



**Network Provider
Pathology Group
Contract**

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APPENDIX

NETWORK FACILITY APPLICATION REQUIREMENTS
NETWORK FACILITY APPLICATION
ELECTRONIC FUNDS TRANSFER FORM
SIGNATURE PAGE



Network Provider Pathology Group Contract

It is hereby agreed between the Office of Management and Enterprise Services Employees Group Insurance Department (EGID), and the Pathology Group named on the signature page, that the Pathology Group shall be a provider in EGID's network of providers.

This Contract is entered into for the purpose of defining the conditions for reimbursement by EGID to the Pathology Group. It in no way is meant to impact on the Pathology Group's decision as to what is considered appropriate medical treatment.

I. RECITALS

- 1.1 EGID (hereinafter, EGID) is a statutory body created by 74 O.S.2012, § 1301 et seq., as amended, to administer and manage certain insurance benefits for employees of the State of Oklahoma.
- 1.2 The physicians that comprise the Pathology Group are duly licensed by the state of practice and satisfy additional credentialing criteria as established by EGID.
- 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 EGID 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 Pathology Group for a specific procedure in accordance with the provisions in Article VI of this Contract. The Pathology Group shall charge the usual and customary fee unless the fee schedule limits otherwise.
- 2.2 "Concurrent Review" means a function performed by EGID or its designee that determines and updates medical necessity for continued inpatient hospitalization.
- 2.3 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating physicians, physician groups and other health care professionals and facilities.
- 2.4 "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

- jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.
- 2.5 HELP/Wellness (Health Education Lifestyle Planning) means the program established to actively promote responsible behavior and the adoption of lifestyles that are in the best interest of the Plan member's good health.
- 2.6 "Pathology Group Services" means those acute care inpatient and outpatient Pathology Group services that are covered by the Employees Health Insurance Plan.
- 2.7 "Medical" means belonging to the study and practice of medicine for the prevention, alleviation or management of a physical or mental defect, illness, or condition.
- 2.8 "Medically Necessary" means services or supplies that, under the provisions of this Contract, are determined to be:
- a) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
 - b) provided for the diagnosis and treatment of the medical condition, and
 - c) within standards of acceptable, prudent medical practice within the community, and
 - d) not primarily for the convenience of the member, the member's Pathology Group 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.
- 2.9 "Medical Services" means the professional services provided by a Network Pathology Group and covered by EGID's Plan.
- 2.10 "Members" means all persons covered by EGID'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.
- 2.11 "Network Pathology Group" means a Pathology Group that has entered into this Contract with EGID to accept scheduled reimbursement for covered medical services provided to members.
- 2.12 "Network Physician" means a licensed practitioner of the healing arts who has entered into a Contract with EGID to accept scheduled reimbursement for covered medical services provided to members. The Pathology Group must be comprised of practitioners of the healing arts who are duly licensed in the state of practice and satisfy credentialing criteria established by EGID.
- 2.13 "Employees Health Insurance Plan" means the HealthChoice benefit plan designed to enhance the quality of care, and to financially incentivize members to use Network Providers.
- 2.14 "Third Party Payor" means an insurance company or other entity making payment directly to the Pathology Group on behalf of EGID.

III. RELATIONSHIP BETWEEN EGID AND THE PATHOLOGY GROUP

- 3.1 EGID has negotiated and entered into this Contract with the Pathology Group on behalf of the members of the Employees Health Insurance Plan. The Pathology Group, is an independent contractor that 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 EGID 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 EGID and the Pathology Group agree that all of the parties hereto shall respect and observe the physician/patient relationship, which will be established and maintained by the Pathology Group. The Pathology Group may choose not to establish a physician/patient relationship if the Pathology Group would have otherwise made the decision not to establish a physician/patient relationship had the patient not been a member. The Pathology Group 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 Pathology Group named in this Contract.

IV. PATHOLOGY GROUP SERVICES AND RESPONSIBILITIES

- 4.1 The Pathology Group shall provide quality, medically necessary health care services to members, in a cost efficient manner.
- 4.2 For the purposes of reimbursement, the Pathology Group shall provide services to members that are medically necessary and covered under the Health Insurance Plan, in the same manner and quality as those services are provided to all other patients of the Pathology Group.
- 4.3 The Pathology Group agrees to make reasonable efforts to refer covered members to those Network Providers and facilities with which EGID contracts, for medically necessary services that the Pathology Group cannot or chooses not to provide. Failure of the Pathology Group to use Network Providers will result in a review pursuant to the credentialing plan.
- 4.4 The Pathology Group shall prescribe for EGID members medications identified on the adopted formulary or explain, in writing, on behalf of the members of EGID why it is medically inappropriate to do so.
- 4.5 The Pathology Group shall participate in the pre-admission certification, concurrent review and prior authorization procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from that review subject to the rights of reconsideration, review and appeal.
- 4.6 The Pathology Group shall furnish, at no cost to EGID, any medical and billing records covering any Pathology Group services, for any member, with the understanding that each member, as a condition of enrollment in the Education Employees Group Insurance Plan, has authorized such disclosure.

