

**HealthChoice**

**Network Provider**

**Laboratory**

**Contract**

# TABLE OF CONTENTS

I.	RECITALS .....	1
II.	DEFINITIONS.....	1
III.	RELATIONSHIP BETWEEN THE INSURANCE BOARD AND THE LABORATORY.....	2
IV.	LABORATORY SERVICES AND RESPONSIBILITIES.....	3
V.	INSURANCE BOARD SERVICES AND RESPONSIBILITIES .....	4
VI.	COMPENSATION AND BILLING.....	4
VII.	LIABILITY AND INSURANCE .....	6
VIII.	MARKETING, ADVERTISING AND PUBLICITY .....	6
IX.	DISPUTE RESOLUTION .....	6
X.	TERM AND TERMINATION .....	6
XI.	GENERAL PROVISIONS .....	7

APPENDIX:  
SIGNATURE PAGE



## Network Provider Laboratory Contract

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

### I. RECITALS

- 1.1 The Oklahoma 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 Laboratory shall be qualified and duly certified by the Clinical Laboratory Improvement Act of 1988 (CLIA) and certified to participate in the Medicare program under Title XVIII of the Social Security Act, and shall comply with all applicable federal, state, and local laws regulating such a laboratory providing clinical laboratory health services 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 Laboratory for a specific procedure in accordance with the provisions in Article VI of this Contract. The Laboratory 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 facilities 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 "Laboratory Services" means those laboratory services 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 laboratory 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 "Medical Services" means the professional services provided by a Network Laboratory and covered by the Insurance Board's Plan.
- 2.9 "Members" means all persons covered by the Insurance Board's 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.
- 2.10 "Network Laboratory" means a certified provider of laboratory services who has entered into this Contract with the Insurance Board to accept scheduled reimbursement for covered laboratory services provided to members.
- 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 Facilities.
- 2.12 "Third Party Payor" means an insurance company or other entity making payment directly to the Laboratory on behalf of the Insurance Board.

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

- 3.1 The Insurance Board has negotiated and entered into this Contract with the Laboratory on behalf of the members of the State and Education Employees Health Insurance Plan. The Laboratory is an independent contractor who has entered into this Contract to become a Network Laboratory 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 Laboratory agree that all of the parties hereto shall respect and observe the laboratory/patient relationship which will be established and maintained by the Laboratory. The Laboratory may choose not to establish a laboratory/patient relationship if the Laboratory would have otherwise made the decision not to establish a laboratory/patient relationship had the patient not been a member. The Laboratory reserves the right to refuse to furnish services to a member in the same manner as they would any other patient.
- 3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies of any third party, including but not limited to, a member or a Network Provider other than the Laboratory named in this Contract.

#### **IV. LABORATORY SERVICES AND RESPONSIBILITIES**

- 4.1 The Laboratory shall provide quality, medically necessary laboratory services to members, in a cost efficient manner, when such services are ordered by a licensed practitioner of the healing arts, and has been awarded the prerequisite clinical privileges to order and/or perform such services. Nothing in this Contract shall be construed to require medical staff of the Laboratory to perform any procedure or course of treatment which the staff deems professionally unacceptable or is contrary to Laboratory policy.
- 4.2 The Laboratory shall provide laboratory services to members in the same manner and quality as those services are provided to all other patients of the Laboratory.
- 4.3 The Laboratory has, and shall maintain, in good standing while this Contract is in effect, all licenses required by law, and certification to participate in the Medicare program under Title XVIII of the Social Security Act and/or JCAHO certification and certification by the Clinical Laboratory Improvement Amendment.
- 4.4 The Laboratory agrees to make reasonable efforts to refer covered members to other Network Providers with which the Insurance Board contracts, for medically necessary services that the Laboratory cannot or chooses not to provide. Failure of the Laboratory to use Network Providers will result in a review pursuant to the credentialing plan.
- 4.5 The Laboratory shall furnish, at no cost to the Insurance Board, any medical and billing records covering any laboratory services, for any member, with the understanding that each member, as a condition of enrollment in the Oklahoma State and Education Employees Group Insurance Plan, has authorized such disclosure.
- 4.6 The Laboratory shall accurately complete the Network Laboratory Application which is attached to and made part of this Contract. The Laboratory shall notify the Insurance Board 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 Laboratory shall reimburse the Insurance Board for any overpayments made to the Laboratory within 30 days of the Laboratory's receipt of the overpayment notification.

- 4.8 The Laboratory shall submit to a patient record audit upon 48 hours advance notice.
- 4.9 The Laboratory 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 Laboratory 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 Laboratory the status of "Network Laboratory" and to identify the Laboratory as a Network Laboratory on informational materials disseminated to members.
- 5.3 The Insurance Board agrees to continue listing the Laboratory as a Network Laboratory until this Contract terminates.
- 5.4 The Insurance Board agrees to periodically provide the Laboratory access to a listing of all Network Facilities.
- 5.5 The Insurance Board agrees to provide appropriate identification cards for members.
- 5.6 The Insurance Board agrees to acknowledge the 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.

