



## Physician Membership Application Packet

*Pre-Hire Screening must be completed and approved (if in KHF Malpractice Program) before completing the application packet.*

Enclosed is the new membership application packet for Kids Health First Pediatric Alliance. The following items need to be completed and preferably returned by email to [credentialing@khfirst.com](mailto:credentialing@khfirst.com). If email is unavailable, documents may also be faxed (770-333-1725) or sent by US. Mail:

KIDS HEALTH FIRST PEDIATRIC ALLIANCE  
Attn: Credentialing Coordinator  
2480 Briarcliff Road NE  
Suite 6-334  
Atlanta, GA 30329

### ITEMS THAT NEED TO BE COMPLETED AND/OR SIGNED:

- ☐ Georgia Uniform Healthcare Practitioner Application Parts I & II (Please complete all sections, attach all requested documents, have physician answer attestation questions, and sign/date in all required spaces. **Please include full separate page explanations for all "yes" answers to attestations questions.**)
- ☐ One original, completed, signed, and dated copy of the CIGNA Election to Participate Form
- ☐ IRS W-9 Form, completed.
- ☐ Aetna Individual Provider Addendum (Contract between physician and Aetna – required by Aetna for contract participation. Have physician sign/date if you wish them to participate in Aetna contract)
- ☐ Peach State Medicaid CMO Health Plan Physician Participation Attestation (Contract between physician and Peach State – required by Peach State for Medicaid CMO contract participation. Have physician sign/date if you wish them to participate in the Peach State Medicaid CMO contract)

☐ Physician Supplemental Information Form contains additional data fields required for CareSource/Peach State Health Plans participation submission.

☐ Kids Health First Participating Physician Agreement (Contract between the physician and Kids Health First, please have new physician sign/date on pages 13 and 16)

**CREDENTIALING DOCUMENTS REQUIRED:**

☐ Complete CV showing entire education and job history to the present  
**(6-month gaps must be explained)**

☐ Legible copy of physician's current Georgia State Medical License

☐ Legible copy of physician's current DEA Certificate

☐ Legible copy of physician's current ABP Board Certificate  
**(if not Board Certified, please send complete contact information for verification of residency)**

☐ Legible copy of physician's current Malpractice Certificate for your practice (must include retro date, must be for your practice)

☐ Complete listing of hospital admitting privileges for all local hospitals **(new providers cannot be credentialed without local hospital privileges)**

☐ Completed IRS W-9 Form **(completed for the Physician at each location)**

**IMPORTANT!** Providers are responsible for initiating and updating information with Medicaid. KHF does not have access to GAMMIS accounts and cannot make updates for providers.

***Please retain a copy of all completed applications for your records. If you have any questions, please contact Kathryn Glass at (770) 333-0033, Ext. 203.***



# **GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM**

Please contact the Hospital, Health Plan or other Healthcare Organization, hereinafter "Healthcare Entity(ies)", to which you are applying for instructions on how to proceed. The Healthcare Entity may not have adopted this form for use and/or may require a pre-application prior to submitting this form.

**This Application has been designed and organized into two main parts: Part One and Part Two.**

**Part One is standardized for Healthcare Entity(ies), and contains identical questions that Healthcare Entities need to ask as a part of their credentialing processes. Part One is available on the Georgia Uniform Healthcare Practitioner Credentialing Application Form (UHPCAF) web site at [www.georgiacredentialing.org](http://www.georgiacredentialing.org).**

**Part Two for health plans is standardized and contains additional identical questions that health plans need to ask as part of their credentialing processes and, is also available at [www.georgiacredentialing.org](http://www.georgiacredentialing.org).**

**Part Two for hospitals contains additional, customized or more specific questions as part of their credentialing and privileging processes.**

## **PREPARED AND ENDORSED BY MEMBERS OF:**

**GHA/AN ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS  
GEORGIA IN-HOUSE COUNSEL ASSOCIATION  
GEORGIA ASSOCIATION MEDICAL STAFF SERVICES  
GEORGIA ASSOCIATION OF HEALTH PLANS**

# GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

**Prior to completing this Application, please read and observe the following:**

## GENERAL INSTRUCTIONS

- Please type or print legibly your responses.
- Please note that modification to the wording or format of this Application will invalidate it.
- All information requested must be FULLY and TRUTHFULLY provided.
- Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- If an entire section does not apply to you, then please check the box provided at the top of the section. If a particular question does not apply to you, then write "N/A" in the answer blank. If there are multiple, repetitive answer blanks in a particular section (as, for example, in the section entitled "Residencies and Fellowships"), it is not necessary to mark "N/A" in each unneeded answer blank.
- Unless *specifically permitted* by a particular question, please understand that a reference to "See CV" for an answer is not appropriate.
- **If more space than is provided on this Application is needed in order to answer a question completely, use the attached Explanation Form as necessary. Make as many copies of the Explanation Form as needed to fully answer each question. Include the section and page number of the question being answered as well as your name and Social Security Number on each Explanation Form. Attach all Explanation Forms to this Application.**
- After **Part One** of the Application has been completed in its entirety but *before* you sign and date it or fill in the information on page **ii**, make a copy of the Application to retain in your files and/or computer for future use.  
In so doing, at the time of a submission to another Healthcare Entity, all you will need to do is to check to ensure that all the information remains complete, current and accurate before completing page **ii** and signing and forwarding the Application as needed.
- Any gaps of time greater than thirty (30) days from completion of medical school to the present date must be accounted for before your Application will be considered complete.
- Please sign and date the Application.
- Please sign and date Schedule A, Schedule B and Schedule C (as appropriate).
- Identify the Healthcare Entity to which you are submitting this Application and for what practice area(s) you are applying in the spaces provided on page **ii**.
- Mail the Application, Schedules, any Explanation Form(s) prepared in order to answer any question(s) completely, as well as a copy of all applicable enclosures listed on page **ii** to the Healthcare Entity.

## **GENERAL INSTRUCTIONS - continued**

**A current copy of the following documents must be submitted with your Application:**

- One recent passport size photograph of yourself
- State Professional License(s)
- Federal Narcotics License (DEA Registration)
- Curriculum Vitae with complete professional history in chronological order (month & year)
- Diplomas and/or certificates of completion (e.g. medical school, internship, residency, fellowship, etc.)
- Diplomate of National Board of Medical Examiners or Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable)
- Specialty/Subspecialty Board Certification or letter from Board(s) stating your status (if applicable)
- Declaration Page (Face Sheet) of Professional Liability Policy or Certificate of Insurance
- Permanent Resident Card or Visa Status (if applicable)
- Military Discharge Record (Form DD-214) (if applicable)

Name of Healthcare Entity to which you are submitting this Application:

For what type of relationship (i.e., staff membership, network participation, etc.):



# GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

\*\*\*\*\**PART ONE*\*\*\*\*\*

**If more space than is provided on this Application is needed in order to answer a question completely, please use the attached Explanation Form as necessary.**

|                                                                                                                                                                                |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| <b>I. IDENTIFYING INFORMATION</b> <i>Please provide the practitioner's full legal name.</i>                                                                                    |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
| Last Name (include suffix; Jr., Sr., III):                                                                                                                                     |                          | First:                                          |                                                                                                     | Middle:                                                                                                                                   |                                |
| Degree(s):                                                                                                                                                                     |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
| Is there any other name under which you have been known or have used (e.g. maiden name)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Name(s) and Date(s) Used: |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
| Home Street Address:                                                                                                                                                           |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
| City:                                                                                                                                                                          |                          | State:                                          |                                                                                                     | Zip:                                                                                                                                      |                                |
| Home Telephone Number: ( ) -                                                                                                                                                   |                          | E-Mail Address: @                               |                                                                                                     | Citizenship (if not USA, provide type and status of visa and enclose a copy)                                                              |                                |
| Date of Birth: / /                                                                                                                                                             |                          | Place of Birth:                                 |                                                                                                     | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female                                                                     |                                |
| Social Security Number: - -                                                                                                                                                    |                          | UPIN:                                           |                                                                                                     | National Provider Identifier (NPI) (Type 1 Only):                                                                                         |                                |
| Medicare Provider Number:                                                                                                                                                      |                          | Georgia Medicaid Provider Number(s):            |                                                                                                     | Other State Medicaid Provider Number:                                                                                                     |                                |
| Georgia License Number:                                                                                                                                                        | Expiration Date mm/yy: / | Drug Enforcement Administration Registration #: | Expiration Date mm/yy: /                                                                            | Controlled Substance Registration Number                                                                                                  | Date Issued (if applicable): / |
| Marital Status (optional):<br><input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widow             |                          | Name of Spouse (if applicable) (optional):      |                                                                                                     | <u>Medical Specialty for Which Applying</u><br>Primary:<br>Secondary:                                                                     |                                |
| <b>II. PRACTICE INFORMATION</b>                                                                                                                                                |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
| <b>A. NAME OF PRIMARY CLINICAL PRACTICE:</b>                                                                                                                                   |                          |                                                 | Type of Practice Setting:<br><input type="checkbox"/> Solo<br><input type="checkbox"/> Group/Single | Specialty:<br><input type="checkbox"/> Group/Multi-Specialty<br><input type="checkbox"/> Hospital Based<br><input type="checkbox"/> Other |                                |
| Primary Clinical Practice Street Address:                                                                                                                                      |                          |                                                 | Start Date at Location (mm/yy): /                                                                   |                                                                                                                                           |                                |
| City:                                                                                                                                                                          |                          | County:                                         | State:                                                                                              | Zip:                                                                                                                                      |                                |
| Primary Office Telephone Number: ( ) -                                                                                                                                         |                          | Primary Office Fax Number: ( ) -                |                                                                                                     | Patient Appointment Telephone Number: ( ) -                                                                                               |                                |
| Mailing Address (if different from above):                                                                                                                                     |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
| Name of Office Manager /Administrative Contact:                                                                                                                                |                          | Office Manager's Telephone Number: ( ) -        |                                                                                                     | Office Manager's Fax Number: ( ) -                                                                                                        |                                |
| Answering Service Number: ( ) -                                                                                                                                                |                          | Pager/Beeper Number: ( ) -                      |                                                                                                     | Office E-Mail Address: @                                                                                                                  |                                |
| Credentialing Contact and Address (if different from above):                                                                                                                   |                          |                                                 |                                                                                                     |                                                                                                                                           |                                |
| Credentialing Contact's Telephone Number: ( ) -                                                                                                                                |                          |                                                 | Credentialing Contact's Fax Number: ( ) -                                                           |                                                                                                                                           |                                |
| Federal Tax ID Number for this Practice Address:                                                                                                                               |                          |                                                 | Name Affiliated with Tax ID Number:                                                                 |                                                                                                                                           |                                |

