OSEEGIB

Oklahoma State and Education Employees Group Insurance Board

HealthChoice

Network Provider Contract

This Contract applies to the following providers:

Audiologists
Certified Nurse Midwives
Certified Orthotists
Certified Prosthetists
Chiropractors
Christian Science Practitioners
Licensed Alcohol & Drug Counselors
Licensed Behavioral Practitioners
Licensed Clinical Social Workers
Licensed Marital Family Therapists
Licensed Professional Counselors
Occupational Therapists
Ocularists
Optometrists
Perfusionists
Physical Therapists
Psychologists
Speech Language Pathologists

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HealthChoice
Network Provider Contract

It is hereby agreed between the Oklahoma State and Education Employees Group Insurance Board, and the Provider named on the Signature Page, that the Provider shall be a Provider in the Oklahoma State and Education Employees Group Insurance Board's Network of Providers.

This Contract is entered into for the purpose of defining the conditions for reimbursement by the Oklahoma State and Education Employees Group Insurance Board to the Provider. It in no way is meant to impact on the Provider's decision as to what is considered appropriate medical treatment.

I. RECITALS

1.1 The State and Education Employees Group Insurance Board (hereinafter, Insurance Board) is a statutory body created by 74 O.S., § 1301 et seq., as amended, to administer and manage certain insurance benefits for employees of the State of Oklahoma.

1.2 The Provider is duly licensed or certified by the state of practice as a practitioner of the healing arts and satisfies additional credentialing criteria as established by the Insurance Board.

1.3 The intent of this Contract is to provide access to enhanced quality health care, utilizing managed care components, at an affordable, competitive cost to the Insurance Board and its members.

1.4 Failure to abide by any of the following provisions may result in non-renewal of the Contract or may be cause for termination.

II. DEFINITIONS

2.1 "Allowable Fee" means the maximum charge payable to a Provider for a specific procedure in accordance with the provisions in Article VI of this Contract. The Provider shall charge the usual and customary fee unless the fee schedule limits otherwise.

2.2 "Concurrent Review" means a function performed by the Insurance Board or its designee that determines and updates medical necessity for continued inpatient hospitalization.

2.3 “Credentialing Plan” means a general guide and process for the acceptance, cooperation and termination of participating Providers and other health care professionals.

2.4 "Emergency" means a sudden onset of a medical or mental condition displaying acute symptoms that are so severe that the absence of immediate medical attention could reasonably result in:

a) permanently placing the patient's health in jeopardy; or
b) causing other serious medical consequences; or
c) causing serious impairment to bodily functions; or
d) causing serious and permanent dysfunction of any body organ or part.

2.5 HELP/Wellness (Health Education Lifestyle Planning) means the program established to actively promote responsible behavior and the adoption of lifestyles that are in the best interest of the Plan member’s good health.

2.6 "Hospital Services" means those acute care inpatient and outpatient hospital services that are covered by the State and Education Employees Health Insurance Plan.

2.7 "Medical" means belonging to the study and practice of medicine for the prevention, alleviation or management of a physical or mental defect, illness or condition.

2.8 "Medically Necessary" means services or supplies that, under the provisions of this Contract, are determined to be:

a) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
b) provided for the diagnosis and treatment of the medical condition, and
c) within standards of acceptable, prudent medical practice within the community, and
d) not primarily for the convenience of the member, the member's health care Provider, or another Provider, and
e) any condition which, if left untreated, could deteriorate into a life threatening situation, and
f) the most appropriate supply or level of service that can safely be provided. For hospital stays, this means that the acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

2.9 "Medical Services" means the professional services provided by a Network Provider and covered by the State and Education Employees Health Insurance Plan.

2.10 "Members" means all persons covered by the Group Insurance Plans, including active, retired, or vested employees, survivors and others on approved leave or disability and their covered dependents eligible at the time of service.

2.11 "Network Provider" means a licensed practitioner of the healing arts who has entered into this Contract with the Insurance Board to accept scheduled reimbursement for covered health services provided to members.

2.12 "Precertification" means a function performed by the Insurance Board, or its designee to review and certify medical necessity prior to the receipt of service for hospital admissions.

2.13 "Prior Authorization" means a function performed by the Insurance Board, or its designee, to review for medical necessity in identified areas of practice as defined at 7.11 of this Contract, prior to services being rendered.

