

**HealthChoice**

**Network Provider**

**Dietician**

**Contract**

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APPENDIX:

SIGNATURE PAGE

# HealthChoice

## Network Dietician 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 Dietician 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 Dietician. It in no way is meant to impact on the Dietician's decision as to what he or she considers appropriate services.

### I. RECITALS

- 1.1 The State and Education Employees Group Insurance Board (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 by the state of practice as a registered Dietician 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 diabetes self-management training and training related to medical nutrition therapy, utilizing managed care components, at an affordable, competitive cost to the Insurance Board and its members and to comply with the mandates stipulated in 74 O.S. § 1307.2 (1996) regarding the treatment of Type I, Type II and gestational diabetes.
- 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 the Dietician for a specific procedure in accordance with the provisions in Article VI of this Contract. The Dietician shall charge the usual and customary fee unless the fee schedule limits otherwise.
- 2.2 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating Network Providers and other health care professionals.
- 2.3 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.
- 2.4 "Health Services" means the professional services provided by a Network Provider and covered by the State and Education Employees Health Insurance Plan.

- 2.5 "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.
- 2.6 "Network Provider" means a licensed Dietician who has entered into this Contract with the Insurance Board to accept scheduled reimbursement for covered health services provided to members.
- 2.7 "State and Education Employees Health Insurance Plan" means the HealthChoice benefit plan designed to enhance the quality of care, and to financially incentivise members to use Network Dieticians.
- 2.8 "Third Party Payor" means an insurance company or other entity making payment directly to the Dietician on behalf of the Insurance Board.

### **III. RELATIONSHIP BETWEEN THE INSURANCE BOARD AND THE DIETICIAN**

- 3.1 The Insurance Board has negotiated and entered into this Contract with the Dietician on behalf of the individuals who are members of the State and Education Employees Health Insurance Plan. The Dietician 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 Dietician agree that all of the parties hereto shall respect and observe the provider/patient relationship that will be established and maintained by the Dietician. The Dietician may choose not to establish a provider/patient relationship if the Dietician would have otherwise made the decision not to establish a provider/patient relationship had the patient not been a member. The Dietician reserves the right to refuse to furnish services to a member in the same manner as he 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 Dietician named in this Contract.

### **IV. DIETICIAN SERVICES AND RESPONSIBILITIES**

- 4.1 The Dietician agrees to provide quality health care in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the Dietician shall provide diabetes self-management training and training related to medical nutrition therapy, which is covered under the Health Insurance Plan. The Plan does not cover medical nutrition therapy for which the only purpose is weight reduction or nutritional therapy associated with any medical condition other than diabetes. For the purpose of reimbursement, the Dietician shall provide diabetes self-management training and training related to medical nutrition therapy which is covered under the Health Insurance Plan and prescribed by a physician or any other prescribing authority.

- 4.3 The Dietician 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 Dietician cannot or chooses not to provide. Failure of the Dietician to use Network Providers will result in a review pursuant to the credentialing plan.
- 4.4 The Dietician shall accurately complete the Network Provider Application that is attached to and made part of this Contract. The Dietician shall notify the Insurance Board's Network Manager of any change in the information contained in the Application within 15 days of such change.
- 4.5 The Dietician shall reimburse the Insurance Board for any overpayments made to the Dietician within 30 days of the Dietician's receipt of the overpayment notification.
- 4.6 The Dietician shall submit to a patient record audit upon 48 hours advance notice.
- 4.7 The Dietician 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 Dietician 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 Dietician the status of "Network Provider" and to identify the Dietician as a Network Provider on informational materials disseminated to members.
- 5.3 The Insurance Board agrees to continue listing the Dietician as a Network Provider until this Contract terminates.
- 5.4 The Insurance Board agrees to provide access to a listing 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.