**II. PRACTICE INFORMATION - continued**Does Not Apply ☐**NAME OF SECONDARY CLINICAL PRACTICE:**

Type of Practice Setting:

- ☐
- Solo
- 
- ☐
- Group/Single

Specialty:

- ☐
- Group/Multi-Specialty
- 
- ☐
- Hospital Based
- 
- ☐
- Other

Secondary Clinical Practice Street Address:

Start Date at Location (mm/yy): /

City:

County:

State:

Zip:

Answering Service Number: ( ) -

Pager/Beeper Number: ( ) -

Office E-Mail Address:  
@

Federal Tax ID Number for this Practice Address:

Name Affiliated with Tax ID Number:

**B. OTHER OFFICES:** Please list any other current office locations with the above information on Explanation Form(s).**C. BILLING ADDRESS:** If different than primary clinical site address, please provide complete billing address:

Name of Office Manager/Administrative Contact:

Office Phone Number:  
( ) -Office Fax Number:  
( ) -**D. INTENTION:** If you are not currently in practice, please describe your intentions regarding beginning and/or reinstating your practice.**E. CORRESPONDENCE:** To what address would you like all correspondence forwarded?

- ☐
- Primary Office
- ☐
- Secondary Office
- ☐
- Billing Office
- ☐
- Home
- ☐
- Other (Please specify)

**F. LANGUAGES:**

1. Please list any language other than English (including sign language) in which you are fluent:
2. Please list any language other than English (including sign language) in which a member of your staff is fluent and identify staff member:

**III. BOARD CERTIFICATION/RECERTIFICATION**Are you board certified? ☐ YES ☐ NO List all current and past board certifications.

| Name of Issuing Board | Specialty | Date Certified (mm/yy): | Date Recertified (mm/yy): | Date Recertified (mm/yy): | Expiration Date (if any) (mm/yy): |
|-----------------------|-----------|-------------------------|---------------------------|---------------------------|-----------------------------------|
|                       |           | /                       | /                         | /                         | /                                 |
|                       |           | /                       | /                         | /                         | /                                 |
|                       |           | /                       | /                         | /                         | /                                 |

Please answer the following questions. Attach Explanation Form(s), if necessary.

|    |                                                                                                                                               |                                                          |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| A. | Have you ever been examined by any specialty board, but failed to pass? If yes, please provide name of board(s) and date(s):                  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| B. | 1. If you are not currently certified, have you applied for the certification examination?                                                    | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|    | 2. If you have not applied for the certification examination, do you intend to apply for the certification examination? If yes, when? Date: / | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|    | 3. If you have applied for the certification examination, have you been accepted to take the certification examination?                       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|    | 4. If you have been accepted, when do you intend to take the certification examination?                                                       | Date: /                                                  |
|    | 5. If you do not intend to apply for the certification examination, please attach reason on Explanation Form(s)                               |                                                          |

### III. BOARD CERTIFICATION / RECERTIFICATION - continued

|    |                                                                                                                                                                                                                                                                                                             |                                                          |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| C. | If you are not currently board certified, please provide the expiration date of admissibility.                                                                                                                                                                                                              | Date (mm/yy):<br>/                                       |
| D. | Have you ever had board certification revoked, limited, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, received a letter of reprimand from a specialty board, or is any such action currently pending or under review? If yes, please attach Explanation Form(s). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| E. | Have you ever voluntarily relinquished a board certification, including any voluntary non-renewal of a time limited board certification? If yes, please attach Explanation Form(s).                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE

#### A. UNDERGRADUATE

|                       |                     |                            |
|-----------------------|---------------------|----------------------------|
| Complete School Name: | Degree(s) Received: | Graduation Date (mm/yy): / |
| City:                 | State/Country:      | Course of Study or Major:  |

#### B. GRADUATE OR OTHER PROFESSIONAL DEGREES

Does Not Apply ☐

|                       |                     |                            |
|-----------------------|---------------------|----------------------------|
| Complete School Name: | Degree(s) Received: | Graduation Date (mm/yy): / |
| City:                 | State/Country:      | Course of Study or Major:  |

#### C. MEDICAL / PROFESSIONAL

Medical / Professional School Name and Street Address:

|                                                                                                                                                                 |                  |                                  |                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------|---------------------|
| City:                                                                                                                                                           | State/Country:   | Zip:                             |                     |
| From (mm/yy):<br>/                                                                                                                                              | To (mm/yy):<br>/ | Date of Completion (mm/yy):<br>/ | Degree(s) Received: |
| Did you complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you did not complete the program, please attach Explanation Form(s)) |                  |                                  |                     |

#### D. FOREIGN MEDICAL GRADUATE

Does Not Apply ☐

|                                                                                                                                                 |                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| <b>Educational Commission for Foreign Medical Graduates (ECFMG) Number:</b><br>Please enclose a copy of your Certificate.                       | Date Issued (mm/yy): /         |
| <b>Other:</b><br>Fifth Pathway <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide name and address of institution. | Dates of Attendance (mm/yy): / |

#### E. INTERNSHIP ☐ RESIDENCY ☐ Include all programs you attended, whether or not completed.

Does Not Apply ☐

|                                                                                                                                                                |                  |                                  |            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------|------------|
| Institution Name and Street Address:                                                                                                                           |                  |                                  |            |
| City:                                                                                                                                                          | State/Country:   | Zip:                             |            |
| From (mm/yy):<br>/                                                                                                                                             | To (mm/yy):<br>/ | Date of Completion (mm/yy):<br>/ | Specialty: |
| Name of Program Director:                                                                                                                                      |                  |                                  |            |
| Did you complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No If you did not complete the program, please attach Explanation Form(s). |                  |                                  |            |

#### IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE - continued

INTERNSHIP ☐ RESIDENCY ☐

|                                                                                                                                                                |                |                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------|--|
| Institution Name and Street Address:                                                                                                                           |                | Specialty:                    |  |
| City:                                                                                                                                                          | State/Country: | Zip:                          |  |
| From (mm/yy): /                                                                                                                                                | To (mm/yy): /  | Date of Completion (mm/yy): / |  |
| Name of Program Director:                                                                                                                                      |                |                               |  |
| Did you complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No If you did not complete the program, please attach Explanation Form(s). |                |                               |  |

**F. FELLOWSHIPS** If you completed more than one fellowship, please provide the information on an explanation form. Does Not Apply ☐

|                                                                                                                                                                |                |                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------|--|
| Institution Name and Street Address:                                                                                                                           |                | Specialty:                    |  |
| City:                                                                                                                                                          | State/Country: | Zip:                          |  |
| From (mm/yy): /                                                                                                                                                | To (mm/yy): /  | Date of Completion (mm/yy): / |  |
| Name of Program Director:                                                                                                                                      |                |                               |  |
| Did you complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No If you did not complete the program, please attach Explanation Form(s). |                |                               |  |

**G. OTHER CLINICAL TRAINING PROGRAMS**  
(For example, preceptorship, procedural certificate course, etc.) Does Not Apply ☐

|                                                                                                                                                                |                |                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------|--|
| Institution Name and Street Address:                                                                                                                           |                | Specialty:                    |  |
| City:                                                                                                                                                          | State/Country: | Zip:                          |  |
| From (mm/yy): /                                                                                                                                                | To (mm/yy): /  | Date of Completion (mm/yy): / |  |
| Name of Program Director:                                                                                                                                      |                | Certificate Awarded:          |  |
| Did you complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No If you did not complete the program, please attach Explanation Form(s). |                |                               |  |
| Institution Name and Street Address:                                                                                                                           |                | Specialty:                    |  |
| City:                                                                                                                                                          | State/Country: | Zip:                          |  |
| From (mm/yy): /                                                                                                                                                | To (mm/yy): /  | Date of Completion (mm/yy): / |  |
| Name of Program Director:                                                                                                                                      |                | Certificate Awarded:          |  |
| Did you complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No If you did not complete the program, please attach Explanation Form(s). |                |                               |  |