2.14 "State and Education Employees Health Insurance Plan" means the HealthChoice benefit plan designed to enhance the quality of care, and to financially incentivize members to use Network Providers.

2.15 "Third Party Payor" means an insurance company or other entity making payment directly to the Provider on behalf of the Insurance Board.

2.16 “Certification” means a function performed by the Insurance Board or its designee to review and certify medical necessity for emergency admissions and observation stays with duration of more than 24 hours within one working day after services are incurred.

2.17 “Prior Approval” means a function performed by the Insurance Board, or its designee, to review and certify medical necessity prior to the member’s receipt of services for outpatient surgical procedures as referenced in 7.3.

III. RELATIONSHIP BETWEEN THE INSURANCE BOARD AND THE PROVIDER

3.1 The Insurance Board has negotiated and entered into this Contract with the Provider on behalf of the individuals who are members of the State and Education Employees Health Insurance Plan. The Provider is an independent contractor who has entered into this Contract to become a Network Provider and is not, nor is intended to be, the employee, agent or other legal representative of the Insurance Board in the performance of the provisions of this Contract.

Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of independent contractor for the purposes of this Contract.

3.2 The Insurance Board and the Provider agree that all of the parties hereto shall respect and observe the provider/patient relationship that will be established and maintained by the Provider. The Provider may choose not to establish a provider/patient relationship if the Provider would have otherwise made the decision not to establish a provider/patient relationship had the patient not been a member. The Provider reserves the right to refuse to furnish services to a member in the same manner as he/she would any other patient.

3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies in any third party, including but not limited to, a member or a Network Provider other than the Provider named in this Contract.

IV. PROVIDER SERVICES AND RESPONSIBILITIES

4.1 The Provider agrees to provide quality health care in a cost efficient manner.

4.2 For the purpose of reimbursement, the Provider shall provide services to members that are medically necessary and covered under the Health Insurance Plan.

4.3 The Provider agrees to make reasonable effort to refer covered members to those Network Providers, with which the Insurance Board contracts, for medically necessary services that the Provider cannot or chooses not to provide. Failure of the Provider to use Network Providers will result in a review pursuant to the credentialing plan.

4.4 The Provider shall prescribe for the Insurance Board members medications identified on the adopted formulary or explain, in writing, on behalf of the member to the Insurance Board why it is medically inappropriate to do so.

4.5 The Provider shall participate in the preadmission certification, concurrent review, and prior authorization procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from those reviews subject to rights of reconsideration, review and appeal.

4.6 The Provider shall accurately complete the Network Provider Application that is attached to and made part of this Contract. The Provider shall notify the Insurance Board's Network Manager of any change in the information contained in the Application within 15 days of such change, including resolved litigation listed as "pending" on the original Application.

4.7 The Provider shall reimburse the Insurance Board for any overpayments made to the Provider within 30 days of the Provider's receipt of the overpayment notification.

4.8 The Provider shall submit to a patient record audit upon 48 hours advance notice.

4.9 The Provider shall participate in HELP/Wellness promotions sponsored by the Insurance Board, at the Insurance Board's allowable under the terms of the promotion.

V. INSURANCE BOARD SERVICES AND RESPONSIBILITIES

5.1 The Insurance Board agrees to pay the Provider compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.

5.2 The Insurance Board agrees to grant the Provider the status of "Network Provider" and to identify the Provider as a Network Provider on informational materials disseminated to members.

5.3 The Insurance Board agrees to continue listing the Provider as a Network Provider until this Contract terminates.

5.4 The Insurance Board agrees to periodically provide the Provider with a list of all Network Providers.

5.5 The Insurance Board agrees to provide appropriate identification cards for members.

5.6 The Insurance Board agrees to adhere to confidentiality of patient's records and to only release pertinent clinical information in accordance with state and federal guidelines.

5.7 The Insurance Board shall give a 48 hour notice prior to an audit.

5.8 The Insurance Board shall maintain prior authorization, precertification and concurrent review programs in order to aid its members in making decisions that will maximize medical benefits and reduce their financial risk.

VI. COMPENSATION AND BILLING

6.1 The Provider shall seek payment only from the Insurance Board for the provision of medical services except as provided in paragraphs 6.3, 6.4 and 6.9. The

payment from the State and Education Employees Health Insurance Plan shall be limited to the amounts referred to in paragraph 6.2.

