional product or service, however, all of the provisions of this Agreement shall remain in force.

35. Execution in Counterparts

This Agreement may be executed in any number of counterparts including facsimiles. Each counterpart shall be deemed to be an original against any part whose signature appears thereon, and all of which shall together constitute one and the same instrument.

36. HIPAA Compliance

USA and Provider agree to comply with the requirements of 45 CFR § 164.504(e) as such may apply to USA as a business associate and Provider as a covered entity.

This Agreement is effective upon the date of execution by USA.

For and on behalf of:	**For and on behalf of:**
USA MANAGED CARE ORGANIZATION, INC. **1250 South Capital of Texas Highway** **Building 3, Suite 500** **Austin, Texas 78746**	_____ _____ _____ _____
_____ **Date**	_____ **Date**
_____ **Signature**	_____ **Signature**
_____ **Printed Name**	_____ **Printed Name**
_____ **Title**	_____ **Title**

ATTACHMENT A

USA MANAGED CARE ORGANIZATION, INC.
POLICIES FOR PROVIDER PARTICIPATION
USA WORKERS INJURY NETWORK
TEXAS SPECIFIC

Pursuant to the agreement of the parties set out in Section 1(a) of the Health Care Provider Agreement, USA Managed Care Organization, Inc. (USA) has adopted the following policies and procedures for Provider participation in the USA Workers Injury Network that are applicable to those Providers organized in the State of Texas or providing services under the Workers' Compensation statutes of Texas.

1. Provider may not send an invoice to or attempt to collect any amounts of payment from an employee who is employed in the State of Texas and subject to the Texas Workers' Compensation laws for injuries that are compensable under those laws under any circumstances, including the insolvency of the INSURER of the employee or insolvency of USA.

2. Provider must follow treatment guidelines, return-to-work guidelines and individual treatment protocols adopted by USA and set out in Exhibit C, Cost Containment Guidelines, to the Health Care Provider Agreement.

3. Provider may not deny treatment for a compensable injury to an employee solely on the basis that the treatment is not specifically addressed by the treatment guidelines used by USA or an INSURER.

4. USA may not refuse to renew a contract with a Provider because the Provider has, on behalf of an employee, filed a complaint against an INSURER that is a client of USA or appealed a decision or requested reconsideration or independent review of the decision of an INSURER.

5. If the Health Care Provider Agreement with a Provider is terminated for any reason, at Provider's request, Provider will continue to be paid or reimbursed (as applicable) the agreed upon rates (as set out in Exhibit B to the Health Care Provider Agreement) for care of an employee with a life-threatening condition or an acute condition for which disruption of care will harm the employee for a period of ninety (90) days from the termination date. If there is a dispute regarding the continuity of care for an employee being provided services by a Provider whose contract with USA has terminated, the parties must resolve the dispute through the complaint resolution process set out in Texas Insurance Code §§1305.401-1305.405 and Texas Administrative Code Title 28, Chapter 10, Subchapter G.

6. If the Health Care Provider Agreement is terminated for any reason other than its expiration:

    a. USA agrees to give the Provider notice of termination at least ninety (90) days prior to the effective date of termination that it intends to terminate the Agreement;

    b. The Provider, on receipt of the termination notice may request a review of the termination by USA's advisory panel within thirty (30) days from the date the notice is received.

    c. For purpose of the review of Provider contract termination, USA will set up an advisory review panel that consists of three providers with the same licensure and the same or similar specialty as that of the terminated Provider with the authority to review the termination of Provider.

    d. The USA advisory panel will be provided with the documentation necessary to review the termination and the advisory panel must complete its review prior to the effective date of the termination.

    e. USA may not notify any patient of the Provider that the Provider is no longer a part of the USA WIN Network until the earlier of (i) the effective date of the termination or (ii) the date the advisory review panel makes a formal recommendation (assuming that the report of the advisory review panel confirms the termination).

    f. If there is potential of imminent injury or harm to the health of an employee who is the patient of the Provider that is being terminated for suspension or termination of an applicable license to practice, or a fraudulent act, USA may terminate the Provider immediately and will immediately notify the employees (if any) receiving medical services from the Provider that the Provider has been terminated.

g. If a Provider terminates its contract with USA, USA will notify employees of the clients of USA who are receiving medical care from the terminating Provider as soon as practicable and no later than the termination date that the Provider is terminating its agreement with USA.

