

**HealthChoice**

**Network Provider**

**Wig/Scalp Prosthesis**

**Contract**

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APPENDIX:  
SIGNATURE PAGE



## **Network Provider Wigs/Scalp Prosthesis Contract**

It is hereby agreed between the Oklahoma State and Education Employees Group Insurance Board and the Wig/Scalp Prosthesis Vendor named on the signature page, that the Wig/Scalp Prosthesis Vendor 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 Wig/Scalp Prosthesis Vendor. It in no way is meant to impact on the Wig/Scalp Prosthesis Vendor's decision as to what is considered appropriate in the delivery of 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 Network Provider is a Wig/Scalp Prosthesis Vendor that is duly licensed by the Board of Cosmetology in the state in which the Wig/Scalp Prosthesis Vendor operates 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 wig/scalp prosthesis for those members who have received chemotherapy/radiation treatment, 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 Wig/Scalp Prosthesis Vendor for a specific product in accordance with the provisions in Article VI of this Contract.
- 2.2 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating Network Providers and other health care providers.
- 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 "Wig/Scalp Prosthesis" means those services provided by a Network Wig/Scalp Prosthesis Vendor that are covered by the State and Education Employees Health Insurance Plan for members who have received chemotherapy/radiation treatment.
- 2.5 "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.

- 2.6 "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 condition, and
  - c) within standards of acceptable, prudent practice within the community, and
  - d) not primarily for the convenience of the member, the member's Wig/Scalp Prosthesis Vendor 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.
- 2.7 "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.
- 2.8 "Network Provider" means a Wig/Scalp Prosthesis Vendor who has entered into this Contract with the Insurance Board to accept scheduled reimbursement for covered wig/scalp prosthesis services provided to members.
- 2.9 "Prior Authorization" means a function performed by the Insurance Board, or its designee, to review for the necessity of a wig/scalp prosthesis prior to services being rendered.
- 2.10 "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.
- 2.11 "Third Party Payor" means an insurance company or other entity making payment directly to the Network Provider on behalf of the Insurance Board.

### **III. RELATIONSHIP BETWEEN THE INSURANCE BOARD AND THE WIG/SCALP PROSTHESIS VENDOR**

- 3.1 The Insurance Board has negotiated and entered into this Contract with the Network Provider Wig/Scalp Prosthesis Vendor on behalf of the individuals who are members of the State and Education Employees Health Insurance Plan. The Network Provider Wig/Scalp Prosthesis Vendor 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 Wig/Scalp Prosthesis Vendor agree that all of the parties hereto shall respect and observe the provider/patient relationship that will be established and maintained by the Wig/Scalp Prosthesis Vendor. The Wig/Scalp Prosthesis Vendor may choose not to establish a provider/patient relationship if the Wig/Scalp Prosthesis Vendor would have otherwise made the decision not to establish a provider/patient

relationship had the patient not been a member. The Wig/Scalp Prosthesis Vendor reserves the right to refuse to furnish services to a member in the same manner as 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 Wig/Scalp Prosthesis Vendor named in this Contract.

#### **IV. WIG/SCALP PROSTHESIS VENDOR SERVICES AND RESPONSIBILITIES**

- 4.1 The Wig/Scalp Prosthesis Vendor agrees to provide quality wig/scalp prosthesis services in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the Wig/Scalp Prosthesis Vendor shall provide wig/scalp prosthesis services to members that are necessary and covered under the Health Insurance Plan.
- 4.3 The Wig/Scalp Prosthesis Vendor agrees to make reasonable effort to refer covered members to other Network Providers. Failure of the Wig/Scalp Prosthesis Vendor to use Network Providers will result in a review pursuant to the credentialing plan.
- 4.4 The Network Provider Wig/Scalp Prosthesis Vendor shall request prior authorization from the Insurance Board before providing wig/scalp prosthesis services. The Network 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) physician's prescription including the diagnosis and type of chemotherapy and/or radiation being utilized in the patient's treatment
  - f) patient status (i.e., employee, dependent)
- 4.5 The Wig/Scalp Prosthesis Vendor shall participate in the prior authorization procedures provided in Articles IV and VII and for purposes of reimbursement and abide by decisions resulting from those reviews subject to rights of reconsideration, review and appeal.
- 4.6 The Wig/Scalp Prosthesis Vendor shall accurately complete the Network Provider Application that is attached to and made part of this Contract. The Wig/Scalp Prosthesis Vendor 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 Wig/Scalp Prosthesis Vendor shall reimburse the Insurance Board for any overpayments made to the Wig/Scalp Prosthesis Vendor within 30 days of the Provider's receipt of the overpayment notification.
- 4.8 The Wig/Scalp Prosthesis Vendor shall submit to a patient record audit upon 48 hours advance notice.