- 4.7 The Pathology Group shall accurately complete the Network Pathology Group Application, which is attached to and made part of this Contract. The Pathology Group shall notify EGID 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.
- 4.8 The Pathology Group shall reimburse EGID for any overpayments made to the Pathology Group within 30 days of the Pathology Group's receipt of the overpayment notification.
- 4.9 The Pathology Group shall submit to a patient record audit upon 48 hours advance notice.
- 4.10 The Pathology Group shall participate in HELP/Wellness promotions sponsored by EGID, at EGID's allowable under the terms of the promotion.

V. EGID SERVICES AND RESPONSIBILITIES

- 5.1 EGID agrees to pay the Pathology Group compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.
- 5.2 EGID agrees to grant the Pathology Group the status of "Network Provider" and to identify the Pathology Group as a Network Provider on informational materials disseminated to members.
- 5.3 EGID agrees to continue listing the Pathology Group as a Network Provider until this Contract terminates.
- 5.4 EGID agrees to periodically provide the Pathology Group with access to a listing of all Network Providers.
- 5.5 EGID agrees to provide appropriate identification cards for members.
- 5.6 EGID 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 EGID shall give a 48 hour notice prior to an audit.
- 5.8 EGID shall maintain prior authorization; precertification and concurrent review programs in order to aid its members in making decisions that will maximize medical benefits and reduce their financial risk.

VI. COMPENSATION AND BILLING

- 6.1 The Pathology Group shall seek payment only from EGID for the provision of medical services except as provided in paragraphs 6.3, 6.4 and 6.9. The payment from EGID shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 EGID agrees to pay the Pathology Group's billed charge for each procedure or the fee set by EGID for that procedure, whichever is less.
 - a) EGID may reduce the payment by any deductibles, coinsurance and copayments.

- b) EGID shall have the right to categorize what shall constitute a procedure. EGID and the member's financial liability shall be limited to the procedures allowable as determined by the EGID, paid by applying appropriate coding methodology, whether the Pathology Group has billed appropriately or not.
 - c) The Pathology Group agrees not to charge more for medical services to members than the amount normally charged (excluding Medicare) by the Pathology Group to other patients for similar services. The Pathology Group may, however, contract with other third party payors for services. The Pathology Group's usual and customary charges may be requested by EGID and verified through an audit.
- 6.3 The Pathology Group agrees that the only charges for which a member may be liable and be billed by the Pathology Group shall be for medical services not covered by Employees Health Insurance Plan, or as provided in paragraphs 6.4 and 6.9. The Pathology Group shall not waive any deductibles, copayments and coinsurance required by EGID, except during times of HELP/Wellness promotions, when the copayment/coinsurance is waived by EGID.
- 6.4 The Pathology Group shall not collect amounts in excess of the Plan limits unless the member has exceeded his/her annual or lifetime maximum.
- 6.5 The Pathology Group 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, EGID shall pay the amounts due under this Contract. In a case in which EGID is other than primary under the coordination of benefit rules, EGID shall pay only those amounts not payable from other sources pursuant to the applicable coordination of benefit rules, up to EGID's maximum liability under the terms of this Contract.
- 6.7 The Pathology Group shall bill EGID on forms acceptable to EGID within 60 days of providing the medical services. The Pathology Group shall use the current CPT codes with appropriate modifiers and ICD or DSM-3 diagnostic codes, when applicable. The Pathology Group shall furnish, upon request at no cost, all information, including medical records, reasonably required by EGID to verify and substantiate the provision of medical services and the charges for such services if the member and the Pathology Group are seeking reimbursement through EGID.
- 6.8 EGID shall reimburse the Pathology Group within 30 days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. EGID will not be responsible for delay of reimbursement due to circumstances beyond EGID's control.
- 6.9 The Pathology Group shall not charge the member for medical services denied during preadmission certification, concurrent review or the prior authorization procedures described in Article VII, unless the Pathology Group has obtained a written waiver from that member. Such a waiver shall be obtained only upon the denial of admission, concurrent review or prior authorization and prior to the provision of those medical services. The waiver shall clearly state that the member shall be responsible for payment of medical services denied by EGID.
- 6.10 EGID 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 EGID or the member.