## **VI. COMPENSATION AND BILLING**

- 6.1 The Dietician shall seek payment only from the Insurance Board for the provision of medical services except as provided in paragraphs 6.3 and 6.4. 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 Dietician'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 Dietician agrees not to charge more for health services to members than the amount normally charged (excluding Medicare) by the Dietician to other patients for similar services. The Dietician may, however, contract with other third party payors for services. The Dietician's usual and customary charges may be requested by the Insurance Board and verified through an audit.
- 6.3 The Dietician agrees that the only charges for which a member may be liable and be billed by the Dietician shall be for health services not covered by State and Education Employees Health Insurance Plan, or as provided in paragraph 6.4. The Dietician 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 Dietician shall not collect amounts in excess of the Plan limits unless the member has exceeded his/her annual or lifetime maximum.
- 6.5 The Dietician shall refund within 30 days of discovery to the member any overpayments 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 Dietician shall bill the Insurance Board on forms acceptable to the Insurance Board within 60 days of providing the health services. The Dietician shall use the current CPT codes with appropriate modifiers and ICD-9 diagnostic codes, when applicable. The Dietician 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 health services and the charges for such services if the member and the Dietician are seeking reimbursement through the Insurance Board.
- 6.8 The Insurance Board shall reimburse the Dietician 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 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.

## **VIII. LIABILITY AND INSURANCE**

- 7.1 Neither party to this Contract, the Insurance Board nor the Dietician, 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.
- 7.2 The Dietician, at his/her sole expense, shall maintain a minimum of \$1,000,000 per occurrence and \$3,000,000 aggregate of insurance coverage for professional liability. If the Dietician is employed by a health care facility which has different liability insurance limits, the Dietician is subject to those limits per this Contract.

## **IX. MARKETING, ADVERTISING AND PUBLICITY**

- 8.1 The Insurance Board shall encourage its members to use the services of the Network Dietician.
- 8.2 The Insurance Board shall have the right to use the name, office address, telephone number and specialty of the Dietician for purposes of informing its members and prospective members of the identity of the Network Providers.
- 8.3 The Dietician, upon prior approval of the Insurance Board, shall have the right to publicize the Dietician's status in the Insurance Board's Network of Providers.

## **X. DISPUTE RESOLUTION**

- 9.1 The Insurance Board and the Dietician 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**

- 10.1 The term of this Contract shall commence on the effective date on the signature page, and shall remain in effect until terminated by either party subject to 10.2.
- 10.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 11.2.
- 10.3 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.
- 10.4 This Contract shall terminate with respect to a Dietician upon:
- a) the loss or suspension of the Dietician's license in the state of practice; or
  - b) failure to maintain Dietician's professional liability insurance in accordance with this Contract.

- 10.5 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.
- 10.6 Following termination of this Contract, the Insurance Board shall continue to have access to the Dietician'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 6.9.

## **XII. GENERAL PROVISIONS**

- 11.1 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.
- 11.2 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.
- 11.3 Notwithstanding the provisions of Paragraph 11.1 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.
- 11.4 This Contract, together with its exhibits, contains the entire agreement between the Insurance Board and the Dietician relating to the rights granted and the obligations assumed by the parties concerning the provision of health 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.
- 11.5 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 Dietician.
- 11.6 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.
- 11.7 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.



## 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***



## 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. 58<sup>th</sup> 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: \_\_\_\_\_

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## LICENSE INFORMATION

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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: \_\_\_\_\_

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## INSURANCE INFORMATION

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*(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: \_\_\_\_\_

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## STAFF PRIVILEGES

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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. 58<sup>th</sup> Street, Suite 600  
Oklahoma City, OK 73112  
Phone: 405-717-8790 or 1-800-543-6044  
Fax: 405-717-8977  
[oseegibproviderrelations@sib.ok.gov](mailto:oseegibproviderrelations@sib.ok.gov)

**HealthChoice**  
**Network Provider**  
**Dietician 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:**

**FOR THE BOARD:**

Signature Date: \_\_\_\_\_

Name (typed or printed):  
\_\_\_\_\_

Signature:  
\_\_\_\_\_

SSN: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_

Primary Service Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
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. 58<sup>th</sup> Street, Suite 600**  
**Oklahoma City, OK 73112**  
**Phone: 405-717-8860 or 1-800-543-6044**  
**Fax: 405-717-8977**