**H. FACULTY POSITIONS** List all academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments. Does Not Apply ☐

|                                             |  |                         |                     |
|---------------------------------------------|--|-------------------------|---------------------|
| <b>Program Specialty &amp; Institution:</b> |  | Academic Rank or Title: |                     |
| Institution Name & Address:                 |  | City:                   | State/Country: Zip: |
| From (mm/yy): /                             |  | To (mm/yy): /           |                     |
| <b>Program Specialty &amp; Institution:</b> |  | Academic Rank or Title: |                     |
| Institution Name & Address:                 |  | City:                   | State/Country: Zip: |
| From (mm/yy): /                             |  | To (mm/yy): /           |                     |

## IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE - continued

|                                                                                                                                  |         |                                                                                                                  |                                    |                                         |
|----------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------|
| <b>I. MILITARY/PUBLIC HEALTH SERVICE</b>                                                                                         |         |                                                                                                                  |                                    | Does Not Apply <input type="checkbox"/> |
| Location of Last Duty Station:                                                                                                   |         |                                                                                                                  |                                    |                                         |
| Rank at Discharge:                                                                                                               | Branch: | Active Duty Dates:<br>From (mm/yy) /                                                                             | Active Duty Dates:<br>To (mm/yy) / |                                         |
| Honorable Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, attach Explanation Form(s).                 |         | Are you currently in the Reserves or National Guard?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |                                         |
| Have you ever been court-martialed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach Explanation Form(s). |         |                                                                                                                  |                                    |                                         |
| Attach a copy of DD-214 Form.                                                                                                    |         |                                                                                                                  |                                    |                                         |

### J. CONTINUING MEDICAL EDUCATION

*If not listed on your Curriculum Vitae, please list on Explanation Form(s) all post graduate activities and scientific meetings that you have attended or for which you have received Category 1 credit in the past twenty-four months, or provide copies of certificates.*

### K. PROFESSIONAL MEDICAL ASSOCIATIONS

*Please list, on the Explanation Form, all professional organizations and societies (local, state and national) in which you have membership.*

## V. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES

Does Not Apply ☐

*Please include all ever held. If more room is needed please list on an attached Explanation Form.*

|                  |                    |                |                            |
|------------------|--------------------|----------------|----------------------------|
| Type and Status: | Number:            | State/Country: | Expiration Date (mm/yy): / |
| Year Obtained:   | Year Relinquished: | Reason:        |                            |
| Type and Status: | Number:            | State/Country: | Expiration Date (mm/yy): / |
| Year Obtained:   | Year Relinquished: | Reason:        |                            |

## VI. CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

***Please list in reverse chronological order with the current affiliation(s) first: (A) current hospital affiliations, (B) hospital applications in process, (C) previous hospital affiliations and (D) other current facility affiliations (which includes surgery centers, dialysis centers, nursing homes and other health care related facilities). Do not list residencies, internships or fellowships. Please list all employment in Section VII.***

|                                                               |                             |                                         |
|---------------------------------------------------------------|-----------------------------|-----------------------------------------|
| <b>A. CURRENT HOSPITAL AFFILIATIONS</b>                       |                             | Does Not Apply <input type="checkbox"/> |
| Primary Facility Name:                                        |                             | Complete Address:                       |
| Department/Status (e.g. active, courtesy, provisional, etc.): | Appointment Date (mm/yy): / |                                         |
| Facility Name:                                                |                             | Complete Address:                       |
| Department/Status (e.g. active, courtesy, provisional, etc.): | Appointment Date (mm/yy): / |                                         |
| Facility Name:                                                |                             | Complete Address:                       |
| Department/Status (e.g. active, courtesy, provisional, etc.): | Appointment Date (mm/yy): / |                                         |
| Facility Name:                                                |                             | Complete Address:                       |
| Department/Status (e.g. active, courtesy, provisional, etc.): | Appointment Date (mm/yy): / |                                         |

|                                                                                                      |                            |                                         |
|------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------|
| <b>B. HOSPITAL APPLICATIONS IN PROCESS</b> <i>Please list all applications currently in process.</i> |                            | Does Not Apply <input type="checkbox"/> |
| Facility Name:                                                                                       |                            | Complete Address:                       |
| Department/Status (e.g. active, courtesy, provisional, etc.):                                        | Submission Date (mm/yy): / |                                         |
| Facility Name:                                                                                       |                            | Complete Address:                       |
| Department/Status (e.g. active, courtesy, provisional, etc.):                                        | Submission Date (mm/yy): / |                                         |

**VI. CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS - continued**

|                                                               |                               |                   |
|---------------------------------------------------------------|-------------------------------|-------------------|
| Facility Name:                                                |                               | Complete Address: |
| Department/Status (e.g. active, courtesy, provisional, etc.): | Submission Date (mm/yy):<br>/ |                   |

**C. PREVIOUS HOSPITAL AFFILIATIONS** *Please list all previous affiliations.*Does Not Apply ☐

|                 |               |                   |
|-----------------|---------------|-------------------|
| Facility Name:  |               | Complete Address: |
| From (mm/yy): / | To (mm/yy): / |                   |

Reason for Leaving:

|                 |               |                   |
|-----------------|---------------|-------------------|
| Facility Name:  |               | Complete Address: |
| From (mm/yy): / | To (mm/yy): / |                   |

Reason for Leaving:

**D. OTHER FACILITY AFFILIATIONS** *Please list all current affiliations with other facilities.*Does Not Apply ☐

|                 |               |                   |
|-----------------|---------------|-------------------|
| Facility Name:  |               | Complete Address: |
| From (mm/yy): / | To (mm/yy): / |                   |

Reason for Leaving:

|                 |               |                   |
|-----------------|---------------|-------------------|
| Facility Name:  |               | Complete Address: |
| From (mm/yy): / | To (mm/yy): / |                   |

Reason for Leaving:

**VII. PROFESSIONAL PRACTICE / WORK HISTORY***A curriculum vitae is not sufficient for a complete answer to these questions.*Does Not Apply ☐

**Please list in reverse chronological order all work and professional and practice history activities not detailed under Section II, IV or VI. Include any previous office addresses and any military experience. Explain below any gaps greater than thirty (30) days.**

Name of Current Practice / Employer:

|                         |               |                   |
|-------------------------|---------------|-------------------|
| Contact Name:           |               | Complete Address: |
| Telephone Number: ( ) - |               |                   |
| From (mm/yy): /         | To (mm/yy): / |                   |

Name of Previous Practice / Employer:

|                         |               |                   |
|-------------------------|---------------|-------------------|
| Contact Name:           |               | Complete Address: |
| Telephone Number: ( ) - |               |                   |
| From (mm/yy): /         | To (mm/yy): / |                   |

Name of Previous Practice / Employer:

|                         |               |                   |
|-------------------------|---------------|-------------------|
| Contact Name:           |               | Complete Address: |
| Telephone Number: ( ) - |               |                   |
| From (mm/yy): /         | To (mm/yy): / |                   |

## VII. PROFESSIONAL PRACTICE / WORK HISTORY - continued

*If your training, practice, military or work experience has been interrupted for more than thirty (30) days by, for example, illness, injury or family medical leave, then please explain below any such gap since completing medical school.*

Does Not Apply ☐

| Explanation of Interruption: | From (mm/yy): | To (mm/yy): |
|------------------------------|---------------|-------------|
|                              | /             | /           |
|                              | /             | /           |
|                              | /             | /           |

## VIII. PEER REFERENCES

*Please list three (3) references, from licensed professional peers who through recent observations have personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives. At least one reference must be a practitioner in your same professional discipline. (Please refer to Part Two of this Application for any additional specific reference requirements.)*

|                                                |                   |
|------------------------------------------------|-------------------|
| Name of Reference:                             | Complete Address: |
| Specialty:                                     |                   |
| Dates of Association: / - /                    |                   |
| Telephone Number: ( ) -      Fax Number: ( ) - |                   |
| Name of Reference:                             | Complete Address: |
| Specialty:                                     |                   |
| Dates of Association: / - /                    |                   |
| Telephone Number: ( ) -      Fax Number: ( ) - |                   |
| Name of Reference:                             | Complete Address: |
| Specialty:                                     |                   |
| Dates of Association: / - /                    |                   |
| Telephone Number: ( ) -      Fax Number: ( ) - |                   |

## IX. PROFESSIONAL LIABILITY INSURANCE

|                                                                          |                            |                                                                                                           |
|--------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------------------|
| Current Insurance Carrier / Provider of Professional Liability Coverage: | Policy Number:             | Type of Coverage (check one):<br><input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |
| Name of Local Contact (e.g. Insurance Agent or Broker):                  | Mailing Address:           |                                                                                                           |
| Contact Telephone Number: ( ) -                                          |                            |                                                                                                           |
| Per claim limit of liability: \$      Aggregate amount: \$               |                            |                                                                                                           |
| Effective Date (mm/yy): /                                                | Expiration Date (mm/yy): / | Retroactive Date, if applicable (mm/yy): /                                                                |

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not on an Explanation Form of the Application.