6.2 The Insurance Board agrees to pay the Provider's billed charge for each procedure or the fee set by the Insurance Board for that procedure, whichever is less.

a) The Insurance Board may reduce the payment by any deductibles, coinsurance and copayments.

b) The Insurance Board shall have the right to categorize what shall constitute a procedure. The Insurance Board and the member's financial liability shall be limited to the procedures allowable as determined by the Insurance Board, paid by applying appropriate coding methodology, whether the Provider has billed appropriately or not.

c) The Provider agrees not to charge more for medical services to members than the amount normally charged (excluding Medicare) by the Provider to other patients for similar services. The Provider may, however, contract with other third party payors for services. The Provider's usual and customary charges may be requested by the Insurance Board and verified through an audit.

6.3 The Provider agrees that the only charges for which a member may be liable and be billed by the Provider shall be for medical services not covered by State and Education Employees Health Insurance Plan, or as provided in paragraphs 6.4 and 6.9. The Provider shall not waive any deductibles, copayments and coinsurance required by the Insurance Board, except during times of HELP/Wellness promotions, when the copayment/coinsurance is waived by the Insurance Board.

6.4 The Provider shall not collect amounts in excess of the Plan limits unless the member has exceeded his/her annual or lifetime maximum.

6.5 The Provider shall refund within 30 days of discovery to the member any overpayment made by the member.

6.6 In a case in which the Insurance Board is primary under applicable coordination of benefit rules, the Insurance Board shall pay the amounts due under this Contract. In a case in which the Insurance Board is other than primary under the coordination of benefit rules, the Insurance Board shall pay only those amounts not payable from other sources pursuant to the applicable coordination of benefit rules, up to the Insurance Board's maximum liability under the terms of this Contract.

6.7 The Provider shall bill the Insurance Board on forms acceptable to the Insurance Board within 60 days of providing the medical services. The Provider shall use the current CPT codes with appropriate modifiers and ICD-9 or DSM-3

diagnostic codes, when applicable. The Provider shall furnish, upon request at no cost, all information, including medical records, reasonably required by the Insurance Board to verify and substantiate the provision of medical services and the charges for such services if the member and the Provider are seeking reimbursement through the Insurance Board.

6.8 The Insurance Board shall reimburse the Provider within 30 days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. The Insurance Board will not be responsible for delay of reimbursement due to circumstances beyond the Insurance Board's control.

6.9 The Provider shall not charge the member for medical services denied during preadmission certification, concurrent review or the prior authorization procedures described in Article VII, unless the Provider has obtained a written waiver from that member. Such a waiver shall be obtained only upon the denial of admission, concurrent review or prior authorization and prior to the provision of those medical services. The waiver shall clearly state that the member shall be responsible for payment of medical services denied by the Insurance Board.

6.10 The Insurance Board shall have the right at all reasonable times and, to the extent permitted by law, to inspect and duplicate all medical and billing records relating to medical services rendered covered members at no cost to the Insurance Board or the member.

VII. UTILIZATION REVIEW

7.1 The Provider shall adhere to and cooperate with the Insurance Board's precertification, concurrent review and prior authorization procedures. These procedures do not guarantee a member’s eligibility or that benefits are payable, but assure the Provider that the medical services to be provided are covered under the Plan.

7.2 The Provider, or his/her representative, shall notify the Insurance Board, or its designee, of any admission. The Provider shall request precertification at least three days prior to the scheduled admission. A request for certification shall be made within one working day after an emergency admission, or observation stay with a duration greater than 24 hours. Such notification shall be at no charge to the Insurance Board or the member. Failure to comply with the precertification, concurrent review or prior authorization requirements shall result in the Provider’s reimbursement being penalized by 10% if medical necessity is confirmed retrospectively and, if not confirmed, there shall be no reimbursement.

7.3 The Provider or his/her representative shall obtain prior approval from the Insurance Board or its designee for the following outpatient surgical procedures, which are to be performed outside the provider's office:

a) Blepharoplasty
b) Rhinoplasty
c) Breast implant removal
d) Scar revision
e) Breast reduction
f) Panniculectomy
g) Surgical treatment of varicosities

7.4 The precertification, prior authorization and concurrent review requirements are intended to maximize insurance benefits assuring that hospital and medical services are provided to the member at the appropriate level of care. In no event is it intended that the procedures interfere with the Provider's decision to order admission or discharge of the patient to or from the hospital.

