Dear Provider:

Thank you for your interest in joining the Mississippi Physicians Care Network's panel of Participating Providers. MPCN, sponsored by the Mississippi State Medical Association, currently has more than 4500 physicians, 110 hospitals and 400+ ancillary providers servicing our clients. MPCN strives to keep competition alive in Mississippi by offering an extensive network that competes with the largest insurance companies in the state. We now represent more than 300,000 lives statewide.

**TO ENROLL:**

- **Complete all applicable items on the APPLICATION CHECKLIST. Failure to include all items on the checklist may result in a delay in the credentialing process.**

- **You should not begin providing services as an MPCN participating provider until your application is processed and you have received confirmation of network approval.**

Return all required materials to:

Mississippi Physicians Care Network
ATTENTION Credentialing / New Enrollment
P. O. Box 1530
Ridgeland, MS 39158-1530

We look forward to your participation with MPCN. If you have any questions regarding the network or our application process, please contact the Credentialing Department at 800-931-8533 or 601-605-4756.

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors**.

## APPLICATION CHECKLIST
## (Allied Health Professionals)

- ☐ $150 Application/Credentialing Fee
  *****Please note there is a $150 annual membership fee*****
- ☐ Signed Allied Services Agreement and completed Application
- ☐ Signed Certification Statement Form (page 10 of Application)
- ☐ Signed Attestation Statement (page 11 of Application)
- ☐ Signed Authorization to Release Form (page 12 of Application)
- ☐ Copy of Board Certification Certificate(s) if applicable
- ☐ Copy of current state license
- ☐ Copy of nurses' protocols (Collaborative Practice Protocol)
- ☐ Copy of current Federal DEA Certificate (if applicable)
- ☐ Copy of CLIA certificate
- ☐ Copy of malpractice policy document. Must show policy number, coverage amount, expiration date, and address of carrier. Verify does not expire within three months.
- ☐ Copy of ECFMG if licensed after 1986 (for Foreign Medical graduates)
- ☐ Copy of W-9
- ☐ Curriculum Vitae – this is required in addition to the application in order to document continuous education and practice dates. Include past five years to present.
- ☐ Any gaps of time six (6) months or greater from professional school or training to the present must be documented.
- ☐ Completed Provider Registration form
- ☐ Verification of NPI number from NPPES NPI Registry

P. O. Box 1530 Ridgeland, MS 39158-1530
TEL: 601-605-4756 800-931-8533 FAX: 601-605-4753

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors.**

# PROVIDER REGISTRATION FORM

- **Name of Provider** _____
- **Social Security Number** _____
- **Tax ID Number** _____
- **National Provider Identifier (NPI)** _____
- **Group NPI** _____
- **Medicaid Identification Number (if applicable)** _____
- **Medicare Number (if applicable)** _____
- **Provider Taxonomy Code** _____
- **CLIA Number** _____
- **State License Number** _____
- **PCP** ☐ **Specialist** ☐
- **Area of Provider Primary Specialty and Secondary Specialty, if any**

  _____
- **Ages seen** _____
- **Group Name, if applicable** _____
- **Languages Spoken by Provider (other than English)** _____
- **Name of Hospital (s) where physician has admitting privileges**

  _____

P. O. Box 1530 Ridgeland, MS 39158-1530
TEL: 601-605-4756 800-931-8533 FAX: 601-605-4753

**Primary Practice Address** _____

_____

**County** _____

**Phone** _____ **Fax** _____

**Billing Address** _____

_____

**Phone Number** _____

**Administration Contact/Office Manager** _____

**Email** _____ **Phone** _____

**Credentialing Contact** _____

**Email** _____ **Phone** _____

**Accounts Payable Contact** _____

**Address (if different from Primary)** _____

**Email** _____ **Phone** _____

P. O. Box 1530 Ridgeland, MS 39158-1530
TEL: 601-605-4756 800-931-8533 FAX: 601-605-4753

# ADDITIONAL LOCATIONS PAGE

**Please complete a form for each physical location. Make copies if necessary**

| Provider Name (As listed on the W-9) | Clinic DBA Name |
|---|---|
| | |

| Tax Id Number | Individual NPI | Group NPI |
|---|---|---|
| | | |

| Office Phone | Office Fax | Email Address |
|---|---|---|
| | | |

| Physical Address | Suite Number |
|---|---|
| | |

| City | State | Zip | County |
|---|---|---|---|
| | | | |

| Office POC | Title/Position | Direct Phone Number |
|---|---|---|
| | | |

| Billing Address | Suite Number |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Mailing Address | Suite Number |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

**Give Form to the requester. Do not send to the IRS.**

Print or type
See **Specific Instructions** on page 2.