**NOTE: IF YOU ARE COVERED BY A MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM THAT IS A CLAIMS MADE POLICY, YOU ARE REQUIRED TO SHOW EVIDENCE OF PURCHASE OF CURRENT REPORTING ENDORSEMENT COVERAGE (TAIL COVERAGE) OR PRIOR OCCURRENCE/ACTS COVERAGE TO COVER PREVIOUS YEARS OF PRACTICE.**

## IX. PROFESSIONAL LIABILITY INSURANCE - continued

**Please list all previous professional liability carriers within the past ten (10) years (including any carriers during medical training if within the ten year period).**

Does Not Apply ☐

|                                                                  |                      |                                                 |                  |                                                                                                           |  |
|------------------------------------------------------------------|----------------------|-------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|--|
| Insurance Carrier / Provider of Professional Liability Coverage: |                      | Policy Number:                                  |                  | Type of Coverage (check one):<br><input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |  |
| Name of Local Contact:                                           |                      |                                                 | Mailing Address: |                                                                                                           |  |
| Contact Telephone Number: (    ) -                               |                      |                                                 |                  |                                                                                                           |  |
| Per claim limit of liability: \$                                 | Aggregate amount: \$ |                                                 |                  |                                                                                                           |  |
| Effective Date (mm/yy):<br>/ /                                   |                      | Retroactive Date, if applicable (mm/yy):<br>/ / |                  | Expiration Date (mm/yy):<br>/ /                                                                           |  |

  

|                                                                  |                      |                                                 |                  |                                                                                                           |  |
|------------------------------------------------------------------|----------------------|-------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|--|
| Insurance Carrier / Provider of Professional Liability Coverage: |                      | Policy Number:                                  |                  | Type of Coverage (check one):<br><input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |  |
| Name of Local Contact:                                           |                      |                                                 | Mailing Address: |                                                                                                           |  |
| Contact Telephone Number: (    ) -                               |                      |                                                 |                  |                                                                                                           |  |
| Per claim limit of liability: \$                                 | Aggregate amount: \$ |                                                 |                  |                                                                                                           |  |
| Effective Date (mm/yy):<br>/ /                                   |                      | Retroactive Date, if applicable (mm/yy):<br>/ / |                  | Expiration Date (mm/yy):<br>/ /                                                                           |  |

**Professional Insurance History: Please answer each of the following questions in full. If the answer to any question is "YES", or requires further information, please give a full explanation of the specific details on an Explanation Form and attach to the Application.**

|    |                                                                                                                                                                                                                                                                                   |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | Has your professional liability insurance coverage ever been terminated or not renewed by action of the insurance company?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide date, name of company(s), and basis for termination or non-renewal. |
| 2. | Have you ever been denied coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please provide details.                                                                                                                                                     |
| 3. | Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify procedures and provide details.                                      |

**Professional Claims History: (If the answer to any of these questions is "Yes," please complete a separate Professional Liability Claims Information Form for each. A Professional Liability Claims Information Form has been provided as Schedule B to this Application. Please make additional copies as necessary.)**

|    |                                                                                                                                                                                                                                          |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | Have there ever been any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you? <input type="checkbox"/> Yes <input type="checkbox"/> No                              |
| 2. | Are any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you <i>currently pending</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| 3. | Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability? <input type="checkbox"/> Yes <input type="checkbox"/> No |

## X. HEALTH STATUS

**Please answer each of the following questions in full.**

|    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                          |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. | Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? <b>If the answer to this question is "YES," please give full explanation of the specific details on an Explanation Form and attach to the Application.</b><br>(Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. | <b>Are you able to perform</b> all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? If reasonable accommodation is required, please specify such on <b>an attached Explanation Form.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## XI. ATTESTATION QUESTIONS

*This section to be completed by the Practitioner. Modification to the wording or format of these Attestation Questions will invalidate the Application.*

Please answer the following questions “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons, as specified in each question, on an Explanation Form and attach to the Application.

For the purpose of the following questions, the term “adverse action” means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial, or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment. “Adverse action” also means, with respect to professional licensure registration or certification, any previously successful or currently pending challenges to such licensure, registration or certification including any voluntary or involuntary restriction, suspension, revocation, denial, surrender, non-renewal, public or private reprimand, probation, consent order, reduction, withdrawal, limitation, relinquishment, or failure to proceed with an application for such licensure, registration or certification.

|    |                                                                                                                                                                                                                  |                                                          |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| A. | To your knowledge, have you ever been the subject of an investigation or <b>adverse action</b> (or is an investigation or <b>adverse action</b> currently pending) by:                                           |                                                          |
|    | • a hospital or other healthcare facility (e.g. surgical center, nursing home, renal dialysis facility, etc.)?                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|    | • an education facility or program (medical school, residency, internship, etc.)?                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|    | • a professional organization or society?                                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|    | • a professional licensing body (in any jurisdiction for any profession)?                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|    | • a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, HMO, PPO, PHO, PSHCC, network, system, managed care organization, etc.)?                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|    | • a state or federal agency (DEA, etc.) regarding your prescription of controlled substances?                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. | To your knowledge, have you ever been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity?                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. | Has your application for clinical privileges or medical staff membership or change in staff category at any hospital or healthcare facility ever been denied in whole or in part or is any such action pending?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. | Have you ever resigned from a hospital or other health care facility medical staff to avoid disciplinary action, investigation or while under investigation or is such an investigation pending?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| E. | Have you ever been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any <i>federal or state</i> health insurance program (for example, Medicare or Medicaid)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| F. | Have you ever been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any <i>private</i> health insurance program?                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| G. | Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| H. | Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)?                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I. | Are any criminal charges currently pending against you?                                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| J. | Have you ever been arrested for or charged with a crime involving children?                                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| K. | Have you ever been arrested for or charged with a sexual offense?                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| L. | Have you ever been arrested for or charged with a crime involving moral turpitude?                                                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| M. | Are you currently using illegal drugs or legal drugs in an illegal manner?                                                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## **XII. ATTESTATION AND SIGNATURE**

*By signing this Application, I certify, agree, understand and acknowledge the following:*

1. The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.
3. A photocopy of this Application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided in this Application should there be any change in the information.
6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7. This attestation statement and Application must be signed no more than 180 days prior to the credentialing decision date.

**Signature:**

**Printed Name:**

**Date:**

# GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

## EXPLANATION FORM

Please make as many copies of this page as needed to fully respond to each question. For each response/explanation, please provide your name and Social Security Number, together with the corresponding page and section number from the Application.

NAME:

SS#:

| <u>Section #</u> | <u>Page #</u> |
|------------------|---------------|
|                  |               |
|                  |               |
|                  |               |
|                  |               |
|                  |               |
|                  |               |
|                  |               |
|                  |               |
|                  |               |
|                  |               |

# Schedule A

## GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

### **AUTHORIZATION AND RELEASE OF INFORMATION FORM**

#### **Modified Releases Will Not Be Accepted**

**By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:**

1. As an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization, network, medical society, professional association, medical school faculty position, or other healthcare delivery entity or system (hereinafter referred to as a "Healthcare Entity")*] indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.
2. I also understand that I have the continuing responsibility to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.
3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.
4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to my qualifications or matters addressed in this Application (my "Qualifications").
5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this Application and my Qualifications.
6. I consent to and authorize the inspection of records and documents (including medical records and peer review information) that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.
7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes), as long as in each instance such release of information is done in good faith and without malice. I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.

# Schedule A--continued

## GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

### **AUTHORIZATION AND RELEASE OF INFORMATION FORM**

#### **Modified Releases Will Not Be Accepted**

**By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:**

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.
9. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.
10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.
11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluations undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

|                      |              |
|----------------------|--------------|
| <b>Signature:</b>    |              |
| <b>Printed Name:</b> | <b>Date:</b> |

**I grant permission for the release of the credentials information contained in this Application to the following Healthcare Entity(ies):**

---

---

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## Schedule B

Claim of

# **GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM**

## **PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM**

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; for recredentialing, complete forms only for new/changed status claims since your last recredentialing. One case per sheet (*please photocopy if additional sheets are needed*).