7. Provider must post a notice to employees containing information required by Texas Insurance Code §1305.405 on the process for resolving workers' compensation health care network complaints in the office of the Provider. The notice must include the Texas Department of Insurance toll free telephone number for filing a complaint and must list all workers' compensation health care networks with which the Provider contracts.

8. USA will furnish Provider a list of any treatments that require pre-certification or pre-authorization and the procedures to obtain that certification or authorization.

9. The Health Care Provider Agreement may not be interpreted in a manner that would allow the transfer of risk to an employee, as the transfer of risk is defined in Texas Insurance Code §1305.004(a)(26).

10. Provider and any subcontracting Provider must comply with all applicable statutory and regulatory requirements under both the laws of the State of Texas and the United States of America.

11. Exhibit B to the Health Care Provider Agreement sets out the rates for medical services that are applicable to the Health Care Provider Agreement with USA.

12. A Provider whose specialty has been designated by USA as Treating Doctor is a network Treating Doctor and agrees to any applicable provision as a Treating Doctor.

13. Billing by Provider and payment to Provider will be made in the manner and process set out in Texas Labor Code §408.027 and applicable rules.

14. Provider must provide treatment to injured employees who are presented to Provider through USA WIN Network and contracted INSURERS of the USA WIN Network.

15. USA will require contracted INSURERS to not use financial incentives or make payment to Provider that acts directly or indirectly as an inducement to limit medically necessary services.

16. Provider agrees to allow INSURER to effect a contingency plan in the event that INSURER is required to reassume functions from USA WIN as contemplated under Texas Insurance Code §1305.155.

EXHIBIT A
COST CONTAINMENT GUIDELINES

1. Provider agrees to provide health care service in conformity with accepted prevailing medical, surgical, chiropractic, physical therapy and mental health/substance abuse practices in the community in which Provider practices.

2. Provider agrees to utilize participating facilities, providers, and ancillary services (i.e., laboratory, x-ray, ultrasound, Hubbard Tank, isokinetic equipment, etc.) when not available in Provider's office and when consistent with good medical practice.

3. Provider agrees to perform pre-admission testing whenever INSURED is to be hospitalized.

4. Provider agrees to encourage the use of generic drugs, whenever medically possible, and when in the best interest of the patient.

5. Provider agrees not to bill separately for components of a procedure to increase reimbursement.

6. While Utilization Management is primarily conducted by telephone, certain situations may require an on-site visit. Should this occur, Provider agrees to accept Utilization Review Representatives on Provider's office setting for the purpose of reviewing medical records pertinent to continued stay or retrospective review of INSURED. Utilization Review Representatives agree to conduct reviews in accordance with Provider's policies.

7. Provider agrees to promote and implement the aggressive treatment of an INSURED that will encourage the timely return to a quality standard of life as well as employment.

8. Provider agrees to follow treatment guidelines equivalent to those required by the state in which Provider provides services or as outlined by Provider's specialty.

9. Provider agrees to ONLY provide those services actually necessary to effectively treat an INSURED and ONLY provide treatment that does not constitute "maintenance care". Maintenance care is defined as treatment that has no definable condition and the treatment goal is only to maintain INSURED'S condition of health. Provider agrees to ONLY perform those tests which are needed to properly diagnose and treat INSURED.

Current INSURED medical records shall immediately be made available by Provider, upon request, with proper patient authorization, for the purpose of concurrent review and retrospective review.

In addition to the above, when Provider is treating a work-related illness/injury;

1. Provider agrees to provide INSURED with a return to work agenda, treatment plan and Provider's expectations of functional capacity concurrent with treatment. Provider agrees, with the proper patient consent, to share this information with case managers assigned to the claim, adjusters, employers and other health care professionals who may be involved with the claim.