**1** Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

**2** Business name/disregarded entity name, if different from above

**3** Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

**Note.** For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

**4** Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

*(Applies to accounts maintained outside the U.S.)*

**5** Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

**6** City, state, and ZIP code

**7** List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

**Social security number**

| | | | – | | | – | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

**or**

**Employer identification number**

| | | – | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

**Sign Here** **Signature of U.S. person** ▶ **Date** ▶

# General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments**. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding.* See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Please check one:

☐ Original Application

☐ Reappointment

# Mississippi Participating Physician Application

This application is submitted to _____, herein, this Managed Care Entity [1].

## SECTION A.

### *Practice, Educational, Licensure and Work History Information*

## I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application.**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

## II. IDENTIFYING INFORMATION

| | | |
|---|---|---|
| Last Name: | First: | Middle: |
| Is there any other name under which you have been known (AKA/Maiden Name)? Name(s): | | |
| Home Mailing Address: | City: | |
| | State: | ZIP: |
| Home Telephone Number: | E-Mail Address: | |
| Home Fax Number: | Pager Number: | |
| Birthday Date: Birth Place (City/State/Country): | Citizenship (If not a United States citizen, please include a copy of Alien Registration Card). | |
| Social Security #: | Gender [2]: ☐ Male ☐ Female | |
| Specialty: | Race/Ethnicity [2] (voluntary): | |
| Subspecialties: **Internal Medicine** | | |

## III. PRACTICE INFORMATION

| | |
|---|---|
| Practice Name (if applicable): | Department Name (if Hospital based): |
| Primary Office Street Address: | Primary Office Mailing Address if different from Street Address: |
| City: State: County: Zip: | City: State: County: Zip: |
| Telephone Number: | FAX Number: |
| Office Manager/Administrator: | Telephone Number: |
| | Fax Number: |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |

[1] As used in the information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

| | |
|---|---|
| Secondary Office Street Address: | City:<br>State: ZIP: |
| Office Manager/Administrator: | Telephone Number:<br>FAX Number: |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |
| Tertiary Office Street Address: | City:<br>State: ZIP: |
| Office Manager/Administrator: | Telephone Number: ( )<br>FAX Number: ( ) |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |
| Handicap Access: ☐ Yes ☐ No | 24 Hour Coverage: ☐ Yes ☐ No |
| Will you accept new patients? ☐ Yes ☐ No | Back office Telephone Number: ( ) |

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

| Name of Network | Address | Reason for Denial or Deselection |
|---|---|---|
| | | |
| | | |
| | | |

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc? ☐ Yes ☐ No

If Yes, please list:

Medical Group(s) / IPA(s) Affiliation:

| | |
|---|---|
| Do you intend to serve as a primary care provider? ☐ Yes ☐ No<br>Do you intend to serve as a specialist? ☐ Yes ☐ No<br>If Yes, please list specialty(s): | Please check all that apply:<br>☐ Solo Practice ☐ Single Specialty<br>☐ Group Practice ☐ Multi Specialty |

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No
If so, please list:

| Name: | Type of Provider: | License Number: |
|---|---|---|
| | | |
| | | |
| | | |

Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) ☐ Yes ☐ No

| Name: | Mississippi Medical License Number: |
|---|---|
| | |
| | |
| | |

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you **do not** perform that are typically associated with your specialty:

Is your practice limited to certain ages? ☐ Yes ☐ NO If Yes, specify limitations:

Do you participate in EDI (electronic date interchange)? ☐ Yes ☐ No
If so, which Network**?**

Do you use a practice management system/software: ☐ Yes ☐ No
If so, which one?

What type of anesthesia do you provide in your group/office?
☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify):

Has your office received any of the following accreditation's, certifications, or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) ☐ Medicare Certification
☐ Mississippi Department of Health Licensure ☐ Other:

## IV. BILLING INFORMATION

Billing Company

Street Address:

City:

State**:**

ZIP:

Contact:

Telephone Number:

Name Affiliated with Tax ID Number:

Federal Tax ID Number:

## V. OFFICE HOURS – Please indicate the hours your office is open:

| Monday 24 HOUR COVERAGE | Tuesday 24 HOUR COVERAGE | Wednesday 24 HOUR COVERAGE | Thursday 24 HOUR COVERAGE | Friday 24 HOUR COVERAGE | Saturday 24 HOUR COVERAGE | Sunday 24 HOUR COVERAGE | Holidays 24 HOUR COVERAGE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)

Answering Service Company:

Telephone Number: ( )