## **VI. COMPENSATION AND BILLING**

- 6.1 The Laboratory 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 Insurance Board shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 The Insurance Board agrees to pay the Laboratory's billed charges for each procedure or the fee set by the Insurance Board for that procedure, whichever is less. This shall be allowed when the member has received medically necessary covered services subject to the following policy limitation and conditions:
  - a) The Insurance Board will pay 80% of the allowable and the member will pay 20% of the allowable unless the member has met the stop loss limitation, and then the Insurance Board shall pay the allowable and the member has no liability.
  - b) The Insurance Board may reduce the payment by any deductibles, coinsurance and copayments.

- c) The Insurance Board shall have the right to categorize what shall constitute a procedure. The Insurance Board's and the member's financial liability shall be limited to the procedure's allowable as determined by the Insurance Board, paid by applying appropriate coding methodology, whether the Laboratory has billed appropriately or not.
  - d) The Laboratory agrees not to charge more for medical services to members than the amount normally charged (excluding Medicare) by the Laboratory to other patients for similar services. The Laboratory may, however, contract with other third party payors for services. The Laboratory's usual and customary charges may be requested by the Insurance Board and verified through an audit.
  - e) The Laboratory shall provide, at no additional charge, all supplies necessary for the collection, preparation and preservation of all specimens to be submitted to the laboratory for testing.
- 6.3 The Laboratory agrees that the only charges which a member may be liable and be billed by the Laboratory shall be for deductibles, coinsurance, copayments or services not covered by the Oklahoma State and Education Employees Health Insurance Plan, or as provided in paragraph 6.4 and 6.9. The Laboratory 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 Laboratory shall not collect amounts in excess of the Plan limits unless the member has exceeded his/her annual or lifetime maximum.
- 6.5 The Laboratory 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 Laboratory shall bill the Insurance Board on forms acceptable to the Insurance Board within 60 days of providing the laboratory services. The Laboratory shall use the current CPT codes with appropriate modifiers and ICD-9 diagnostic codes, when applicable. The Laboratory 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 Laboratory are seeking reimbursement through the Insurance Board. This provision shall not apply in cases involving litigation, multiple payors, or where the patient has failed to notify the Laboratory that they were a member.
- 6.8 The Insurance Board shall reimburse the Laboratory 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 the 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 to covered members at no cost to the Insurance Board or the member.

## **VII. LIABILITY AND INSURANCE**

- 7.1 Neither party to this Contract, the Insurance Board nor the Laboratory, or any agent, employee or other representative of a party, shall be liable to third parties for any act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.
- 7.2 The Laboratory shall be required to obtain general and medical liability coverages for claims of acts and omissions of the Laboratory and its employees and agents. Such coverage shall be maintained at a level of not less than that which is mandated by state statute or less than \$1,000,000 per incident, when the Laboratory is not regulated by statute. The Insurance Board shall be notified 30 days prior to cancellation. If coverage is lost or reduced below specified limits, this Contract may be canceled by the Insurance Board.

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

- 8.1 The Insurance Board shall encourage its members to use the services of the Network Laboratory.
- 8.2 The Insurance Board shall have the right to use the name, address, phone number and specialty of the Laboratory in a provider listing for purposes of informing members and prospective members of the identity of the Laboratory, and otherwise carrying out the terms of this Contract.
- 8.3 The Laboratory, upon prior approval of the Insurance Board, shall have the right to publicize its status as a Network Facility.

## **IX. DISPUTE RESOLUTION**

- 9.1 The Insurance Board and the Laboratory 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.

## **X. 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 10.1 at any time during the term of this Contract.

- 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 Following termination of this Contract, the Insurance Board shall continue to have access, at no cost to the Insurance Board, to the Laboratory'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.
- 10.5 This Contract shall terminate with respect to a Laboratory upon:
  - a) the loss or suspension of the Laboratory's Medicare, JCAHO or CLIA certification;  
or
  - b) failure to maintain Laboratory's professional and general liability coverage in accordance with this Contract.

## **XI. 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 in Section 11.1, the Insurance Board may designate an Administrator to administer any of the terms of this Contract.
- 11.4 This Contract, together with exhibits, contains the entire agreement between the Insurance Board and the Laboratory relating to the rights granted and the obligations assumed by the parties concerning the provision of laboratory 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 or section of 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 Laboratory.
- 11.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract, which 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 determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Contract, or any one provision, in accordance with the intent and purpose of the parties hereto.

11.8 Nothing in this contract shall imply that the Laboratory is obligated to perform any medical procedure which would be contradicted by the Directives for Catholic Health Care Facilities.



**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.**

---

---

# 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 58<sup>th</sup> 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***

---

---

***PHYSICAL 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***

---

---

***PHYSICAL 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. 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)

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

**HealthChoice**  
**Network Provider Laboratory**  
**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 HCLCv1.1 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:**

**FOR OSEEGIB:**

Legal Name of Owner (typed or printed):

\_\_\_\_\_

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

Trade Name/dba (typed or printed)

\_\_\_\_\_

Address of the Facility:

\_\_\_\_\_

City State Zip

Authorized Officer or Representative (typed or printed)

\_\_\_\_\_

Title: \_\_\_\_\_

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

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

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