- 4.9 The Wig/Scalp Prosthesis Vendor shall participate in HELP/Wellness promotions sponsored by the Insurance Board under the terms of the promotion.

## **V. INSURANCE BOARD SERVICES AND RESPONSIBILITIES**

- 5.1 The Insurance Board agrees to pay the Wig/Scalp Prosthesis Vendor compensation pursuant to the provisions of Article VI.
- 5.2 The Insurance Board agrees to grant the Wig/Scalp Prosthesis Vendor the status of "Network Provider" and to identify the Wig/Scalp Prosthesis Vendor as a Network Provider on informational materials disseminated to members.
- 5.3 The Insurance Board agrees to continue listing the Wig/Scalp Prosthesis Vendor as a Network Provider until this Contract terminates.
- 5.4 The Insurance Board agrees to periodically provide the Wig/Scalp Prosthesis Vendor 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 Wig/Scalp Prosthesis Vendor shall seek payment only from the Insurance Board for the provision of wig/scalp prosthesis 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 Wig/Scalp Prosthesis Vendor's billed charges for wig/scalp prosthesis services or the fee set by the Insurance Board for those services, 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's financial liability shall be paid by applying appropriate coding methodology, whether the Wig/Scalp Prosthesis Vendor has billed appropriately or not.

- c) The Wig/Scalp Prosthesis Vendor agrees not to charge more for wig/scalp prosthesis services to members than the amount normally charged (excluding Medicare) by the Wig/Scalp Prosthesis Vendor to other patients for similar services. The Wig/Scalp Prosthesis Vendor may, however, contract with other third party payors for services. The Wig/Scalp Prosthesis Vendor's usual and customary charges may be requested by the Insurance Board and verified through an audit.
- 6.3 The Wig/Scalp Prosthesis Vendor agrees that the only charges for which a member may be liable and be billed are as provided in paragraphs 6.2, 6.4 and 6.9. The Wig/Scalp Prosthesis Vendor 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 Wig/Scalp Prosthesis Vendor shall refund within 30 days of discovery to the member any overpayments made by the member.
- 6.5 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.
- 6.6 The Wig/Scalp Prosthesis Vendor shall bill the Insurance Board on forms acceptable to the Insurance Board within 60 days of providing the wig/scalp prosthesis services. The Wig/Scalp Prosthesis Vendor shall bill using the most appropriate codes based on industry guidelines, including the current HCFA Common Procedure Coding System (HCPCS) with appropriate modifiers and ICD-9 codes. The Wig/Scalp Prosthesis Vendor 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 services and the charges for such services if the member and the Wig/Scalp Prosthesis Vendor are seeking reimbursement through the Insurance Board.
- 6.7 The Insurance Board shall reimburse the Wig/Scalp Prosthesis Vendor 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.
- 6.8 The Wig/Scalp Prosthesis Vendor shall not charge the member for services denied during prior authorization procedures described in Article VII, unless the Wig/Scalp Prosthesis Vendor 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 services. The waiver shall clearly state that the member shall be responsible for payment of services denied by the Insurance Board.
- 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.