Fax Number: ( )

Mailing Address:

City:

State:

ZIP:

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

## VII. FOREIGN LANGUAGES SPOKEN

| Fluently by Physician: | Fluently by Staff: |
|---|---|
| | |

## VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

| Tax ID #: | Billing Name: | Type of Service Provided: |
|---|---|---|
| | | |

| Do you have a CLIA Certificate? ☐ Yes ☐ No | Do you have a CLIA waiver? ☐ Yes ☐ No |
|---|---|
| Certificate Number: | Certificate Expiration Date: |

## IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

| Medical School: | Degree Received: | Date of Graduation (mm/yy) |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Medical/Professional School: | Degree Received: | Date of Graduation (mm/yy) |
| Mailing Address: | City: | |
| | State & Country | ZIP: |

## X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)

| Institution: | Program Director: | |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Type of Internship: | | |
| Specialty: | From: (mm/yy) | To: (mm/yy) |

## XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

| Institution: | Program Director: | |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Type of Training (e.g. residency, etc) | Specialty: | From: (mm/yy) / To: (mm/yy) |

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

| | | | |
|---|---|---|---|
| Institution: | | Program Director: | |
| Mailing Address: | | City: | |
| | | State & Country: | ZIP: |
| Type of Training (e.g. residency, etc) | Specialty: | From: (mm/yy) | To: (mm/yy) |

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

| | | | |
|---|---|---|---|
| Institution: | | Program Director: | |
| Mailing Address: | | City: | |
| | | State: | ZIP: |
| Type of Training (e.g. residency, etc) | Specialty: | From: (mm/yy) | To: (mm/yy) |

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

## XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which are duly organized and recognized by:
- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

| **Name of Issuing Board**: | **Specialty:** | **Certification Number**: | **Date Certified/ Rectified:** | **Expiration Date (if any):** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you applied for board certification other than those indicated above?
☐ Yes ☐No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? ☐ Yes ☐ No If Yes, Provide details.

## XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

| | | |
|---|---|---|
| Type: | Number: | Expiration Date: |
| Type: | Number: | Expiration Date: |

## XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)

| | | | |
|---|---|---|---|
| Mississippi State Medical License Number: | Issue Date: | Expiration Date: | Active: ☐ Yes ☐ No |
| Drug Enforcement Administration (DEA) Registration Number: Unlimited? ☐ Yes ☐ No If "No", please explain on separate sheet | | Expiration Date: | |
| Controlled Dangerous Substances Certificate (CDS) (if applicable): | | Expiration Date: | |

| ECFMG Number (applicable to foreign medical graduates): | Date Issued: | Valid Through: |
|---|---|---|
| Visa Number: | Date Issued: | Valid Through: |

| Medicare UPIN/National Physician Identifier (NPI): | Mississippi Medicare Number: | Mississippi Medicaid Number: |
|---|---|---|

## XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical licenses now or Previously Held. (Attach additional sheets if necessary. Reference this section number and title.)

| State | License Number: | Expiration Date: | Active: |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| State: | License Number: | Expiration Date: | Active: |
| | | | ☐ Yes ☐ No |
| State: | License Number: | Expiration Date: | Active: |
| | | | ☐ Yes ☐ No |

## XVI. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

| ORGANIZATION NAME | Applicant | Member |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

Are you an Officer or Director of any of the professional organizations listed above?
If Yes, please list: ☐ Yes ☐ No

## XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

| Current Insurance Carrier: | Policy Number: | Original effective date: |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Telephone Number: ( ) | Fax Number: ( ) | |
| Per Claim Amount: $ | Aggregate Amount: $ | Expiration Date: |

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

**If you have had professional liability carriers in the last five years other than the one listed above, please list them below.**

| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
|---|---|---|---|
| Mailing Address: | | City: | |
| | | State and Country:: | ZIP: |
| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
| Mailing Address: | | City: | |
| | | State and Country: | ZIP: |

| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
|---|---|---|---|
| Mailing Address: | | City: | |
| | | State & Country: | ZIP: |
| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
| Mailing Address: | | City: | |
| | | State & Country: | ZIP: |

## XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

### A. CURRENT AFFILIATIONS **(Attach additional sheets if necessary. Reference this section number and title.)**

| Name and Mailing Address of Primary Admitting Hospital: | City: | |
|---|---|---|
| | State: | ZIP: |
| Department/Status (Active, provisional, courtesy, etc.): | Appointment Date: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | ZIP: |
| Department/Status (Active, provisional, courtesy, etc.): | Appointment Date: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | ZIP: |
| Department/Status (Active, provisional, courtesy, etc) | Appointment Date: | |
| If you do not have hospital privileges, please explain. | | |