7.5 The Insurance Board shall maintain review procedures and screening criteria that take into account professionally acceptable standards for quality medical care in the community. The Insurance Board or its designee shall consider all relevant information concerning the member before medical necessity is approved or denied.

7.6 The Insurance Board, or its designee, shall respond to requests for precertification by immediately assigning a code number to each request.

7.7 At the time of the precertification request the Provider should be prepared to give the following information:

a) member's name and social security number,
b) age and sex,
c) diagnosis,
d) reason for admission,
e) scheduled date of admission,
f) planned procedure or surgery,
g) scheduled date of surgery,
h) name of hospital,
i) name of provider, and
j) member status (i.e.: employee, dependent).

7.8 The Insurance Board shall not retrospectively deny any previously approved care. The Provider and/or his/her designee shall update the Insurance Board, or its designee, as the member's condition or diagnosis changes. Updated information may result in a change of the originally approved length of stay.

7.9 Upon the member's request, the Insurance Board shall reconsider any non-approved services. The Provider may submit a formal written appeal to the Insurance Board.

7.10 The Provider shall request precertification before the admission or referral of members to non-network hospitals. The Insurance Board shall review emergency referrals to non-network hospitals to determine whether the admission was medically necessary and an emergency as defined in this Contract.

7.11 The Provider shall request prior authorization from the Insurance Board or its designee for the following:

a) solid organ transplantation, including ABMT/HDCT/peripheral stem cell recovery,
b) home health care,
c) durable medical equipment,
d) home infusion therapies,
e) mental health/substance abuse (day and residential treatment),
f) bone growth stimulators, and
g) breast surgeries, implants, reductions and reconstruction.

VIII. LIABILITY AND INSURANCE

8.1 Neither party to this Contract, the Insurance Board nor the Provider, nor any agent, employee or other representative of a party, shall be liable to third parties for any negligent act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.

8.2 The Provider, at his/her sole expense, shall maintain a minimum of $1,000,000 per occurrence and $1,000,000 aggregate of insurance coverage for professional liability. If the hospital at which the Provider has admitting privileges has different limits, the Provider is subject to those limits per this Contract.

IX. MARKETING, ADVERTISING AND PUBLICITY

9.1 The Insurance Board shall encourage its members to use the services of the Network Provider.

9.2 The Insurance Board shall have the right to use the name, office address, telephone number and specialty of the Provider for purposes of informing its members and prospective members of the identity of the Network Providers.

9.3 The Provider, upon prior approval of the Insurance Board, shall have the right to publicize the Provider’s status in the Insurance Board’s Network of Providers.

X. DISPUTE RESOLUTION

10.1 The Insurance Board and the Provider agree that their authorized representatives will meet in a timely manner and negotiate in good faith to resolve any problems or disputes that may arise in performance of the terms and provisions of this Contract. Nothing in this Article shall interfere with either party's rights under Article XI.

XI. TERM AND TERMINATION

11.1 It is agreed by the parties that no changes to the Contract, which include coverages or fee reimbursements, shall be made with less than 60 days notice to all affected parties, <u>but for in the instance of revisions to injectable medications, in which case the Insurance Board shall implement the revisions as soon as possible with proper and timely notification to the Providers.</u>

11.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 12.2.

11.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.

11.4 This Contract shall terminate with respect to a Provider upon:

a) the loss or suspension of the Provider's license to practice medicine in the state of practice; or
b) failure to maintain Provider's professional liability insurance in accordance with this Contract.

11.5 Following the effective date of termination, this Contract shall be of no further force or effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this Contract.

11.6 Following termination of this Contract, the Insurance Board shall continue to have access to the Provider’s records of care and services provided to members for five years from the date of provision of the services to which the records refer as set forth in Paragraph 6.10.

XII. GENERAL PROVISIONS

12.1 This Contract or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.

12.2 At any place within this Contract that notice is required, it is the intention of the parties that only those with regard to termination by either party of participation in the Contract must be sent by certified mail, a return receipt requested, at no other time when notice is required by this Contract is there an obligation by either party to use certified mail.