2. Provider agrees when performing and/or assisting in the assessment of INSURED for the purpose of establishing Impairment Ratings and Disability Ratings, to utilize AMA Guidelines to Physical Impairment or those guidelines that may be required by the state in which Provider provides services.

EXHIBIT B

Payment Schedule for
USA H&W (Health and Wellness), USA AUTO (Motorist Medical), and USA HMO

_____ is a Practitioner providing services in the State of _____.

PPO Payment Schedule

NOT VALID WITHOUT EXHIBIT B

SIGNATURE PAGE

Please contact USA MCO's Network Development at
1-800-872-0820 ext. 4887
or
providermarketinginfo@usamco.com

for full Payment Schedule and Signature Page.

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For and on behalf of:

USA MANAGED CARE ORGANIZATION, INC.
1250 South Capital of Texas Highway
Building 3, Suite 500
Austin, Texas 78746

_____
Date

_____
Signature

_____
Printed Name

_____
Title

For and on behalf of:

_____
_____
_____
_____

_____
Date

_____
Signature

_____
Printed Name

_____
Title

Provider Credentialing / Recredentialing Application

Please complete ONE application for each Provider

(Universal State recognized application also accepted along with the completed Workers' Injury/Illness section below)

Last Name		First Name		M.I.	Jr., Sr., as applicable
Gender (M/F)	Birth Date (mm/dd/yy)	Professional Degree	NPI:	Social Security Number (Billing Purposes ☐ Yes ☐No)	
Clinical Name or D.B.A. Name				Tax I.D. Number (Billing Purposes ☐ Yes ☐ No)	
Nurse Practitioner, Certified Registered Nurse First Assistant or Physician Assistants Supervising/Authorizing Physician (Last Name, First Name, Prof. Degree)					
Nurse Practitioner, Certified Registered Nurse First Assistant or Physician Assistants Supervising/Authorizing Physician (Address and Phone)					

OFFICE LOCATIONS

Office Location #1 (Directory Information) Address: _____ City, State, Zip: _____	Phone: (_____) _____ Fax: (_____) _____ E-mail : _____
Office Location #2 (Directory Information) Address: _____ City, State, Zip: _____	Phone: (_____) _____ Fax: (_____) _____ E-mail : _____
Office Location #3 (Directory Information) Address: _____ City, State, Zip: _____	Phone: (_____) _____ Fax: (_____) _____ E-mail : _____

BILLING LOCATION

Billing Address (if different from above) Address: _____ City, State, Zip: _____	Billing Phone: (_____) _____ Fax: (_____) _____ Repricing Statement E-mail : _____

AVAILABILITY/ACCESSIBILITY OF SERVICE/OFFICE HOURS

Monday	Hours _____	a.m. _____	p.m.	
Tuesday	Hours _____	a.m. _____	p.m.	
Wednesday	Hours _____	a.m. _____	p.m.	
Thursday	Hours _____	a.m. _____	p.m.	
Friday	Hours _____	a.m. _____	p.m.	
Saturday	Hours _____	a.m. _____	p.m.	
Sunday	Hours _____	a.m. _____	p.m.	

Do you accept walk-in patients?	☐Yes	☐ No	
Do you accept new patients?	☐Yes	☐ No	
Is your office bilingual?	☐Yes	☐ No	If yes, please identify secondary language: _____

WORKERS' INJURY/ILLNESS

Does provider agree to participate in USA's Workers Injury Network? (check one) ☐Yes ☐ No

If yes, please answer the following regarding Occupational Medicine Training and/or expertise. Please indicate 'yes' if you perform or assist in the assessment of:

Maximum Medical Improvement Determinations?	☐Yes ☐ No
Impairment ratings using AMA Guides to Physical Impairment?	☐Yes ☐ No
Independent/Required Medical Examinations?	☐Yes ☐ No
Second opinions?	☐Yes ☐ No

For Texas providers, has provider filed financial disclosure in accordance with Texas Labor Code §408.023 and §413.041? ☐Yes ☐ No

HOSPITAL/SURGICENTER STAFF PRIVILEGES

Facility _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Type of Privileges: _____
Facility _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Type of Privileges: _____
Facility _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Type of Privileges: _____

CURRENT LICENSURE

License Number	State	Effective Date	Expiration Date
License Number	State	Effective Date	Expiration Date
Federal DEA Registration Number	State	Date Issued	Expiration Date
State CDS Registration Number	State	Effective Date	Expiration Date
CLIA Certification Number	State	Effective Date	Expiration Date
Medicaid Number		Medicare Number	UPIN

If you answer "Yes" to any of the following questions, please provide a full narrative description of the circumstance. Your application will not be considered complete without this information.