### B. PREVIOUS AFFILIATIONS **(Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)**

| Name and Mailing Address of Other Hospital/Institution: | City: | |
|---|---|---|
| | State: | ZIP: |
| From: (mm/yy) To: (mm/yy) | Reason for Leaving: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | ZIP: |
| From: (mm/yy) To: (mm/yy) | Reason for Leaving: | |
| Name and Mailing Address of other Hospital/institution: | City: | |
| | State: | ZIP: |
| From: (mm/yy) To: (mm/yy) | Reason for Leaving: | |

| Name and Mailing Address of Other Hospital/Institution: | City: | |
|---|---|---|
| | State: | ZIP: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: |

## XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

| Name of Reference: | Specialty: | Telephone Number: |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |

| Name of Reference: | Specialty: | Telephone Number: |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |

| Name of Reference: | Specialty: | Telephone Number: |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |

## XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

| Current Practice: | Contact Name: | Telephone Number: |
|---|---|---|
| | | Fax Number: |
| Mailing Address: | City: | |
| | State: | ZIP: |
| From: (mm/yy) | To: (mm/yy) | |

| Name of Practice/Employer: | Contact Name: | Telephone Number: |
|---|---|---|
| | | Fax Number: ( ) |
| Mailing Address: | City: | |
| | State: | ZIP: |
| From: (mm/yy) | To: (mm/yy) | |

| Name of Practice/Employer: | Contact Name: | Telephone Number: ( ) |
|---|---|---|
| | | Fax Number: ( ) |
| Mailing Address: | | City: |
| | | State: / ZIP: |
| From: (mm/yy) | To: (mm/yy) | |

# Section B.

## *Professional Liability Action Explanation*

Please complete this section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

## I. CASE INFORMATION

| City, County and State where lawsuit filed: | Court case number, if known: | | |
|---|---|---|---|
| Date of alleged incident serving as basis for the lawsuit/arbitration: | Date Suit Filed: | Sex of patient: | Age of patient: |

Location of Incident:

☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center

☐ Other, (please specify) _____

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consulting, etc.):

Allegation:

Is/was there any insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If Yes, please provide company name, contact person, phone number, location and claim identification number of insurance company or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney to serve as your authorization:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

## II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE ONE)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgement rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgement rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled, no judgement rendered, no payment made on my behalf.

**Summarize** the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include: (1) condition and diagnosis at time of incident. (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. **Please print.**

# SUMMARY

# SECTION C.
## *Certification*

I certify that the information in Section A and B of this application and any attached documents (including my curriculum-vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is not Acceptable)

# Section D.

## *Attestation Questions*

Please answer the following questions "Yes" or "No". If your answer to any question is "Yes" please provide full details on separate sheet.

**1.** Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending**?**

Yes ☐ No ☐

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending**?**

Yes ☐ No ☐

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?

Yes ☐ No ☐

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes ☐ No ☐

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes ☐ No ☐

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?

Yes ☐ No ☐

8. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)

Yes ☐ No ☐

10. Have any judgements or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?

Yes ☐ No ☐

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?

Yes ☐ No ☐

12. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written Notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes ☐ No ☐

13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself, or others? (**A "YES" ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.)**

Yes ☐ No ☐

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services? Yes ☐ No ☐

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

## Section E.
## *Information Release/Acknowledgements*

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Managed Care Entity" and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively. "Healthcare Organizations"), for the purpose of evaluating this applications and any recredentialing application regarding my professional training, experience, character, conduct and judgement, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there by any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including , without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11, and 12 of this application.

Print Name Here:_____

Physician Signature: _____Date_____
(Stamped Signature Is Not Acceptable)

---

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

***This Application is endorsed by:***
- ***Mississippi Association of Health Plans***
- ***Mississippi State Medical Association***
- ***Mississippi Hospital Association***

[3] The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.

**MISSISSIPPI PHYSICIANS CARE NETWORK**
**ALLIED HEALTH PROFESSIONAL SERVICE AGREEMENT**

This SERVICE AGREEMENT ("Agreement") is made and entered into this _____ day of _____, _____, by and between Mississippi Physicians Care Network ("MPCN"), located at 408 West Parkway Place, Ridgeland, MS 39157, and _____, ("Participating Provider"), having his or her principal place of business at _____.