|                                                                                                                                     |            |                                                                    |                                  |                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------|
| <b>PROVIDER'S NAME:</b><br>(Required even if N/A)                                                                                   |            |                                                                    |                                  | <b>Does Not Apply</b> <input type="checkbox"/><br><i>Note: Signature Required even if checked.</i> |
| <b>Name of Patient Involved</b>                                                                                                     | <b>Age</b> | <b>Month and Year of Occurrence</b><br>(Event precipitating claim) | <b>Month and Year of Lawsuit</b> | <b>Insurance Carrier at Time</b>                                                                   |
|                                                                                                                                     |            | /                                                                  | /                                |                                                                                                    |
| <b>What is/was your status?</b>                                                                                                     |            | <b>List other defendants:</b>                                      |                                  |                                                                                                    |
| <input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant<br><input type="checkbox"/> Other, please explain: |            |                                                                    |                                  |                                                                                                    |
| <b>What was the patient's outcome?</b>                                                                                              |            |                                                                    |                                  |                                                                                                    |
|                                                                                                                                     |            |                                                                    |                                  |                                                                                                    |
| <b>How were you alleged to have caused harm or injury to this patient?</b>                                                          |            |                                                                    |                                  |                                                                                                    |
|                                                                                                                                     |            |                                                                    |                                  |                                                                                                    |
| <b>Please provide specifics in reference to the adverse event:</b>                                                                  |            |                                                                    |                                  |                                                                                                    |
|                                                                                                                                     |            |                                                                    |                                  |                                                                                                    |
| <b>What is/was your role in this event?</b>                                                                                         |            |                                                                    |                                  |                                                                                                    |
|                                                                                                                                     |            |                                                                    |                                  |                                                                                                    |
| <b>CURRENT STATUS</b>                                                                                                               |            |                                                                    |                                  |                                                                                                    |
| <input type="checkbox"/> Still pending (as of) Date: / /                                                                            |            | Who is handling the defense of the case?                           |                                  |                                                                                                    |
| <input type="checkbox"/> Trial date set - awaiting trial                                                                            |            | Trial Date: / /                                                    |                                  |                                                                                                    |
| <input type="checkbox"/> Dismissed                                                                                                  |            | Date of Dismissal: / /                                             |                                  |                                                                                                    |
| <input type="checkbox"/> Defense Verdict                                                                                            |            | Date of Defense Verdict: / /                                       |                                  |                                                                                                    |
| <input type="checkbox"/> Settled out of court                                                                                       | Date: / /  | Total Amount of Settlement:<br>\$                                  | Amount Paid by You:<br>\$        |                                                                                                    |
| <input type="checkbox"/> Judgment                                                                                                   | Date: / /  | Total Amount of Judgment:<br>\$                                    | Amount Paid by You:<br>\$        |                                                                                                    |

This Professional Liability Claims Information Form is required on all claims/lawsuits that are reported by your malpractice insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

***I certify that the information contained in this form is correct and complete (even if N/A) to the best of my knowledge.***

|                                 |  |              |  |
|---------------------------------|--|--------------|--|
| <b>Signature:</b><br>(Required) |  | <b>Date:</b> |  |
|---------------------------------|--|--------------|--|

# Schedule C

## GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

### REGULATION ACKNOWLEDGEMENT

#### NOTICE TO PHYSICIANS

Medicare and Tri-Care payment to hospitals is based in part on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

By my signature below, I acknowledge receipt of this notice.

|                      |              |
|----------------------|--------------|
| <b>Signature:</b>    |              |
| <b>Printed Name:</b> | <b>Date:</b> |



# GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

\*\*\*\*\**PART TWO*\*\*\*\*\*

## GEORGIA ASSOCIATION OF HEALTH PLANS

|                                                                                                                                                                                    |                                                                                                 |         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------|
| <b>I. Personal Identification</b>                                                                                                                                                  |                                                                                                 |         |
| Last Name (include suffix; Jr., Sr., III):                                                                                                                                         | First:                                                                                          | Middle: |
| Are you eligible to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            |                                                                                                 |         |
| <b>II. Practice Location Information</b>                                                                                                                                           |                                                                                                 |         |
| Physician group name/practice name to appear in directory:                                                                                                                         |                                                                                                 |         |
| Group/Corporate name as it appears on W-9, if different from Physician group/practice name:                                                                                        |                                                                                                 |         |
| <b>III. License and Other Identification Information</b>                                                                                                                           |                                                                                                 |         |
| National Provider Identifier (NPI) when available.                                                                                                                                 |                                                                                                 |         |
| Are you a Participating Medicare Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                |                                                                                                 |         |
| Are you a Participating Medicaid Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                |                                                                                                 |         |
| <b>IV. Professional/Medical Specialty Information - Primary Specialty:</b>                                                                                                         |                                                                                                 |         |
| Based on your contracted agreement do you wish to be listed in the directory under your primary specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No                | Specify: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS |         |
| <b>V. Professional/Medical Specialty Information - Secondary Specialty:</b>                                                                                                        |                                                                                                 |         |
| Based on your contracted agreement do you wish to be listed in the directory under your secondary specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No              | Specify: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS |         |
| <b>VI. Professional/Medical Specialty Information - Additional Specialty:</b>                                                                                                      |                                                                                                 |         |
| Based on your contracted agreement do you wish to be listed in the directory under an additional specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No               | Specify: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS |         |
| Additional areas of professional/practice interest or focus:                                                                                                                       |                                                                                                 |         |
| <b>VII. Hospital/Affiliations</b>                                                                                                                                                  |                                                                                                 |         |
| Do you have hospital admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                |                                                                                                 |         |
| Do you admit patients and follow them in an inpatient care setting? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                       |                                                                                                 |         |
| <b>Primary hospital where you have admitting privileges:</b>                                                                                                                       |                                                                                                 |         |
| Name:                                                                                                                                                                              | Address:                                                                                        |         |
| Contact:                                                                                                                                                                           | Phone #: ( ) -                                                                                  |         |
| Are your admitting privileges Full Unrestricted? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                          |                                                                                                 |         |
| Are privileges temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                 |                                                                                                 |         |
| Of the total number of your admissions to all hospitals in the past year, what percentage is to this specific hospital? (N/A is a potential option for hospital based physicians.) |                                                                                                 |         |
| <b>Other hospital(s) where you have admitting privileges: ( Use additional sheets if necessary.)</b> N/A <input type="checkbox"/>                                                  |                                                                                                 |         |
| Name:                                                                                                                                                                              | Address:                                                                                        |         |
| Contact:                                                                                                                                                                           | Phone #: ( ) -                                                                                  |         |
| Are your admitting privileges Full Unrestricted? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                          |                                                                                                 |         |
| Are privileges temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                 |                                                                                                 |         |
| Of the total number of your admissions to all hospitals in the past year, what percentage is to this specific hospital? (N/A is a potential option for hospital based physicians.) |                                                                                                 |         |
| <b>VIII. Work History</b>                                                                                                                                                          |                                                                                                 |         |
| Are you currently on active military duty or on military reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                         |                                                                                                 |         |

**IX. Other Practice Information** *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

|                                                                                                                                                                                                              |                                                                                                                                    |                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| Site Address:                                                                                                                                                                                                | Type of service provided: <input type="checkbox"/> primary care specialist<br><input type="checkbox"/> non-primary care specialist |                                                                   |
| List the names of colleagues providing regular coverage, their specialties and coverage arrangements:                                                                                                        |                                                                                                                                    |                                                                   |
| List names of partners in your practice:                                                                                                                                                                     |                                                                                                                                    |                                                                   |
| After hours, back office phone number for health plan business use only:                                                                                                                                     |                                                                                                                                    |                                                                   |
| Office business hours, hours that patients are seen:                                                                                                                                                         |                                                                                                                                    |                                                                   |
| Evening or weekend hours:                                                                                                                                                                                    |                                                                                                                                    |                                                                   |
| Do you want to list site in the directory?                                                                                                                                                                   |                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Do you make 24-hour/7 day a week phone coverage available?                                                                                                                                                   |                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| If Yes, Indicate type of coverage arrangements.                                                                                                                                                              |                                                                                                                                    |                                                                   |
| <b>BILLING INFORMATION:</b>                                                                                                                                                                                  |                                                                                                                                    |                                                                   |
| E-mail for billing contact: @                                                                                                                                                                                | Department name if hospital based:                                                                                                 |                                                                   |
| Who check should be payable to:                                                                                                                                                                              | Billing representative's name:                                                                                                     |                                                                   |
| Do you accept new patients into your practice? (specify for each health plan) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | Accept new patients from physician referral only? <input type="checkbox"/> Yes <input type="checkbox"/> No                         |                                                                   |
| Accept all new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                            | Accept new Medicare patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                             |                                                                   |
| Accept existing patients with change of payor? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                      | Accept new Medicaid patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                             |                                                                   |
| Practice limitations: (patient ages, sex)                                                                                                                                                                    |                                                                                                                                    |                                                                   |
| Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, provide name, address, state license, specialty, if contracted as a PCP.                                                   |                                                                   |
| Availability of interpreters (specify languages):                                                                                                                                                            |                                                                                                                                    |                                                                   |
| Do you provide handicap accessibility for each of the following areas:                                                                                                                                       |                                                                                                                                    |                                                                   |
| Building <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                            | Parking <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                   | Restroom <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the site accessible by public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                    | If yes, indicate types of transportation.                                                                                          |                                                                   |
| Does your site provide childcare services? (for each site) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                          |                                                                                                                                    |                                                                   |
| Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)? <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |                                                                                                                                    |                                                                   |
| Does your office qualify as a minority business enterprise? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                         |                                                                                                                                    |                                                                   |
| Do you or someone in your office have the following additional certifications? (show expiration dates.)                                                                                                      |                                                                                                                                    |                                                                   |
| BLS (Basic Life Support)                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| ACLS (Advanced Cardiac Life Support)                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| ALSO (Advance Life Support in OB)                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| PALS (Pediatric Advanced Life Support) Classification                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| ATLS (Advanced Trauma Life Support) Certified                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| NALS (Neonatal Advanced Life Support)                                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| NRS (Neonatal Resuscitation Program) Classification                                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| CPR classification                                                                                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| Other (Please list on an Explanation Form(s))                                                                                                                                                                |                                                                                                                                    |                                                                   |
| <b>Additional office services provided:</b>                                                                                                                                                                  |                                                                                                                                    |                                                                   |
| Laboratory services provided <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                        | Flexible sigmoidoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No                                                    |                                                                   |
| Radiology Service <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                   | Tympanometry/audiometry screening <input type="checkbox"/> Yes <input type="checkbox"/> No                                         |                                                                   |
| EKGs <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                | Asthma treatment <input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                   |
| Care of minor lacerations <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                           | Osteopathic manipulation <input type="checkbox"/> Yes <input type="checkbox"/> No                                                  |                                                                   |
| Pulmonary function <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                  | IV hydration/treatment <input type="checkbox"/> Yes <input type="checkbox"/> No                                                    |                                                                   |
| Allergy injections, allergy skin testing <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                            | Cardiac stress tests <input type="checkbox"/> Yes <input type="checkbox"/> No                                                      |                                                                   |
| Office gynecology (routine pelvic/pap) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                              | Physical therapy <input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                   |
| Drawing blood <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                       | Additional office procedures provided <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |                                                                   |
| Age appropriate immunizations <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                       | Surgical procedures <input type="checkbox"/> Yes <input type="checkbox"/> No                                                       |                                                                   |
| Is anesthesia administered in your office? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                          | If yes, what category of anesthesia do you use?                                                                                    |                                                                   |
| Specify the class or category:                                                                                                                                                                               | Who administers it?                                                                                                                |                                                                   |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| <b>X. Required Attachments or Supplemental Information – Hard Copy or Scanned</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |
| Copy of state controlled dangerous substance (CDS) certificate.<br>Copy(ies) of W-9 for verification of each tax identification number used.<br>Copy of workers compensation certificate of coverage, if applicable.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |
| Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, preceptorship, or other clinical education program? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |
| <b>XI. Attestation and Signature – Part II</b> <i>By signing this application, I certify, agree, understand and acknowledge the following:</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |
| 1. The information in this entire application is complete, current, correct, and not misleading<br>2. Any misstatements or omissions (whether intentional or unintentional) on this application may constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.<br>3. A photocopy of this application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.<br>4. I have reviewed the information in this application on the most recent date indicated below and it continues to be true and complete.<br>5. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.<br>6. No action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved.<br>7. This attestation statement and application must be signed no more than 180 days prior to the credentialing decision date.. |              |
| <b>Signature:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |
| <b>Printed Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Date:</b> |

