HealthChoice

Network Provider

Infusion Therapy

Contract

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APPENDIX:
SIGNATURE PAGE

Network Infusion Therapy Provider Contract

It is hereby agreed between the Oklahoma State and Education Employees Group Insurance Board and the Infusion Therapy Provider named on the signature page, that the Infusion Therapy 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 Infusion Therapy Provider. It in no way is meant to impact on the Infusion Therapy Provider's decision as to what is considered appropriate infusion therapy treatment.

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 Infusion Therapy Provider is a Medicare and/or JCAHO certified Infusion Therapy Provider 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 infusion therapy, 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 an Infusion Therapy Provider for a specific procedure in accordance with the provisions in Article VI of this Contract. The Infusion Therapy Provider 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 Providers and other health care providers.

2.3 “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.

2.4 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.

2.5 “Infusion Therapy” means the services provided by a Network Infusion Therapy Provider that are covered by the State and Education Employees Health Insurance Plan.

2.6 “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.

2.7 “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 Infusion Therapy 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.

2.8 “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.

2.9 “Network Provider” means an Infusion Therapy Provider who has entered into this Contract with the Insurance Board, to accept scheduled reimbursement for covered infusion therapy services provided to members.

2.10 “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 7.1 of this Contract, prior to services being rendered.

2.11 “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 Providers.

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

III. RELATIONSHIP BETWEEN THE INSURANCE BOARD AND THE INFUSION THERAPY PROVIDER

3.1 The Insurance Board has negotiated and entered into this Contract with the Infusion Therapy Provider on behalf of the individuals who are members of the State and Education Employees Health Insurance Plan. The Infusion Therapy 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 the independent contractor for the purposes of this Contract.

3.2 The Insurance Board and the Infusion Therapy Provider agree that all of the parties hereto shall respect and observe the provider/patient relationship that will be established and maintained by the Infusion Therapy Provider. The Infusion Therapy Provider may choose not to establish a provider/patient relationship if the Infusion Therapy Provider would have otherwise made the decision not to establish a provider/patient relationship had the patient not been a member. The Infusion Therapy Provider 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 Infusion Therapy Provider named in this Contract.

IV. PROVIDER SERVICES AND RESPONSIBILITIES

4.1 The Infusion Therapy Provider agrees to provide quality infusion therapy services in a cost efficient manner.

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

4.3 The Infusion Therapy 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 Infusion Therapy Provider cannot or chooses not to provide. Failure of the Infusion Therapy Provider to use Network Providers will result in a review pursuant to the credentialing plan.

4.4 The Infusion Therapy Provider shall provide patient progress update reports to the Insurance Board by phone, mail or fax. This may result in a change of the approved length of services.

4.5 The Infusion Therapy Provider shall participate in the 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 Infusion Therapy Provider shall accurately complete the Network Provider Application that is attached to and made part of this Contract. The Infusion Therapy 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 Infusion Therapy Provider shall reimburse the Insurance Board for any overpayments made to the Infusion Therapy Provider within 30 days of the Infusion Therapy Provider's receipt of the overpayment notification.

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

4.9 The Infusion Therapy 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 Infusion Therapy Provider compensation pursuant to the provisions of Article VI.

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

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

5.4 The Insurance Board agrees to periodically provide The Infusion Therapy Provider access to 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 notice prior to an audit.

5.8 The Insurance Board shall maintain a prior authorization program 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 Infusion Therapy Provider shall seek payment only from the Insurance Board for the provision of infusion therapy 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 Infusion Therapy Provider's designated per diem value or 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, and coinsurance.

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 Infusion Therapy Provider has billed appropriately or not. The per diem rates do not include any professional component fees which are considered for payment according to separately billed CPT codes.

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

6.3 The Infusion Therapy Provider agrees that the only charges for which a member may be liable and be billed by the Infusion Therapy Provider shall be for infusion therapy services not covered by State and Education Employees Health Insurance Plan, or as provided in paragraphs 6.4 and 6.9. The Infusion Therapy Provider shall not waive any deductibles 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 Infusion Therapy Provider shall not collect amounts in excess of Plan limits unless the member has exceeded his/her annual or lifetime maximum.

6.5 The Infusion Therapy Provider 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 Infusion Therapy Provider shall bill the Insurance Board on forms acceptable to the Insurance Board within 60 days of providing the infusion therapy services. The Infusion Therapy Provider shall use the current CPT codes with appropriate modifiers and ICD-9 codes, when applicable. The Infusion Therapy Provider shall furnish, upon request at no cost, all information, including progress notes, signed physician's orders, and treatment plans required by the Insurance Board to verify and substantiate the provision of infusion therapy services and the charges for such services if the member and the Infusion Therapy Provider are seeking reimbursement through the Insurance Board.