WHEREAS, MPCN's primary objective is to arrange for the provision of high quality, cost effective health care services to Qualified Health Plans and their Covered Individuals; and

WHEREAS, MPCN intends to enter into agreements with Participating Physicians, Hospitals, and other Allied Health Professionals which authorize MPCN to contract with self-insured employers, insurance companies, health and welfare trust funds and other entities ("Companies") which maintain or sponsor health plans; and,

WHEREAS, Participating Allied Health Professional is licensed by the State, and

WHEREAS, MPCN and Participating Provider desire to enter into an agreement whereby Participating Provider agrees to provide Covered Services on behalf of MPCN to Covered Individuals of Qualified Health Plans which contract with MPCN and Participating Provider agrees to comply with certain MPCN administrative requirements and quality assurance, utilization and peer review procedures, in providing such covered services, and

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties agree as follows:

## ARTICLE 1
## Definitions

1.1 Clean Claim. A claim submitted by a Participating Provider in a manner and format prescribed by a Qualified Health Plan for health care services rendered to a Covered Individual which contains all information necessary to process and administer the claim.

1.2 Companies. Any entity which self-insures group health benefits offered to their employees or an insurance company or other entity that has signed an agreement with MPCN for subscriber and eligible dependent coverage under a Qualified Health Plan as a participant in MPCN.

1.3 Covered Individuals. Subscribers, enrollees or members and dependents of the subscriber, enrollee or member to a health plan who are eligible to receive covered services under a Qualified Health Plan which utilizes Participating Providers.

1.4 Covered Services. The medical and other ancillary services and related benefits to which Covered Individuals are entitled under the Evidence of Coverage and for which the Qualified Health Plan provides funding.

1.5 Emergency. The sudden and unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected as determined by a prudent layperson to jeopardize the Covered Individual's life, cause serious injury or impairment of bodily functions, or cause serious injury or permanent dysfunction of any bodily organ or part.

1.6 Evidence of Coverage. A document which explains services and benefits covered by a Qualified Health Plan and defines the rights and responsibilities of the Covered Individual.

1.7 Medically Necessary. Services or supplies determined in good faith and in accordance with the utilization review functions of the companies to be necessary for the diagnosis or treatment of a medical condition, provided in accordance with generally accepted professional standards of medical care, requested and authorized in accordance with the Evidence of Coverage requirements, and not provided primarily for the convenience of the Covered Individual or the Participating Provider.

1.8 Participating Hospital. A hospital which has entered into an agreement with MPCN to provide hospital services to Covered Individuals in accordance with the terms and conditions of the Evidence of coverage.

1.9 Participating Physician. A physician with an unencumbered license to practice medicine or osteopathy in the State of Mississippi who has entered into an agreement with MPCN to provide Covered Services to Covered Individuals.

1.10 Participating Provider. A hospital, other health care facility, pharmacy, or other allied health care professional which has entered into an agreement with MPCN to provide Covered Services to Covered Individuals of Qualified Health Plans.

1.11 Professional Service. Those services which a Participating Provider agrees to make available to Covered Individuals of Qualified Health Plans at rate calculations set forth in Schedule A, attached hereto, when such services are covered under the Qualified Health Plan, and such services are required by a Covered Individual's medical condition. Participating Providers agree to provide medical care and surgical care as appropriate to Covered Individuals within the parameters of their practice or specialty and within existing office schedules and physician settings which they customarily provide for patients who are not Covered Individuals under a Qualified Health Plans.

1.12 Policy Committee. The governing body of MPCN which has full responsibility and authority to act on behalf of MPCN.

1.13 Qualified Health Plan. A group policy issued through a licensed insurance company or a benefit agreement offered by a self-funded organization pursuant to which a Covered Individual has a financial incentive to use Participating Providers of MPCN.

1.14 Self-Insurers. An employer or other entity which provides a self-funded Qualified Health Plan to eligible persons.

1.15 Utilization Review Committee. A committee or committees established by MPCN for (i) conducting clinical credentialing of MPCN Participating Physicians and individual Participating Providers; (ii) assessing and promoting the quality of health care services and related benefits rendered to subscribers or members of Qualified Health Plans; and (iii) reviewing and making determinations regarding whether health care services provided or to be provided to Covered Individuals by Participating Providers or Providers in connection with the Evidence of Coverage is medically necessary, and regarding whether such services are Covered Services.

1.16 Utilization Review Procedures. A utilization management program and procedures established to review the medical necessity of Covered Services furnished by Participating Hospitals, Physicians and other Providers to Covered Individuals of Qualified Health Plans on an inpatient and outpatient basis. Such program and procedures shall be established by MPCN in its sole and absolute discretion and shall include pre-admission, concurrent and retrospective review and shall be in addition to any utilization management program required by the conditions or provisions of a contracting Qualified Health Plan.