VII. UTILIZATION REVIEW

- 7.1 The Pathology Group shall adhere to and cooperate with EGID's pre- certification, concurrent review and prior authorization procedures. These procedures do not guarantee a member's eligibility or that benefits are payable, but assure the physician that the medical services to be provided are covered under the Plan.
- 7.2 The Pathology Group, or its representative, shall notify EGID, or its designee, of any admission. The Pathology Group shall request precertification at least three days prior to the scheduled admission. A request for certification shall be made within one working day after an emergency admission or observation stay with duration greater than 24 hours. Such notification shall be at no charge to EGID or the member. Failure to comply with the precertification, concurrent review or prior authorization requirements shall result in the Pathology Group's reimbursement being penalized by 10% if medical necessity is confirmed retrospectively and, if not confirmed there shall be no reimbursement.
- 7.3 The Pathology Group or its representative shall notify EGID or its designee of any outpatient surgical procedure, which is to be accomplished outside the Pathology Group.
- 7.4 The precertification, prior authorization and concurrent review requirements are intended to maximize insurance benefits assuring that hospital and medical services are provided to the member at the appropriate level of care. In no event is it intended that the procedures interfere with the physician's decision to order admission or discharge of the patient to or from the hospital.
- 7.5 EGID shall maintain review procedures and screening criteria that take into account professionally acceptable standards for quality medical care in the community. EGID or its designee shall consider all relevant information concerning the member before medical necessity is approved or denied.
- 7.6 EGID, or its designee, shall respond to requests for precertification by immediately assigning a code number to each request.
- 7.7 At the time of the precertification request the Pathology Group should be prepared to give the following information:
 - a) member's name and social security number,
 - b) age and sex,
 - c) diagnosis,
 - d) reason for admission,
 - e) scheduled date of admission,
 - f) planned procedure or surgery,
 - g) scheduled date of surgery,
 - h) name of hospital,
 - i) name of physician, and
 - j) member status (i.e.: employee, dependent).
- 7.8 EGID shall not retrospectively deny any previously approved care. The Pathology Group and/or its designee shall update EGID, or its designee, as the member's condition or diagnosis changes.

Updated information may result in a change of the originally approved length of stay.

- 7.9 Upon the member's request, EGID shall reconsider any non-approved services. The Pathology Group may submit a formal written appeal to EGID.
- 7.10 The Pathology Group shall request precertification before the admission or referral of members to non-network hospitals. EGID shall review emergency referrals to non-network hospitals to determine whether the admission was medically necessary and an emergency as defined in this Contract.
- 7.11 The Pathology Group shall request prior authorization from EGID or its designee for the following:
- a) solid organ transplantation, including autologous bone marrow transplant/high dose chemotherapy/peripheral stem cell recovery,
 - b) home health care,
 - c) durable medical equipment,
 - d) home infusion therapies,
 - e) mental health/substance abuse (day and residential treatment),
 - f) bone growth stimulators, and
 - g) breast surgeries, implants, reductions and reconstruction.

VIII. LIABILITY AND INSURANCE

- 8.1 Neither party to this Contract, EGID nor the Pathology Group, 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.
- 8.2 The Pathology Group shall be required to obtain general and medical liability coverages for claims of acts and omissions of the Pathology Group and its employees and agents. Such coverage shall be maintained at a level of not less than \$1,000,000 per occurrence and \$1,000,000 aggregate. EGID shall be notified 30 days prior to cancellation. If coverage is lost or reduced below specified limits, this Contract may be canceled by EGID.

IX. MARKETING, ADVERTISING AND PUBLICITY

- 9.1 EGID shall encourage its members to use the services of the Network Pathology Group.
- 9.2 EGID shall have the right to use the name, address and phone number of the Pathology Group in a provider listing for purposes of informing members and prospective members of the identity of the Pathology Group, and otherwise carrying out the terms of this Contract.
- 9.3 The Pathology Group, upon prior approval of EGID, shall have the right to publicize its status as a Network Provider.

X. DISPUTE RESOLUTION

- 10.1 EGID and the Pathology Group agree that their authorized representatives will meet in a timely manner, and negotiate in good faith, to resolve any problems or disputes that may arise in

performance of the terms and provisions of this Contract. Nothing in this Article shall interfere with either party's rights under Article XI.