6.8 The Insurance Board shall reimburse the Infusion Therapy 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 Infusion Therapy Provider shall not charge the member for infusion therapy services denied during the prior authorization procedures described in Article VII, unless the Infusion Therapy Provider has obtained a written waiver from that member. Such a waiver shall be obtained only upon the denial of prior authorization and prior to the provision of those infusion therapy services. The waiver shall clearly state that the member shall be responsible for payment of infusion therapy 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 Infusion Therapy Provider shall adhere to and cooperate with the Insurance Board's prior authorization procedures. These procedures do not guarantee a member's eligibility or that benefits are payable, but assure the Infusion Therapy Provider that the professional services to be provided are covered under the Plan. Failure to obtain prior authorization shall result in the Infusion Therapy Provider's reimbursement being penalized by 10% if medical necessity is confirmed retrospectively and, if not confirmed, there shall be no reimbursement.

7.2 The prior authorization requirements are intended to maximize insurance benefits assuring that infusion therapy services are provided to the member at the appropriate level of care. In no event is it intended that the prior authorization procedure interfere with the Infusion Therapy Provider's decision regarding the patient's care.

7.3 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.

7.4 The Insurance Board shall not retrospectively deny any previously approved care. The Infusion Therapy Provider and/or its 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.

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

7.6 The Infusion Therapy Provider shall request prior authorization from the Insurance Board before providing infusion therapy services. The Infusion Therapy Provider shall be prepared to give the following information:

a) patient's name
b) member's name
c) member's social security number
d) patient's age and sex
e) diagnosis and brief description of case
f) scheduled date services are to begin
g) treatment plan – to include physician's letter of medical necessity, signed physician's orders and estimated duration of service. The written plan must be submitted to the Insurance Board.

VIII. LIABILITY AND INSURANCE

8.1 Neither party to this Contract, the Insurance Board nor the Infusion Therapy 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 Infusion Therapy Provider shall maintain a minimum of $1,000,000 per occurrence of insurance coverage for professional liability.

IX. MARKETING, ADVERTISING AND PUBLICITY

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

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

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

X. DISPUTE RESOLUTION

10.1 The Insurance Board and the Infusion Therapy 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 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 11.2.

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 Infusion Therapy Provider upon:

a) the loss or suspension of the Infusion Therapy Provider's Medicare or JCAHO certification; or
b) failure to maintain the Infusion Therapy 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 Infusion Therapy 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 Infusion Therapy 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 Infusion Therapy 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.

NETWORK PROVIDER FACILITY CREDENTIALING INFORMATION

CONTRACT APPLICATIONS

- HealthChoice requires all three addresses on the respective pages of the application.

1. **Service Address**-This address is used for the location where health care services are performed and/or the physical location of the provider. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all HealthChoice Network Providers
2. **Mailing Address**-This address is used for all correspondence (not related to claims) and credentialing information.
3. **Billing Address**-This address is used for submitting all claims to HealthChoice for processing and appears in box 33 of the CMS-1500 claim form or box 2 on the UB-04. If box 2 is not used by the facility, the billing address appears in Box 1 of the UB-04. Claims will be paid exclusively to the billing address.

- Each address must have a corresponding phone number, fax number and contact person.
- Insurance Certificate/Face Sheet must have name of the applicant listed as the insured. The insurance limits must be at the levels required in the contract and must indicate clearly the coverage type(s) stated in the contract. Product liability coverage in lieu of professional/medical liability is acceptable for DME only.
- W-9 forms must be signed and list only the Tax ID number for each location listed on the application which will be used on claim forms

Please return entire application packet with the new information.

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OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

HealthChoice

Network Facility 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 the application. If an area of inquiry is not applicable to the Facility, 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)**

☐ **Face Sheet of current general and medical liability insurance policy**

Insurance Certificate/Face Sheet must have the name or the Facility listed as the insured. The insurance limits must be at the levels in the Contract and must indicate clearly that it is general and medical liability coverage.

☐ **W-9 form for each Federal Tax Identification Number**

W-9 forms must be signed and list only the Federal tax Identification Number listed on the Application which will be used on claim forms submitted to HealthChoice.

☐ **Contract Signature Page**

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

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

☐ **Copy of Medicare Certification Letter**

☐ **Copy of Joint Commission Accreditation Certificate (if applicable)**

☐ **Copy of AAAHC Accreditation Certificate (if applicable)**

Incomplete Applications will be returned

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

HealthChoice

Network Facility Application

The completed Network Facility Application should be returned to the Oklahoma State and Education Employees Group Insurance Board in its entirety, accompanied by the applicable attachments.