## ARTICLE 2
## Covered Individual Eligibility

2.1 Eligibility and/or scope of Covered Services offered by Companies in Qualified Health Plans and performed by Participating Providers, as determined by Companies, should be confirmed according to procedures designated on the Covered Individual's enrollment card.

## ARTICLE 3
## Contracting with Participating Providers

3.1 MPCN shall establish and maintain a panel of Participating Providers who will provide Covered Services to Covered Individuals upon the terms and conditions set forth herein. MPCN shall use its best efforts to assure that all major medical specialties are included among the Participating Providers and that Participating Providers include physicians who provide primary care services and who are readily accessible to Covered Individuals residing throughout the MPCN service area. The parties recognize that the Participating Providers may vary from time to time. MPCN will provide Companies with copies of a directory listing the names and addresses of all Participating Providers.

## ARTICLE 4
## Referral to Participating Providers

4.1 Participating Provider agrees, whenever reasonably and medically appropriate, to admit to a Participating Hospital and to refer Covered Individuals to other Participating Providers when referrals are medically necessary.

## ARTICLE 5
## Participating Provider Billing Procedures

5.1 Participating Provider agrees to submit claims on all Covered Services directly to entity designated on Covered Individual's enrollment card within ninety (90) days from the date the service or services were rendered to Covered Individual in accordance with Schedule A. Claims shall be submitted on a standard HCFA Form 1500 or other paper or electronic format acceptable to payer and shall include gross charges for all services rendered identified by CPT code.

5.2 Participating Provider agrees to accept as payment in full for Covered Services rendered to a Covered Individual fees as set forth in Schedule A. Participating Provider may only bill the Covered Individual for any co-payment, deductible or co-insurance required by the Qualified Health Plan.

5.3 Participating Provider may bill a Covered Individual for services that are not Covered Services under the Covered Individual's Qualified Health Plan.

5.4 Participating Provider agrees that all payments shall be made subject to medical necessity provisions based on valid medical need and subject to MPCN Utilization Review and procedure. Participating Provider agrees to hold the Covered Individual, MPCN and Companies harmless for any and all fees associated with reimbursement determinations for Covered Services.

5.5 This provision shall survive the termination of this Agreement on services rendered while this Agreement was in effect.

## ARTICLE 6
## Payment to Participating Providers

6.1 Companies, under an agreement with MPCN, shall cause automatic assignment of benefits and pay directly to the Participating Provider for Covered Services.

6.2 Companies, under an agreement with MPCN, shall remit payment for a clean claim as specified in Schedule A within forty-five (45) days from the date of receipt of the clean claim for services rendered by a Participating Provider.

6.3 Participating Providers will be provided with each approved payment an explanation of the payment for the Participating Provider's services rendered to Covered Individuals. The explanation of payment shall identify any portion of the bill or claim which has been disallowed as non-covered or covered but deemed medically inappropriate or unnecessary, any amounts of applicable co-payments and any amounts paid by others through Coordination of Benefits.

6.4 Participating Provider agrees to cooperate with Companies or their agents in coordinating benefits with other payers. Participating Providers will make a reasonable effort to determine whether any other payer has primary responsibility for the payment of a claim for Covered Services that was rendered to a Covered Individual. If, after Participating Provider has been paid a claim it is determined that another payer is primarily responsible for all or a portion of the claim, Participating Provider agrees to refund to Company or its agent the amount paid or to be paid by the primary payer.

## ARTICLE 7
## Utilization Review

7.1 Participating Provider agrees to participate in and comply with the requirements of the utilization review, quality improvement, peer review, credentialing and recredentialing, grievance procedures and other utilization management programs established by MPCN.

7.2 Utilization review may include pre-admission, concurrent and retrospective review of claims and the medical records of Covered Individuals.

7.3 Participating Providers shall not charge for copies of medical records required by MPCN for utilization review.

7.4 All negative utilization review determinations will be rendered by a Participating Provider who is a member of MPCN.

7.5 Within thirty (30) days of receipt of notice of a negative determination, Participating Provider may request, in writing, a reconsideration of the negative determination by the MPCN Appeals Committee, which shall be comprised of other Participating Providers with the same or similar credentials and experience as the Participating Provider requesting review. The Appeals Committee shall render a determination within thirty (30) days of receipt of the written request from the Participating Provider seeking review.

7.6 Participating Provider agrees that MPCN determinations are merely advisory and that final determination as to whether services shall be reimbursed under any Qualified Health Plan shall be the sole responsibility of the Companies acting with the advice of MPCN.