## **VII. UTILIZATION REVIEW**

- 7.1 The Wig/Scalp Prosthesis Vendor 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 Wig/Scalp Prosthesis Vendor that the services to be provided are covered under the Plan.
- 7.2 Upon the member's request, the Insurance Board shall reconsider any non-approved services. The Wig/Scalp Prosthesis Vendor may submit a formal written appeal to the Insurance Board.
- 7.3 The Wig/Scalp Prosthesis Vendor shall request prior authorization from the Insurance Board or its designee for all wig/scalp prosthesis products.
- 7.4 Prior authorization requirements are intended to maximize insurance benefits assuring that services are provided to the member at the appropriate level. In no event is it intended that the prior authorization procedures interfere with the Wig/Scalp Prosthesis Vendor's decision regarding the appropriate wig/scalp prosthesis products to be provided to the patient.
- 7.5 The Insurance Board shall maintain review procedures and screening criteria that take into account professionally acceptable standards for quality services in the community. The Insurance Board or its designee shall consider all relevant information concerning the member before necessity is approved or denied.

## **VIII. LIABILITY AND INSURANCE**

- 8.1 Neither party to this Contract, the Insurance Board nor the Wig/Scalp Prosthesis Vendor, 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 Wig/Scalp Prosthesis Vendor, at its sole expense, shall maintain a minimum of \$100,000 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 Provider Wig/Scalp Prosthesis Vendor.
- 9.2 The Insurance Board shall have the right to use the name, office address, telephone number and specialty of the Wig/Scalp Prosthesis Vendor for purposes of informing its members and prospective members of the identity of the Network Providers.
- 9.3 The Wig/Scalp Prosthesis Vendor, upon prior approval of the Insurance Board, shall have the right to publicize the Network Provider status in the Insurance Board's Network of Providers.

## **X. DISPUTE RESOLUTION**

10.1 The Insurance Board and the Wig/Scalp Prosthesis Vendor 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 11.2.

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 Wig/Scalp Prosthesis Vendor upon failure to maintain Wig/Scalp Prosthesis Vendor'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 Wig/Scalp Prosthesis Vendor's records of services and products 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 Wig/Scalp Prosthesis Vendor 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 Wig/Scalp Prosthesis Vendor.
- 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.

# 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**

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OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

**HealthChoice**  
**Network Facility Application**

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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

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**GENERAL INFORMATION**

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Legal Name of Owner: \_\_\_\_\_

Trade Name/dba: \_\_\_\_\_

Medicare Facility Classification: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

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**LICENSE INFORMATION**

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State: \_\_\_\_\_

License Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**Copy of facility license is required for each state of practice**

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**ACCREDITATION**

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Is this Facility accredited by the Joint Commission?  Yes  No

Joint Commission Program ID Number: \_\_\_\_\_

Date of most current accreditation: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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**ACCREDITATION**

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Is this Facility accredited by the AAAHC?  Yes  No

AAAHC Program ID Number: \_\_\_\_\_

Date of most current accreditation: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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**INSURANCE INFORMATION**

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

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**IMPORTANT FACILITY CONTACTS**

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CEO/Administrator: \_\_\_\_\_

Telephone Number: (     ) \_\_\_\_\_

Fax number: (     ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Contracting/Managed Care: \_\_\_\_\_

Telephone Number: (     ) \_\_\_\_\_

Fax Number: (     ) \_\_\_\_\_

Email Address: \_\_\_\_\_

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**ADDRESS INFORMATION**

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Federal Tax ID Number: \_\_\_\_\_ National Provider Identifier Number: \_\_\_\_\_

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

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***PHYSICAL ADDRESS-physical location of the Facility***

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

**Physical Address:** \_\_\_\_\_

(City)

(State)

(Zip)

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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***MAILING ADDRESS-for correspondence/credentialing***

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**Mailing Address:** \_\_\_\_\_

(City)

(State)

(Zip)

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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***BILLING/REMIT ADDRESS – for claim payments and remittance statements***

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

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**ADDITIONAL LOCATION**

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Federal Tax ID Number: \_\_\_\_\_ National Provider Identifier Number: \_\_\_\_\_

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

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***PHYSICAL ADDRESS-physical location of the Facility***

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

**Physical Address:** \_\_\_\_\_

(City)

(State)

(Zip)

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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***MAILING ADDRESS-for correspondence/credentialing***

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**Mailing Address:** \_\_\_\_\_

(City)

(State)

(Zip)

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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***BILLING/REMIT ADDRESS – for claim payments and remittance statements***

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**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



**Network Wig/Scalp Prosthesis  
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 HCWSPv1.1 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**