XI. TERM AND TERMINATION

- 11.1 It is agreed by the parties that no changes to the Contract, which include coverages or fee reimbursements, shall be made with less than 60 days notice to all affected parties, but for in the instance of revisions to injectable medications, in which case EGID shall implement the revisions as soon as possible with proper and timely notification to the Providers.
- 11.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 12.2 at any time during the term of this Contract.
- 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 Following termination of this Contract, EGID shall continue to have access, at no cost to EGID, to the Pathology Group'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.
- 11.5 This Contract shall terminate with respect to a Pathology Group upon:
 - a) the loss or suspension of a license to practice medicine in the state of practice for any of the physicians that comprise the Pathology Group.
 - b) failure to maintain physician's professional liability coverage in accordance with this Contract for each physician that comprises the Pathology Group.
- 11.6 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.

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. The Network Newsletter serves as the primary method by which providers receive all other notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.
- 12.3 Notwithstanding the provisions in Section 12.1, EGID may designate an Administrator to administer any of the terms of this Contract.

- 12.4 This Contract, together with exhibits, contains the entire agreement between EGID and the Pathology Group relating to the rights granted and the obligations assumed by the parties concerning the provision of health care 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 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 EGID and the Pathology Group.
- 12.6 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.
- 12.7 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.
- 12.8 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.
- 12.9 As mandated by HB1086, the Transparency, Accountability, and Innovation in Oklahoma State Government 2.0 Act of 2011, all payments disbursed by the Office of the State Treasurer must be made solely through electronic funds transfer (EFT). Provider/facility hereby agrees to accept EFT payments by July 1, 2013. Provider acknowledges that all health and dental claims received after July 1, 2013, regardless of the date of service, will be denied pending receipt of additional information if EFT payment information is not on file as of July 1, 2013.



**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** – Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.
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, email address, 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.



**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.

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 or bank letter for Electronic Funds Transfers**
- 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.



Network Facility Application

The completed Network Facility Application should be returned to the Office of Management and Enterprise Services Employees Group Insurance Department in its entirety, accompanied by the applicable attachments. You may mail, fax or email the completed application to:

Office of Management and Enterprise Services
Employees Group Insurance Department
ATTN: Network Management
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-844-804-2642
Fax: 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

General Information

Legal Name of Owner: _____
Trade Name/DBA: _____
Medicare Facility Classification: _____ Medicare Number: _____

License Information

State: _____
License Number: _____
Expiration Date: _____

A 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: _____
Is this Facility accredited by the AAAHC? Yes No
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: _____

CFO: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Credentialing Contact: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Address Information

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 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: _____

Mailing Address

Mailing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.

Billing/Remit Address – for claims 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: _____

Additional Location

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 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: _____

Mailing Address- for correspondence/credentialing

Mailing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Billing/Remit Address – for claims 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: _____

Please use copies of these pages to report any additional locations.

HOSPITAL AND NON-HOSPITAL BASED SERVICES; if applicable

Does the Hospital provide the following specialty services?

- | | |
|--|---|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Infusion Therapy |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Long Term Acute Care |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Psych/Substance Abuse |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Independent Diagnostic Testing Facility | <input type="checkbox"/> Sleep Study |

Does the Hospital provide the following services by a group of specialists? If yes, please list the provider group name.

- Anesthesiology Group: _____
- Emergency Physician Group: _____
- Pathology Group: _____
- Radiology Group: _____

Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information

Provider Name: _____
Doing Business As Name (DBA): _____

Provider Address

Street: _____
City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or
Employer Identification Number (EIN): _____
National Provider Identifier (NPI): _____ Provider Type: _____

Financial Institution Information

A VOIDED CHECK OR A BANK LETTER VERIFYING THE ACCOUNT AND ROUTING NUMBERS IS REQUIRED.

Financial Institution Name: _____
Financial Institution Routing Number: _____
Type of Account at Financial Institution: _____
Provider's Account Number with Financial Institution: _____
Account Number Linkage to Provider Identifier: _____
 Provider Tax Identification Number (TIN) or National Provider Identifier (NPI)

You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. Online instructions on how you can determine the status of your EFT enrollment is available at <http://www.ok.gov/sib/Providers/EFT/index.html>

Submission Information

Reason for Submission
 New Enrollment Change Enrollment

Authorized Signature

I hereby authorize the Employees Group Insurance Department (EGID) to initiate credit entries in accordance with HB 1086 Transparency, Accountability and Innovation in Oklahoma State Government 2.0 Act of 2011 to the account indicated above. I hereby authorize the financial institution/bank named above to credit the same to such account.