7.7 Participating Provider agrees that Companies shall have the authority to reduce or omit payment to the extent that review has identified Covered Services that were not medically necessary or appropriate or were not otherwise Covered Services.

7.8 If the Participating Provider has obtained pre-certification of medical necessity, the payer shall accept the determination of medical necessity for payment purposes, unless the Participating Provider has information showing no medical necessity and failed to disclose this or failed to present complete and accurate information. MPCN may review and determine at any time if further treatment is medically necessary.

7.9 Pre-certification or any other determination of medical necessity does not guarantee payment, which may be denied by Companies for reasons other than medical necessity.

## ARTICLE 8
## Confidentiality

8.1 The Participating Providers, MPCN and the Companies shall maintain the confidentiality of the records of Covered Individuals and related information to the maximum extent required by applicable federal, state and local laws.

8.2 MPCN and the Companies agree to maintain the confidentiality of any information provided them under the Utilization Review programs and to use such information only for appropriate insurance and/or plan review purposes, unless specifically authorized otherwise by a Covered Individual or Participating Provider.

## ARTICLE 9
## Patient Relationship

9.1 It is understood and agreed to by the parties that each Participating Provider shall maintain an independent Provider/patient relationship with each Covered Individual and shall be solely responsible to such Covered Individual for his or her treatment. Nothing herein shall be construed to require any Participating Provider to take any action, or refuse to take any action inconsistent with professional judgment.

## ARTICLE 10
## Use of Names, Trademarks and Logos

10.1 The Companies and MPCN may identify in advertising and publications and information distributed to Covered Individuals, the names and addresses of all Participating Providers at which Covered Services are available under a Qualified Health Plan.

10.2 The Participating Provider, by executing this Agreement, provides his or her consent for the Companies to use his or her name and address in all such advertising, publications and information distributed to Covered Individuals and Companies agree to cease the distribution of all materials and the use of any advertising which includes the name and address of the Participating Provider upon the termination of this agreement.

10.3 Under an agreement with MPCN, the Companies agree to permit MPCN and the Participating Providers to identify each employer who agrees to offer a Qualified Health Plan to their eligible employees in any advertising and publications.

10.4 The Companies stipulate in that agreement the use of any symbols, trademarks, or protected service marks may not be used in any form by MPCN or the Participating Providers without the Companies respective and individual written permission.

10.5 The use of the employer name or any trademark, symbol or service mark shall automatically cease at the time the Companies cease to offer its employees a Qualified Health Plan or when the agreement with MPCN is terminated.

## ARTICLE 11
## Liability

11.1 MPCN will be liable for any claims, actions, damages or litigation arising solely from any negligent, fraudulent or dishonest acts of MPCN.

11.2 The Participating Provider will be liable for any claims, actions, damages or litigation arising solely from any negligent, fraudulent or dishonest acts of the Participating Provider.

11.3 The Companies, under an agreement with MPCN, acknowledge their liability for payment of all legitimate health care claims from Participating Providers for Covered Services rendered to Covered Individuals which are medically necessary in addition to any claims, actions, damages or litigation arising solely from any negligent, fraudulent, or dishonest act of the Companies.

## ARTICLE 12
## Insurance

12.1 Each Participating Provider, at their sole and individual expense, shall maintain professional liability insurance with limits of no less than one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate.

12.2 Each Participating Provider and MPCN shall maintain such other insurance as shall be necessary to insure each other, their respective agents and employees against damages arising from their respective duties and obligations under this Agreement or that which would impair their individual ability to carry out the terms of the this Agreement.

## ARTICLE 13
## General Provisions

13.1 Notices. Any notice required by this Agreement shall be given only in written form, sent by United States mail, return receipt requested, with postage prepaid and addressed to

MPCN at Post Office Box 1530, Ridgeland, MS 39158-1530 and to Participating Provider at his or her last known address. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt.

13.2 Severability. The invalidity of any term or provision of this Agreement shall not affect the validity of any other term or provision of this Agreement.

13.3 Waiver. Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

13.4 Amendment. This Agreement may be amended only by the written mutual consent of both parties.

13.5 Assignment. This Agreement shall be binding upon, and shall inure to the benefit of the parties to it, their respective heirs, legal representative, successors and assigns. Notwithstanding the foregoing, neither party may assign any of their respective rights or delegate any of their respective duties hereunder without receiving the prior written consent of the other party.

13.6 Headings. Headings are solely for convenience and shall not be used in interpreting the text of this Agreement.

13.7 Attorney's Fees. In the event either party initiates legal action with respect to the interpretation or performance of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees and costs as the court may award.