Have your licenses to provide medical services in any state ever been or are they currently restricted, modified, challenged, suspended, or revoked?	☐ Yes	☐ No
Have you ever been the defendant in any criminal proceedings other than minor traffic offenses?	☐ Yes	☐ No
Have your DEA licenses ever been or are they currently challenged, restricted, modified, suspended, revoked, or has your application ever been denied?	☐ Yes ☐ N/A	☐ No
Have you been a defendant in a medical malpractice action including out of court settlements or dropped/closed cases in the past 5 years?	☐ Yes	☐ No
Have your staff privileges ever been suspended, restricted or otherwise modified in the past 5 years?	☐ Yes ☐ N/A	☐ No
Have you ever been involved with a voluntary or involuntary termination of professional or medical staff membership or limitation, reduction, or loss of clinical privileges at a hospital or other health care delivery setting?	☐ Yes	☐ No

INSURANCE

Malpractice/Professional Liability Insurance Company Name:	Policy Number:	Expiration Date:

LIMITS OF LIABILITY

Each Medical Incident:	Annual Aggregate:

AMERICAN BOARD CERTIFICATION / QUALIFICATION

American Board Certified ☐ Yes ☐ No (Please refer to the Minimum Standards for Provider Participation for recognized boards.)

Primary/Main Medical Specialty: _____

Subspecialty: _____

American Board Qualified ☐ Yes ☐ No (Please refer to the Minimum Standards for Provider Participation for recognized boards.)

Primary/Main Medical Specialty: _____

Subspecialty: _____

CLINICAL COMPETENCE
(Only For Initial Credentialing)

This section applies to non-medical allied health providers, and those medical providers without clinical privileges.

List two names of peers or physicians in same or similar specialty, not associated in the same group, preferably from an in-network provider, personally acquainted with the applicant's professional and clinical performance either in a teaching facility or in other healthcare settings.

Name: _____

Company Name: _____

City: _____ ST.: ____ Zip: _____

Telephone # (____) _____-_____

Name: _____

Company Name: _____

City: _____ ST.: ____ Zip: _____

Telephone # (_____) _____-_____

Submit, along with your completed application, one letter from each person listed above, describing their opinions of your scope and level of clinical performance, satisfactory fulfillment of professional obligations, clinical judgement, technical skills, and ethical performance, etc. Each letter must be signed. Primary source verification will be performed during the credentialing process.

EDUCATION / TRAINING / CERTIFICATION
(curricular vital accepted)

Medical School Name (Please print school's full name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Completed _____ Specialty _____
Place of Internship/1st Year Residency Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Completed _____ Specialty _____
Place of Residency Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Completed _____ Specialty _____
Place of Fellowship Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Completed _____ Specialty _____
Undergraduate Program (School Name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Graduated _____ Specialty _____
Graduate Program (School Name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Graduated _____ Specialty _____

Chiropractic Graduate Program (School Name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Graduated _____ Specialty _____
NCCPA Examination (required for Physician Assistants) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Certified _____ Specialty _____
Accreditation/State Certifications Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (_____) _____	Year Certified _____ Specialty _____

WORK HISTORY

(At a minimum, past 5 years must be included)

Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (_____) _____ From _____ To _____ Position _____
Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (_____) _____ From _____ To _____ Position _____
Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (_____) _____ From _____ To _____ Position _____
Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (_____) _____ From _____ To _____ Position _____

REQUIRED SUPPORTING DOCUMENTATION

Please include the following supporting documentation with your application.