Written Signature of Person Submitting Enrollment: _____
Printed Name of Person Submitting Enrollment: _____
Printed Title of Person Submitting Enrollment: _____
Submission Date: _____

EFT INSTRUCTIONS

Please complete this EFT form in its entirety. Leaving required fields blank or failing to attach a voided check or bank letter will result in an incomplete application and/or denied claims. If you have any questions regarding the use of this form or any of the information requirements, please contact us using the information listed at the bottom of page 1 of this form. To ensure the security of your information when submitting this form via email, please submit your form and any attachments in an encrypted WinZip file, then submit the password for the WinZip file in a separate email.

THE EFT FORM IS A **MANDATORY** PART OF YOUR ENROLLMENT APPLICATION

Provider Information

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

Provider Address

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (ZIP stands for zone improvement plan) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for EFT with specific provider type description included by the health plan in its instruction and guidance for EFT enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

Financial Institution Information

Financial Institution Name	Official name of the provider's financial institution	Required
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Required
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited	Required
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required

Submission Information

Reason For Submission	Check appropriate box. Please note that EFT cannot be cancelled.	Optional
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Authorized Signature

Written Signature of Person Submitting Enrollment	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment	Required
Printed Name of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Title of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Submission Date	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
	The date on which the enrollment is submitted	Optional



Network Provider Pathology Group Contract
Signature Page

The Office of Management and Enterprise Services Employees Group Insurance Department (EGID), and the Pathology Group incorporated by reference the terms and conditions of the HealthChoice Network Provider Pathology Group Contract (Contract) located in HCPGCv1.8 at www.ok.gov/sib/Providers/Contracts_and_Applications into this Signature Page and acknowledge the Contract is an electronic record created according to 12A O.S. § 15-011 et seq. EGID and the Pathology Group 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 Pathology Group. The original of the signed document will remain on file in the office of EGID.

FOR THE FACILITY:

FOR EGID:

Legal Name of Owner (Typed or Printed)

Diana O'Neal
Deputy Administrator
Employees Group Insurance Department

Trade Name/DBA (Typed or Printed)

Federal Tax ID Number

Address of the Facility:

Authorized Officer or Representative (Typed or Printed)

Title

Signature

Signature Date

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

Office of Management Enterprise Services
Employees Group Insurance Department
ATTN: Network Management
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-844-804-2642
Fax: 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name: _____

Doing Business As Name (DBA): _____

Provider Address

Street: _____

City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _____

National Provider Identifier (NPI) _____ Provider Type: _____

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)

Provider Tax Identification Number (TIN): _____

National Provider Identifier (NPI): _____

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: _____

Clearinghouse Contact Name: _____ Telephone Number: _____

Submission Information

Reason for Submission

New Enrollment

Change Enrollment

Cancel Enrollment

Authorized Signature

I hereby authorize the Office of Management and Enterprise Services Employees Group Insurance Department to send electronic remittance advice (ERA/835) as designated herein. I am authorized to elect Electronic Remittance Advice (ERA) transactions on behalf of the indicated party and I acknowledge the same by signing below.

Written Signature of Person Submitting Enrollment: _____

Printed Name of Person Submitting Enrollment: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____

Please mail, fax or email the completed form or questions to:
Office of Management and Enterprise Services Employees Group Insurance Department
3545 N.W. 58th St, Ste., 110, Oklahoma City, OK 73112
Phone: 405-717-8790 or 800-543-6044 or Fax: 405-717-8977 or 405-717-8702
EGID.EFTEnroll@omes.ok.gov or EGID.NetworkManagement@omes.ok.gov

ERA INSTRUCTIONS

Please complete this ERA Form in its entirety. Leaving any required fields blank will result in an incomplete process. If you have any questions regarding the use of this form, or any of the field requirements, please see our contact information listed at the bottom of page 1 of this form. Information about how to check the status of your ERA is available at www.ok.gov/sib/Providers/Provider_EFT/index.html

Provider Information

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

Provider Address

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for ERA with specific provider type description included by the health plan in its instruction and guidance for ERA enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment	Required
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Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name	Official name of the provider's clearinghouse	Required; i.e., Emdeon This should be the clearinghouse who is currently handling your electronic claims for HealthChoice, Oklahoma Department of Corrections and/or Oklahoma Department of Rehabilitation Services Any request for routing of ERAs to another destination will require additional setup and testing.
Clearinghouse Contact Name	Name of a contact in clearinghouse office for handling ERA issues	Optional
Telephone Number	Telephone number of contact	Optional

Submission Information

Reason For Submission	Check appropriate box.	Required
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Authorized Signature

The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

Required

Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	
Submission Date	The date on which the enrollment is submitted	Optional