12.3 Notwithstanding the provisions of Paragraph 12.1 of this Contract, the Insurance Board may appoint an Administrator to administer any of the terms of the Network Contract referenced herein, and any and all duties or acts required of the Insurance Board under this Contract and to receive any notices required by this Contract.

12.4 This Contract, together with its exhibits, contains the entire agreement between the Insurance Board and the Provider relating to the rights granted and the obligations assumed by the parties concerning the provision of medical services to members. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract not expressly set forth in this Contract are of no force or effect.

12.5 This Contract, or any part, section or exhibit of, or attached to it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the Insurance Board and the Provider.

12.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract that is not in conformity with existing or future legislation shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.

12.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and the determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this entire Contract, or any one of them, in accordance with the intent and purpose of the parties hereto.

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

Network Provider Application Requirements

Thank you for your interest in the HealthChoice Provider Network.

Please complete the attached Application and submit with the required attachments listed below.

Type or print your responses and complete all sections of this Application. If an area of inquiry is not applicable to you or your practice, please indicate. If you need additional space to provide COMPLETE answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

Retain the Contract for your records.

REQUIRED ATTACHMENTS

Please attach a copy of each of the following documents to your completed Application:

☐ **Current state(s) license(s)**

☐ **Current DEA registrations (narcotics license), if applicable**

☐ **Current state narcotics registration, if applicable**

☐ **Face sheet of current professional liability insurance policy**
Insurance Certificate/Face Sheet must have the name of the applicant listed as the insured. The insurance limits must be at the levels required in the Contract and must indicate clearly that it is professional liability coverage.

☐ **W-9 form for each Federal Tax ID Number**
W-9 forms must be signed and list only the Federal Tax ID Number or Social Security Number for each location listed on the Application which will be used on claim forms submitted to HealthChoice.

☐ **Contract Signature Page**

☐ **Electronic Funds Transfer (EFT) Form**

☐ **Copy of a voided check, if electing Electronic Funds Transfer**

Incomplete Applications will be returned

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

HealthChoice

Network Provider Application

The completed Network Provider Application should be returned to the Oklahoma State and Education Employees Group Insurance Board in its entirety, along with any applicable attachments.

You may mail or fax the Application to:

Oklahoma State and Education Employees Group Insurance Board
ATTN: Provider Relations/Network Management
3545 N.W. 58th Street, Suite 600
Oklahoma City, OK 73112
Phone: 405-717-8860 or 1-800-543-6044
Fax: 405-717-8977

GENERAL INFORMATION

Provider's Name: ____
(Last) (First) (Middle)

If your name has changed during the past twenty-four (24) months, please indicate all names you have used on licenses, registrations, etc: ______________________________

Social Security Number: ______________________________

National Provider Identifier Number: ______________________________

SPECIALTY INFORMATION

Profession/License: ______________________________

Primary Specialty: ______________________________

Secondary Specialty: ______________________________

LICENSE INFORMATION

Provide the following information for each state in which you have obtained professional licensure:

State: ___________________ License Number: ____________________ Expiration Date: __________________

State: ___________________ License Number: ____________________ Expiration Date: __________________

State: ___________________ License Number: ____________________ Expiration Date: __________________

DEA Number: ___________________________________ BNDD Number: _____________________________

INSURANCE INFORMATION

(Minimum requirements of $1,000,000 per occurrence and $1,000,000 aggregate)

Please provide the following information about your current professional liability insurance coverage:

Name of Carrier: ____

(Please attach a copy of the Insurance Certificate/Face Sheet)

Coverage Amounts:

Per Occurrence ____________________________ Aggregate: __________________________________

Expiration Date: ____________________________

STAFF PRIVILEGES

Identify all hospitals at which you have current privileges (if applicable):

Hospital: ____

Address ____ Status: ________________

Hospital: ____

Address ____ Status: ________________

Hospital: ____

Address ____ Status: ________________

Hospital: ____

Address ____ Status: ________________

OFFICE INFORMATION

Federal Tax ID Number: ____________________

(Attach a completed W-9 form for each Federal Tax ID Number)