**IX. Other Practice Information** *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

|                                                                                                                                                                                                              |                                                                                                |                                                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--|
| Site Address:                                                                                                                                                                                                |                                                                                                | Type of service provided: <input type="checkbox"/> primary care specialist<br><input type="checkbox"/> non-primary care specialist |  |
| List the names of colleagues providing regular coverage, their specialties and coverage arrangements:                                                                                                        |                                                                                                |                                                                                                                                    |  |
| List names of partners in your practice:                                                                                                                                                                     |                                                                                                |                                                                                                                                    |  |
| After hours, back office phone number for health plan business use only:                                                                                                                                     |                                                                                                |                                                                                                                                    |  |
| Office business hours, hours that patients are seen:                                                                                                                                                         |                                                                                                |                                                                                                                                    |  |
| Evening or weekend hours:                                                                                                                                                                                    |                                                                                                |                                                                                                                                    |  |
| Do you want to list site in the directory?                                                                                                                                                                   |                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           |  |
| Do you make 24-hour/7 day a week phone coverage available?                                                                                                                                                   |                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           |  |
| If Yes, Indicate type of coverage arrangements.                                                                                                                                                              |                                                                                                |                                                                                                                                    |  |
| <b>BILLING INFORMATION:</b>                                                                                                                                                                                  |                                                                                                |                                                                                                                                    |  |
| E-mail for billing contact: @                                                                                                                                                                                |                                                                                                | Department name if hospital based:                                                                                                 |  |
| Who check should be payable to:                                                                                                                                                                              |                                                                                                | Billing representative's name:                                                                                                     |  |
| Do you accept new patients into your practice?<br>(specify for each health plan) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                    |                                                                                                | Accept new patients from physician referral only? <input type="checkbox"/> Yes <input type="checkbox"/> No                         |  |
| Accept all new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                            |                                                                                                | Accept new Medicare patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                             |  |
| Accept existing patients with change of payor? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                      |                                                                                                | Accept new Medicaid patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                             |  |
| Practice limitations: (patient ages, sex)                                                                                                                                                                    |                                                                                                |                                                                                                                                    |  |
| Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | If yes, provide name, address, state license, specialty, if contracted as a PCP.                                                   |  |
| Availability of interpreters (specify languages):                                                                                                                                                            |                                                                                                |                                                                                                                                    |  |
| Do you provide handicap accessibility for each of the following areas:                                                                                                                                       |                                                                                                |                                                                                                                                    |  |
| Building <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                            | Parking <input type="checkbox"/> Yes <input type="checkbox"/> No                               | Restroom <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                  |  |
| Is the site accessible by public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                    |                                                                                                | If yes, indicate types of transportation.                                                                                          |  |
| Does your site provide childcare services? (for each site)                                                                                                                                                   |                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           |  |
| Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?                                                                                          |                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           |  |
| Does your office qualify as a minority business enterprise?                                                                                                                                                  |                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           |  |
| Do you or someone in your office have the following additional certifications? (show expiration dates.)                                                                                                      |                                                                                                |                                                                                                                                    |  |
| BLS (Basic Life Support)                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| ACLS (Advanced Cardiac Life Support)                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| ALSO (Advance Life Support in OB)                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| PALS (Pediatric Advanced Life Support) Classification                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| ATLS (Advanced Trauma Life Support) Certified                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| NALS (Neonatal Advanced Life Support)                                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| NRS (Neonatal Resuscitation Program) Classification                                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| CPR classification                                                                                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Expiration date: /                                                                                                                 |  |
| Other (Please list on an Explanation Form(s))                                                                                                                                                                |                                                                                                |                                                                                                                                    |  |
| <b>Additional office services provided:</b>                                                                                                                                                                  |                                                                                                |                                                                                                                                    |  |
| Laboratory services provided <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                        | Flexible sigmoidoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No                |                                                                                                                                    |  |
| Radiology Service <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                   | Tympanometry/audiometry screening <input type="checkbox"/> Yes <input type="checkbox"/> No     |                                                                                                                                    |  |
| EKGs <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                | Asthma treatment <input type="checkbox"/> Yes <input type="checkbox"/> No                      |                                                                                                                                    |  |
| Care of minor lacerations <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                           | Osteopathic manipulation <input type="checkbox"/> Yes <input type="checkbox"/> No              |                                                                                                                                    |  |
| Pulmonary function <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                  | IV hydration/treatment <input type="checkbox"/> Yes <input type="checkbox"/> No                |                                                                                                                                    |  |
| Allergy injections, allergy skin testing <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                            | Cardiac stress tests <input type="checkbox"/> Yes <input type="checkbox"/> No                  |                                                                                                                                    |  |
| Office gynecology (routine pelvic/pap) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                              | Physical therapy <input type="checkbox"/> Yes <input type="checkbox"/> No                      |                                                                                                                                    |  |
| Drawing blood <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                       | Additional office procedures provided <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                    |  |
| Age appropriate immunizations <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                       | Surgical procedures <input type="checkbox"/> Yes <input type="checkbox"/> No                   |                                                                                                                                    |  |
| Is anesthesia administered in your office? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                          | If yes, what category of anesthesia do you use?                                                |                                                                                                                                    |  |
| Specify the class or category:                                                                                                                                                                               | Who administers it?                                                                            |                                                                                                                                    |  |