- ☐ Current Malpractice/Professional Liability Insurance Face Sheet
- ☐ MMI/Impairment Rating Training Certificate (if applicable)
- ☐ Valid DEA or DPS Controlled Substances Registration Certificate
- ☐ Current State License
- ☐ Blinded Medical Record (Minimum information include author identification, patient identification – properly blinded, date of visit, reason for visit, examination notes, diagnosis notes, plan treatment)
- ☐ Blinded HCFA 1500 Claim Form (Box #31 representing provider's name as appearing on actual claim)

CONSENT/REPRESENTATIONS AND WARRANTIES

I consent to the inspection of my records and documents pertinent to the consideration of my application and continued participation as a provider in the USA Managed Care Organization. In addition, I consent to the performance of site evaluations performed by USA and/or its affiliates and/or agents.

I am able to perform all of my professional activities without impediment or constraint and meet the minimum standards for provider participation. In the past five years, I have had no physical, mental or chemical dependency condition(s), loss or limitation of licenses and/or felony convictions, loss or limitation of privileges or disciplinary activity that affect, or have affected my ability to perform all of my professional activities. I agree to practice within the scope of my licensure.

The undersigned represents, warrants and certifies that the information provided herein is true, correct and complete. The undersigned agrees to notify USA immediately and in writing of any change in name, address or ownership possession and of any material adverse change in any of the information contained in this statement or in the ability of the undersigned to perform its (or their) obligations. In the absence of such notice, the information provided herein should be considered as a continuing statement and substantially correct. If the undersigned fails to notify USA as required above, or if any of the information herein should prove to be inaccurate or incomplete in any material respect, USA shall immediately decline the application for participation or immediately terminate the provider's participation.

I authorize USA to consult with hospital administrators, members of medical staffs, malpractice carriers and other persons to obtain and verify my credentials and qualifications as a provider. I release USA and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I acknowledge I have the right to:

- review information submitted to support the credentialing application;
- correct erroneous information;
- be informed of the status of the credentialing or re-credentialing application; and
- be notified of these rights.

IF YOU DO NOT COMPLETE THIS APPLICATION IN ITS ENTIRETY INCLUDING ANSWERING ALL APPLICABLE QUESTIONS, THE ENTIRE PACKET WILL BE RETURNED FOR COMPLETION.

Applicant's Signature: _____ Date: _____

Applicant's Printed Name: _____

Supervising Physician Signature: _____ Date: _____

Supervising Physician Printed Name: _____

USA MANAGED CARE ORGANIZATION, INC.
NARRATIVE OF MALPRACTICE SUIT

Provider Name: _____

Date: _____

Please provide detailed information regarding any and all malpractice suits. Your narrative should include at a minimum:

Gender: _____ **Age: _____**

Insurance Carrier at the time of suit:

_____

_____

Description of allegations:

_____

_____

_____

_____

_____

_____

_____

Dates of treatment and/or surgery and narrative defense of your activity:

_____

_____

_____

_____

_____

_____

_____

_____

_____

If filed, specify disposition or current status of claim or suit:

_____

_____

_____

_____

_____

Date and dollar amount of settlement (if applicable):

_____

_____

_____

Please return this form to:

USA MANAGED CARE ORGANIZATION, INC.
USA WORKERS INJURY NETWORK, INC.
1250 S. Capital of Texas Hwy, Bldg 3-500, Austin, Texas 78746
New Providers Email: ProviderMarketingInfo@usamco.com Fax: (512) 306-1369
Recredentialing Email: AUSPRREC@usamco.com Fax: (512) 306-1921

PRACTITIONER SITE QUESTIONNAIRE

1. Check all that apply to this site

Setting/Type

- ☐ Ambulatory
  - ☐ Free Standing Building
  - ☐ Mobile Unit
- ☐ Home Care
- ☐ Hospice
- ☐ Hospital
- ☐ Long Term Care
- ☐ Mental Health
  - ☐ Inpatient ☐ Outpatient ☐ Residential
  - ☐ Supervised Living ☐ Partial Hosp
- ☐ Network
  - ☐ POS ☐ HMO ☐ IPA ☐ PPO
- ☐ Practitioner Office
- ☐ Laboratory