PHYSICAL ADDRESS – Physical Location of Practice

THIS PRACTICE ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE

Primary Office or clinic name: ____________________

Physical Address: ____________________

____
(City) (State) (Zip)

Phone: (______)____________________ Fax: (______)____________________

MAILING ADDRESS – for Correspondence/Credentialing

Mailing Office or clinic name: ____________________

Mailing Address: ____________________

____
(City) (State) (Zip)

Credentialing/Contact Person: ____________________

Phone: (______)____________________ Fax: (______)____________________

E-mail: ____________________

BILLING/REMIT ADDRESS – for Claims Payments and EOBs

ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS

Name submitted on claims: ____________________

Billing Office or clinic name: ____________________

Billing Address: ____________________

____
(City) (State) (Zip)

Contact Person: ____________________

Phone: (______)____________________ Fax: (______)____________________

E-mail: ____________________

ADDITIONAL OFFICE LOCATION(S)

Federal Tax ID Number: ______________________________

(Attach a completed W-9 form for each Federal Tax ID number)

PHYSICAL ADDRESS – Physical Location of Practice

THIS PRACTICE ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE

Primary Office or clinic name: ______________________________

Physical Address: ______________________________

____
(City) (State) (Zip)

Phone: (______)______________________ Fax: (______)______________________

MAILING ADDRESS – for Correspondence/Credentialing

Mailing Office or clinic name: ______________________________

Mailing Address: ______________________________

____
(City) (State) (Zip)

Credentialing/Contact Person: ______________________________

Phone: (______)______________________ Fax: (______)______________________

E-mail: ______________________________

BILLING/REMIT ADDRESS – for Claims Payments and EOBs

ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS

Name submitted on claims: ______________________________

Billing Office or clinic name: ______________________________

Billing Address: ______________________________

____
(City) (State) (Zip)

Contact Person: ______________________________

Phone: (______)______________________ Fax: (______)______________________

E-mail: ______________________________

∗Please use a copy of this page to report any additional locations.

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

Oklahoma Department of Rehabilitation Services

Department of Corrections Oklahoma

Electronic Funds Transfer (EFT) Form

SUPPLIER ONLY:

Legal Name of Corporate Owner: ____

Trade Name/dba:: ______________________________ Federal Tax ID #: ______________

PRACTITIONER ONLY:

Practitioner's Name: ____

SSN: __________________________ Federal Tax ID #: __________________________

BANKING INFORMATION

A voided check is required. If the bank account does not have checks, a bank letter verifying the account and routing numbers will be accepted.

A deposit slip will be accepted only if the information provided below matches the MICR line containing the banking ABA number and account between these symbols | : |:

Financial Institution: ____

Account Number: ____________________ Routing Number:__________________

☐ Checking ☐ Savings

BILLING/REMIT

Name Submitted on Claims: ____

Billing Office Name (if applicable): ______________________________________

Billing Address: ____

____
(City) (State) (Zip)

AUTHORIZED SIGNATURE

Signature: ______________________________________ Date: __________________
(Required)

Printed Signature Name: ___________________________ Phone Number:______________

Please mail, fax or email the completed form to:

HealthChoice
Attn: Provider Relations
3545 N.W. 58th Street, Suite 600
Oklahoma City, OK 73112
Phone: 405-717-8790 or 1-800-543-6044
Fax: 405-717-8977
oseegibproviderrelations@sib.ok.gov

HealthChoice

Network Provider Contract Signature Page

The Oklahoma State and Education Employees Group Insurance Board (Insurance Board) and the Provider, incorporate by reference the terms and conditions of the Network Provider Contract (Contract) into this Signature Page. The Insurance Board and Provider further agree that the effective date of the Contract is the effective date denoted on the copy of the executed Signature Page returned to the Provider. The original of the signed document will remain on file in the office of the Insurance Board.

FOR THE PROVIDER:

*Signature Date:*___________________________

Name (typed or printed):

____

Signature:

____

SSN: _______________________________________

Federal Tax ID Number:_______________________

Primary Service Address:

____

____

____

FOR THE BOARD:

____

James L. Reese, II
Deputy Administrator, Operations
Chief Information Officer
Oklahoma State and Education Employees
Group Insurance Board

Please return the completed Application, Signature Page, and required attachments to:

Oklahoma State and Education Employees Group Insurance Board
ATTN: Provider Relations/Network Management
3545 N.W. 58th Street, Suite 600
Oklahoma City, OK 73112
Phone: 405-717-8860 or 1-800-543-6044
Fax: 405-717-8977