You may mail or fax the completed application to:

Oklahoma State and Education Employees Group Insurance Board
ATTN: Provider Relations/Network Management
3545 NW 58th Street, Ste. 600
Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-800-543-6044
Fax: 1-405-717-8977

GENERAL INFORMATION

Legal Name of Owner:____

Trade Name/dba:____

Medicare Facility Classification:______________________ Medicare Number:____________

LICENSE INFORMATION

State: ______________________________

License Number:______________________________

Expiration Date:______________________________

Copy of facility license is required for each state of practice

ACCREDITATION

Is this Facility accredited by the Joint Commission? ☐Yes ☐No

Joint Commission Program ID Number:______________________________

Date of most current accreditation: ____________________ Expiration Date:____________

ACCREDITATION

Is this Facility accredited by the AAAHC? ☐Yes ☐No

AAAHC Program ID Number: ______________________

Date of most current accreditation:______________ Expiration Date:__________

INSURANCE INFORMATION

Copy of Insurance Certificate/face Sheet is required

Please provide the following information about the Facility's current general and medical liability insurance coverage:

Name of Carrier: ______________________

Limits of General and Medical Liability:

Per Occurrence: ______________

Expiration Date: ______________

IMPORTANT FACILITY CONTACTS

CEO/Administrator: ______________________

Telephone Number: (   ) ______________________

Fax number: (   ) ______________________

Email Address: ______________________

Contracting/Managed Care: ______________________

Telephone Number: (   ) ______________________

Fax Number: (   ) ______________________

Email Address: ______________________

ADDRESS INFORMATION

Federal Tax ID Number:____________________ National Provider Identifier Number: ________________________

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

PHYSICIAL ADDRESS-physical location of the Facility

This address and phone number will appear on the website provider directory

Physical Address: ____

____
(City) (State) (Zip)

Phone: ( ) ______________________ Fax: ( ) ______________________

Contact Person: ____

Email Address: ______________________ Phone: ( ) ______________________

MAILING ADDRESS-for correspondence/credentialing

Mailing Address: ____

____
(City) (State) (Zip)

Phone: ( ) ______________________ Fax: ( ) ______________________

Contact Person: ____

Email Address: ______________________ Phone: ( ) ______________________

BILLING/REMIT ADDRESS – for claim payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED

Name Submitted on Claims: ____

Billing Office Name (if applicable) ____

Billing Address: ____

____
(City) (State) (Zip)

Phone: ( ) ______________________ Fax: ( ) ______________________

Contact Person: ____

Email Address: ______________________ Phone: ( ) ______________________

ADDITIONAL LOCATION

Federal Tax ID Number: ____________________ National Provider Identifier Number: ________________

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

PHYSICIAL ADDRESS-physical location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY

Physical Address: ____

____
(City) (State) (Zip)

Phone: ( ) ____________________ Fax: ( ) ____________________

Contact Person: ____

Email Address: ____________________ Phone: ( ) ____________________

MAILING ADDRESS-for correspondence/credentialing

Mailing Address: ____

____
(City) (State) (Zip)

Phone: ( ) ____________________ Fax: ( ) ____________________

Contact Person: ____

Email Address: ____________________ Phone: ( ) ____________________

BILLING/REMIT ADDRESS – for claim payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED

Name Submitted on Claims: ____

Billing Office Name (if applicable): ____

Billing Address: ____

____
(City) (State) (Zip)

Phone: ( ) ____________________ Fax: ( ) ____________________

Contact Person: ____

Email Address: ____________________ Phone: ( ) ____________________

***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

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

Network Provider Infusion Therapy Contract Signature Page

The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) and the Facility incorporated by reference the terms and conditions of the HealthChoice Network Facility Contract (Contract) located in HCITCv1.1 at http://www.sib.ok.gov/contracts into this Signature Page and acknowledge the Contract is an electronic record created according to 12A O.S. § 15-011 et seq. OSEEGIB and the Facility 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 Facility. The original of the signed document will remain on file in the office of OSEEGIB.

FOR THE FACILITY:

Legal Name of Owner (typed or printed):

____

Trade Name/dba (typed or printed)

____

Address of the Facility:

____

____

City State Zip

Authorized Officer or Representative (typed or printed)

____

Title: ____

Signature: ______________________________________

Signature Date: __________________________________

FOR OSEEGIB:

____

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: 1-405-717-8790 or 1-800-543-6044
Fax: 1-405-717-8977