**XII. Other Practice Information** *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

|                                                                                                                                                                                                              |                                                                                                                                    |                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| Site Address:                                                                                                                                                                                                | Type of service provided: <input type="checkbox"/> primary care specialist<br><input type="checkbox"/> non-primary care specialist |                                                                   |
| List the names of colleagues providing regular coverage, their specialties and coverage arrangements:                                                                                                        |                                                                                                                                    |                                                                   |
| List names of partners in your practice:                                                                                                                                                                     |                                                                                                                                    |                                                                   |
| After hours, back office phone number for health plan business use only:                                                                                                                                     |                                                                                                                                    |                                                                   |
| Office business hours, hours that patients are seen:                                                                                                                                                         |                                                                                                                                    |                                                                   |
| Evening or weekend hours:                                                                                                                                                                                    |                                                                                                                                    |                                                                   |
| Do you want to list site in the directory?                                                                                                                                                                   |                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Do you make 24-hour/7 day a week phone coverage available?                                                                                                                                                   |                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| If Yes, Indicate type of coverage arrangements.                                                                                                                                                              |                                                                                                                                    |                                                                   |
| <b>BILLING INFORMATION:</b>                                                                                                                                                                                  |                                                                                                                                    |                                                                   |
| E-mail for billing contact: @                                                                                                                                                                                | Department name if hospital based:                                                                                                 |                                                                   |
| Who check should be payable to:                                                                                                                                                                              | Billing representative's name:                                                                                                     |                                                                   |
| Do you accept new patients into your practice? (specify for each health plan) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       | Accept new patients from physician referral only? <input type="checkbox"/> Yes <input type="checkbox"/> No                         |                                                                   |
| Accept all new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                            | Accept new Medicare patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                             |                                                                   |
| Accept existing patients with change of payor? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                      | Accept new Medicaid patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                                             |                                                                   |
| Practice limitations: (patient ages, sex)                                                                                                                                                                    |                                                                                                                                    |                                                                   |
| Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, provide name, address, state license, specialty, if contracted as a PCP.                                                   |                                                                   |
| Availability of interpreters (specify languages):                                                                                                                                                            |                                                                                                                                    |                                                                   |
| Do you provide handicap accessibility for each of the following areas:                                                                                                                                       |                                                                                                                                    |                                                                   |
| Building <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                            | Parking <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                   | Restroom <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the site accessible by public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                    | If yes, indicate types of transportation.                                                                                          |                                                                   |
| Does your site provide childcare services? (for each site)                                                                                                                                                   |                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?                                                                                          |                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Does your office qualify as a minority business enterprise?                                                                                                                                                  |                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Do you or someone in your office have the following additional certifications? (show expiration dates.)                                                                                                      |                                                                                                                                    |                                                                   |
| BLS (Basic Life Support)                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| ACLS (Advanced Cardiac Life Support)                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| ALSO (Advance Life Support in OB)                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| PALS (Pediatric Advanced Life Support) Classification                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| ATLS (Advanced Trauma Life Support) Certified                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| NALS (Neonatal Advanced Life Support)                                                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| NRS (Neonatal Resuscitation Program) Classification                                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| CPR classification                                                                                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           | Expiration date: /                                                |
| Other (Please list on an Explanation Form(s))                                                                                                                                                                |                                                                                                                                    |                                                                   |
| <b>Additional office services provided:</b>                                                                                                                                                                  |                                                                                                                                    |                                                                   |
| Laboratory services provided <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                        | Flexible sigmoidoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No                                                    |                                                                   |
| Radiology Service <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                   | Tympanometry/audiometry screening <input type="checkbox"/> Yes <input type="checkbox"/> No                                         |                                                                   |
| EKGs <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                | Asthma treatment <input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                   |
| Care of minor lacerations <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                           | Osteopathic manipulation <input type="checkbox"/> Yes <input type="checkbox"/> No                                                  |                                                                   |
| Pulmonary function <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                  | IV hydration/treatment <input type="checkbox"/> Yes <input type="checkbox"/> No                                                    |                                                                   |
| Allergy injections, allergy skin testing <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                            | Cardiac stress tests <input type="checkbox"/> Yes <input type="checkbox"/> No                                                      |                                                                   |
| Office gynecology (routine pelvic/pap) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                              | Physical therapy <input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                   |
| Drawing blood <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                       | Additional office procedures provided <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |                                                                   |
| Age appropriate immunizations <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                       | Surgical procedures <input type="checkbox"/> Yes <input type="checkbox"/> No                                                       |                                                                   |
| Is anesthesia administered in your office? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                          | If yes, what category of anesthesia do you use?                                                                                    |                                                                   |
| Specify the class or category:                                                                                                                                                                               | Who administers it?                                                                                                                |                                                                   |

**ELECTION TO PARTICIPATE WITH  
CIGNA HEALTHCARE OF GEORGIA AND AFFILIATES**

This Election to Participate confirms the undersigned physician's (who is referred to as "You") agreement to provide Covered Services to Participants enrolled with CIGNA HealthCare of Georgia, Inc. ("CIGNA") or its designated affiliates. You acknowledge that You are a "Represented Provider" with Premier Pediatric Providers, L.L.C. d/b/a Kids First Pediatric Alliance as defined in its Managed Care Alliance Agreement ("MCA Agreement") with CIGNA.

1. **Covered Services.** You will provide to Participants Covered Services that are within the scope of your medical practice, and pursuant to the MCA Agreement.

2. **Payment.** You will accept as full and complete payment due from CIGNA, its affiliates or other Payors for provision of Covered Services that are within the scope of your medical practice to Participants, compensation established pursuant to the MCA Agreement. You agree that should the MCA Agreement be terminated for any reason, You will continue to provide Covered Services to Participants pursuant to the terms, conditions and compensation provisions of the terminated MCA Agreement. Until a new agreement between You and CIGNA is effective, all terms and conditions of the MCA Agreement would be effective. Should the MCA Agreement terminate and You do not wish to continue providing services to Participants, You agree to submit in writing to CIGNA Your ninety (90) day notice to terminate this Election to Participate.

3. **Member Hold Harmless.** Under no circumstances, including, without limitation, termination of the MCA Agreement or this Election to Participate, non-payment by CIGNA or other Payor, or their insolvency, will You seek from any Participant or person acting on his/her behalf payment for Covered Services that is payable by CIGNA or other appropriate Payor. This provision shall not prohibit collection of supplemental charges or co-payments in accordance with the terms of the applicable Service Agreement. You agree that this provision shall survive termination of the MCA Agreement or this Election to Participate for Covered Services rendered prior to such termination, regardless of the cause of termination, and shall be construed to be for the Participant's benefit. You agree that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between You and a Participant or person acting on his/her behalf.

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Printed Name:

\_\_\_\_\_  
Tax Identification Number:

\_\_\_\_\_  
Address For Payment/Notice:

\_\_\_\_\_  
DEA Control Number:

\_\_\_\_\_  
Medicare Provider Number:

**ELECTION TO PARTICIPATE WITH  
CIGNA HEALTHCARE OF GEORGIA AND AFFILIATES**

This Election to Participate confirms the undersigned physician's (who is referred to as "You") agreement to provide Covered Services to Participants enrolled with CIGNA HealthCare of Georgia, Inc. ("CIGNA") or its designated affiliates. You acknowledge that You are a "Represented Provider" with Premier Pediatric Providers, L.L.C. d/b/a Kids First Pediatric Alliance as defined in its Managed Care Alliance Agreement ("MCA Agreement") with CIGNA.

1. **Covered Services.** You will provide to Participants Covered Services that are within the scope of your medical practice, and pursuant to the MCA Agreement.

2. **Payment.** You will accept as full and complete payment due from CIGNA, its affiliates or other Payors for provision of Covered Services that are within the scope of your medical practice to Participants, compensation established pursuant to the MCA Agreement. You agree that should the MCA Agreement be terminated for any reason, You will continue to provide Covered Services to Participants pursuant to the terms, conditions and compensation provisions of the terminated MCA Agreement. Until a new agreement between You and CIGNA is effective, all terms and conditions of the MCA Agreement would be effective. Should the MCA Agreement terminate and You do not wish to continue providing services to Participants, You agree to submit in writing to CIGNA Your ninety (90) day notice to terminate this Election to Participate.

3. **Member Hold Harmless.** Under no circumstances, including, without limitation, termination of the MCA Agreement or this Election to Participate, non-payment by CIGNA or other Payor, or their insolvency, will You seek from any Participant or person acting on his/her behalf payment for Covered Services that is payable by CIGNA or other appropriate Payor. This provision shall not prohibit collection of supplemental charges or co-payments in accordance with the terms of the applicable Service Agreement. You agree that this provision shall survive termination of the MCA Agreement or this Election to Participate for Covered Services rendered prior to such termination, regardless of the cause of termination, and shall be construed to be for the Participant's benefit. You agree that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between You and a Participant or person acting on his/her behalf.

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Printed Name:

\_\_\_\_\_  
Tax Identification Number:

\_\_\_\_\_  
Address For Payment/Notice:

\_\_\_\_\_  
DEA Control Number:

\_\_\_\_\_  
Medicare Provider Number:

# Request for Taxpayer Identification Number and Certification

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

► Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Print or type.  
See Specific Instructions on page 3.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1</b> Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                    |
| <b>2</b> Business name/disregarded entity name, if different from above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                    |
| <b>3</b> Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.<br><br><input type="checkbox"/> Individual/sole proprietor or single-member LLC<br><br><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____<br><b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is <b>not</b> disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.<br><br><input type="checkbox"/> Other (see instructions) ► | <b>4</b> Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):<br><br>Exempt payee code (if any) _____<br><br>Exemption from FATCA reporting code (if any) _____<br><br><small>(Applies to accounts maintained outside the U.S.)</small> |
| <b>5</b> Address (number, street, and apt. or suite no.) See instructions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Requester's name and address (optional)                                                                                                                                                                                                                                            |
| <b>6</b> City, state, and ZIP code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                    |
| <b>7</b> 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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

|                                       |  |  |  |   |  |  |  |   |  |  |
|---------------------------------------|--|--|--|---|--|--|--|---|--|--|
| <b>Social security number</b>         |  |  |  |   |  |  |  |   |  |  |
|                                       |  |  |  | - |  |  |  | - |  |  |
| <b>or</b>                             |  |  |  |   |  |  |  |   |  |  |
| <b>Employer identification number</b> |  |  |  |   |  |  |  |   |  |  |
|                                       |  |  |  | - |  |  |  |   |  |  |

## 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 for Part II, later.

|                  |                            |        |
|------------------|----------------------------|--------|
| <b>Sign Here</b> | Signature of U.S. person ► | Date ► |
|------------------|----------------------------|--------|

## General Instructions

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

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

## 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, later.*

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*, later, for further information.