13.8 Independent Contractor. MPCN, the Companies and Participating Providers, their agents and employees respectively, are at all times acting and performing as independent contracts in the performance of their obligations under this Agreement.

13.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Mississippi.

13.10 Healthcare Insurance Portability & Accountability Act Both parties agree, solely to the extent applicable to the terms of this agreement to comply with the Healthcare Insurance Portability and Accountability Act of 1996 (HIPPA) regulations and rules regarding access to personal information for the transmission of healthcare data including but not limited to the Standards for Electronic Transactions and Code Sets, Privacy and Individually Identifiable Health Information, Security and Electronic Signatures, National Standard Health Care Identifier, and National Standard Employer Identifier. Both parties agree to be in compliance with Standards published as the "Final Rule" in the Federal Register not later than the compliance implementation date furnished by the Department of Health & Human Services.

13.11 Entire Agreement. This Agreement, including Schedule A, constitutes the entire agreement between the parties and as of the effective date hereof supersedes all other agreements and understandings between the parties with respect to the subject matter hereof.

## ARTICLE 14
## Term and Termination

14.1 This Agreement shall become effective on the date first written above and shall be effective for a period of twelve (12) months thereafter. This Agreement shall automatically be renewed for successive periods of twelve (12) months each on the same terms and conditions contained herein, unless sooner terminated pursuant to the terms of this Agreement.

14.2 Either party may notify the other party in writing of its intention to terminate this Agreement. Such written notice shall be provided at least thirty (30) days prior to the date of termination.

14.3 Notwithstanding any other provision of this Agreement, MPCN shall have the right to cancel this Agreement immediately in the event the Participating Provider shall be determined by MPCN in its sole and absolute discretion to be in violation of or failing to comply with any of the requirements of this Agreement after thirty (30) days written notice and failure to comply.

14.4 This Agreement will automatically terminate on the earlier of:

(1) The date legislation is effective or any court interprets a law so as to prohibit the continuation of this Agreement; or
(2) The date on which MPCN or the Participating Provider ceases doing business, or files for protection in the U. S. Bankruptcy Court.

14.5 In the event this Agreement is terminated for any reason, the Companies, under a separate agreement with MPCN, agree to continue to make payments to a Participating Provider in accordance with the terms and conditions of this Agreement until the Covered Services being rendered are completed consistent with existing medical ethical and legal requirements for providing continuity of care to a patient unless MPCN or the Companies make reasonable and medically necessary provision for the assumption of such Covered Services by another Participating Provider.

14.6 Unless otherwise required by law, Participating Provider agrees that any MPCN decision to terminate this Agreement pursuant to any Utilization Review decision shall be subject to those appeal rights that are developed by MPCN and are in compliance with State and federal law.

EXECUTED on the date and year first above written.

**Mississippi Physicians Care Network**

By:_____
Scott Dennis

Title: Chief Executive Officer

Date Signed_____

**Participating Provider**

By:_____
Signature

Name: _____
Please Print

Tax ID #: _____

Date Signed: _____

## SCHEDULE A

### 1. REIMBURSEMENT SCHEDULE

Participating Provider shall submit, within ninety (90) days of date of service to COMPANY, his/her claim for Covered Services rendered to Covered Individuals consistent with Article 2 of this AGREEMENT according to each COMPANY'S contract year. Claims submitted after ninety (90) days from contract year will be denied. Such services shall show gross charges for all Covered Services rendered identified by code as it appears in the current Provider's Current Procedural Terminology (CPT). Claims shall be submitted on standard HCFA 1500 Universal Claims Forms or on other forms or using electronic media acceptable to MPCN.

Participating Provider claims for Covered Services shall be paid within 45 calendar days upon receipt unless one of the following has occurred:

1. The claim form is incomplete or incorrect;

2. Billing of services rendered is not consistent with current CPT;

3. Services rendered are subject to Coordination of Benefits (COB) and/or Utilization Review; or

4. Covered Individual's eligibility is under review.

Companies shall pay to Participating Provider the lesser of his/her usual and customary fee or the MPCN fee maximum for the Covered Service rendered for all services that are payable in accordance with the AGREEMENT.

Payment on all claims shall be subject to medical necessity provisions in the Covered Individual's certificate of coverage and payments for Covered Services rendered to Covered Individuals are to be provided only when the services are based on valid medical needs. The Participating Provider agrees to hold the Covered Individual harmless for fees associated with such Covered Services which have been determined to be medical unnecessary.

### 2. FEE MAXIMUMS (UCR)

Fee maximums are established for each eligible CPT procedure code submitted. These maximums will be representative of the general experience accumulated for medical services rendered by the network of Participating Providers.