High Risk Services

- ☐ Anesthesia
- ☐ Average LOS greater than 24 hours
- ☐ Birthing Center
- ☐ Chronic Dialysis
- ☐ Contrast Imaging
- ☐ Infusion Therapy
- ☐ Radiation Oncology
- ☐ Ventilator Care
- ☐ 23-hour Recovery Center
- ☐ Emergency/Urgent Care Center

Other Services

- ☐ Acute Inpatient
- ☐ Alcohol/Drug Rehab Services
- ☐ Chemical Dependency
  - ☐ Adult ☐ Child/Adolescent
- ☐ Dementia/Alzheimer's
- ☐ General Long Term _____
- ☐ Imaging Services _____
- ☐ Mental Health Services _____
  - ☐ Adult ☐ Child/Adolescent
- ☐ MR/DD Services
- ☐ Physical Rehab Services
- ☐ Radiation Services
- ☐ Other_____
- ☐ Acquired Brain Injury
- ☐ Durable Medical Equip
- ☐ Home Healthcare
- ☐ Laboratory Services
- ☐ Pharmaceutical Services
- ☐ Primary Care Services
- ☐ Subacute Services

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

Title	Degree/Training/Certification
_____	_____
_____	_____

3. Availability of Services (check those that apply):

Average length of office visit:	5-10 min ☐	10-20 min ☐	20-30 min ☐	30+ min. ☐
Average length of waiting time:	5-10 min ☐	10-20 min ☐	20-30 min ☐	30+ min. ☐
Average wait time for appointment:	0-7 days ☐	7-14 days ☐	14+ days ☐	

4. Does the practitioner site have specific policies regarding patient record security and confidentiality including appropriate access by staff? YES ☐ NO ☐

5. Does the practitioner site use a standard Patient Assessment form for all patients seen? YES ☐ NO ☐

6. Does the practitioner site have specific policies for scheduling appointments based on the needs of the patient? YES ☐ NO ☐

7. Does the practitioner site office environment provide patients with safety, privacy and access to rest rooms? YES ☐ NO ☐

8. Does the practitioner site provide sufficient patient access and availability including extended hours, parking, proximity to public transportation and accommodations for the handicapped? YES ☐ NO ☐

9. Does the practitioner site provide appropriate maintenance and training in the use of clinical equipment with provisions for emergency power? YES ☐ NO ☐

10. Does the practitioner site have procedures in place to assist patients that need referrals to other facilities or for additional treatments? YES ☐ NO ☐

11. Is the practitioner site accredited? YES ☐ NO ☐

If yes, provide the following:	ID #	Award Date	Expiration Date
☐ Joint Commission	_____	_____	_____
☐ Other, (Identify)	_____	_____	_____

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

☐ Newsletter ☐ Brochures ☐ Pamphlets ☐ Other

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

_____

_____

Provider acknowledges USA may schedule a site visit in accordance with its Policies and Procedures as appropriate for Provider Participation.

Name: _____ Date of Completion: _____

Signature: _____ Phone Number: _____

PROVIDER REFERRALS

In an effort to assist USA in developing a comprehensive network, providing for a full continuum of care, please provide the following information for each entity you commonly refer patients to:

Name _____

Address _____

City, State, Zip _____

Services Provided _____

Contact Name _____ Telephone (_____) _____

Name _____

Address _____

City, State, Zip _____

Services Provided _____

Contact Name _____ Telephone (_____) _____

Name _____

Address _____

City, State, Zip _____

Services Provided _____

Contact Name _____ Telephone (_____) _____

Name _____

Address _____

City, State, Zip _____

Services Provided _____

Contact Name _____ Telephone (_____) _____

Name _____

Address _____

City, State, Zip _____

Services Provided _____

Contact Name _____ Telephone (_____) _____

Contact Sheet
For

_____

(Provider or Provider Group Name)

The following person(s) will be USA's contact(s) for the above named provider or provider group.

CONTRACTING:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

PROVIDER UPDATES:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

CEO / PRESIDENT / DIRECTOR:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

This information shall remain valid until USA is notified, in writing, by the above mentioned provider group of any changes.