**Note:** If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

## Backup Withholding

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the instructions for Part II for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships*, earlier.

## What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

## Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

**Note: ITIN applicant:** Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or “doing business as” (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity’s name as shown on the entity’s tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a “disregarded entity.” See Regulations section 301.7701-2(c)(2)(iii). Enter the owner’s name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner’s name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity’s name on line 2, “Business name/disregarded entity name.” If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

### Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

### Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

| IF the entity/person on line 1 is a(n) . . .                                                                                                                                                                                                                                                   | THEN check the box for . . .                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| • Corporation                                                                                                                                                                                                                                                                                  | Corporation                                                                                                                     |
| • Individual<br>• Sole proprietorship, or<br>• Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.                                                                                                                             | Individual/sole proprietor or single-member LLC                                                                                 |
| • LLC treated as a partnership for U.S. federal tax purposes,<br>• LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or<br>• LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes. | Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation) |
| • Partnership                                                                                                                                                                                                                                                                                  | Partnership                                                                                                                     |
| • Trust/estate                                                                                                                                                                                                                                                                                 | Trust/estate                                                                                                                    |

### Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

#### Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys’ fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

| IF the payment is for . . .                                                            | THEN the payment is exempt for . . .                                                                                                                                                                          |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Interest and dividend payments                                                         | All exempt payees except for 7                                                                                                                                                                                |
| Broker transactions                                                                    | Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012. |
| Barter exchange transactions and patronage dividends                                   | Exempt payees 1 through 4                                                                                                                                                                                     |
| Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup> | Generally, exempt payees 1 through 5 <sup>2</sup>                                                                                                                                                             |
| Payments made in settlement of payment card or third party network transactions        | Exempt payees 1 through 4                                                                                                                                                                                     |

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

**Exemption from FATCA reporting code.** The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

**Note:** You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

## Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

## Line 6

Enter your city, state, and ZIP code.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note:** See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at [www.SSA.gov](http://www.SSA.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/Businesses](http://www.irs.gov/Businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. Go to [www.irs.gov/Forms](http://www.irs.gov/Forms) to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to [www.irs.gov/OrderForms](http://www.irs.gov/OrderForms) to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note:** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

**Signature requirements.** Complete the certification as indicated in items 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.**

You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

## What Name and Number To Give the Requester

| For this type of account:                                                                                                                          | Give name and SSN of:                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| 1. Individual                                                                                                                                      | The individual                                                                                          |
| 2. Two or more individuals (joint account) other than an account maintained by an FFI                                                              | The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup> |
| 3. Two or more U.S. persons (joint account maintained by an FFI)                                                                                   | Each holder of the account                                                                              |
| 4. Custodial account of a minor (Uniform Gift to Minors Act)                                                                                       | The minor <sup>2</sup>                                                                                  |
| 5. a. The usual revocable savings trust (grantor is also trustee)<br>b. So-called trust account that is not a legal or valid trust under state law | The grantor-trustee <sup>1</sup><br>The actual owner <sup>1</sup>                                       |
| 6. Sole proprietorship or disregarded entity owned by an individual                                                                                | The owner <sup>3</sup>                                                                                  |
| 7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))                                     | The grantor <sup>4</sup>                                                                                |
| For this type of account:                                                                                                                          | Give name and EIN of:                                                                                   |
| 8. Disregarded entity not owned by an individual                                                                                                   | The owner                                                                                               |
| 9. A valid trust, estate, or pension trust                                                                                                         | Legal entity <sup>4</sup>                                                                               |
| 10. Corporation or LLC electing corporate status on Form 8832 or Form 2553                                                                         | The corporation                                                                                         |
| 11. Association, club, religious, charitable, educational, or other tax-exempt organization                                                        | The organization                                                                                        |
| 12. Partnership or multi-member LLC                                                                                                                | The partnership                                                                                         |
| 13. A broker or registered nominee                                                                                                                 | The broker or nominee                                                                                   |

| For this type of account:                                                                                                                                                                   | Give name and EIN of: |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| 14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments | The public entity     |
| 15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))                                          | The trust             |

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

**\*Note:** The grantor also must provide a Form W-9 to trustee of trust.

**Note:** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

## Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at [spam@uce.gov](mailto:spam@uce.gov) or report them at [www.ftc.gov/complaint](http://www.ftc.gov/complaint). You can contact the FTC at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see [www.IdentityTheft.gov](http://www.IdentityTheft.gov) and Pub. 5027.

Visit [www.irs.gov/IdentityTheft](http://www.irs.gov/IdentityTheft) to learn more about identity theft and how to reduce your risk.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



## AETNA INDIVIDUAL PROVIDER ADDENDUM

The undersigned health care provider ("Provider"), a member of [Premier Pediatric Providers, L.L.C. d/b/a Kids Health First Pediatric Alliance](#) ("Entity"), has and does hereby designate Entity as his/her attorney-in-fact for the purposes of negotiating, consenting to and executing the [IPA Agreement](#) (the "Agreement"), between [Aetna Health Inc., a Georgia corporation](#) ("Company") and Entity and any documents related to amendments to the Agreement. Terms capitalized herein but not otherwise defined shall have the meanings ascribed to them in the Agreement.

Provider hereby acknowledges that Provider has reviewed the Agreement (a copy of which has been made available to Provider by Entity), under which Entity, on behalf of Provider, agrees to provide Covered Services to Members enrolled in the Plans. Plans include any health benefit product or plan issued, administered, or serviced by Company or one of its Affiliates, including, but not limited to, HMO, preferred provider organization, indemnity, Medicaid, Medicare and Worker's Compensation. Provider hereby agrees to be bound by the terms and conditions of the Agreement, including, without limitation, compliance with the Participation Criteria applicable to Provider and all applicable Company rules, policies and procedures.

Provider hereby agrees that in the event: (i) Provider ceases to be a member of Entity; (ii) the Agreement expires or is terminated for any reason; (iii) the Entity is dissolved; (iv) a voluntary or involuntary bankruptcy or a proposed settlement of outstanding debts under applicable reorganization or insolvency laws is filed by or against Entity, a receiver is appointed or Entity makes an assignment for the benefit of creditors; or (v) the Entity otherwise ceases to exist, either voluntarily or involuntarily (each, a "Triggering Event"), the terms of the Agreement shall, at Company's option, survive with respect to Provider for the first nine (9) months after such Triggering Event, in which case Provider shall continue to provide services to Members in accordance with the terms of the Agreement during said nine (9) month period. Provider agrees to take any and all actions necessary to effectuate the intent of this paragraph, including executing an individual agreement for participation in Company's provider network if so requested by Company.

IN WITNESS WHEREOF, the undersigned has executed this Individual Provider Addendum as of this day of \_\_\_\_\_, 20\_\_, intending to be legally bound hereby.

PROVIDER: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

## ATTACHMENT A

### PHYSICIAN PARTICIPATION ATTESTATION

WHEREAS, Peach State Health Plan ("HMO"), has executed an agreement with [ ] ("Medical Group") dated [ ] pursuant to which Medical Group has agreed to provide Covered Services to HMO Covered Persons through Medical Group Physicians (the "Agreement"); and

WHEREAS, Medical Group has requested that the undersigned physician ("Physician") serve as a Medical Group Physician under the Agreement and Physician so desires to participate; and

WHEREAS, as a condition of such participation and Physician's designation as a "Medical Group Physician" under this Agreement, Physician must satisfy HMO's credentialing criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Agreement.

NOW THEREFORE, Physician hereby agrees as follows:

1. Physician agrees to provide Covered Services to Covered Persons in accordance with the requirements of the Agreement so long as Physician qualifies as a Medical Group Physician.
2. Physician understands and agrees that his/her initial and continued participation as a Medical Group Physician under the Agreement is contingent upon meeting and complying with HMO's credentialing standards and otherwise complying with the terms and conditions of the Agreement.
3. Physician acknowledges that HMO expressly reserves the right to reject, suspend, and/or terminate his/her participation under the Agreement for breaching or otherwise failing to: (i) comply with the term of the Agreement or any Attachment thereto; (ii) meet HMO's credentialing requirements; or (iii) comply with the Participating Health Care Provider Manual.
4. This Attestation shall be effective as of [ ].

Physician

/s/ \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

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

## NQCA Illegal Drug Usage Questionnaire

Provider Name \_\_\_\_\_

Are you currently using illegal drugs that could affect your ability to practice medicine?  
(NQCA Required question: CR3, Element C, Factor 2)

YES \_\_\_\_\_

NO \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

## NCQA Race, Ethnicity, Language

Completion by the practitioner is optional.  
(NCQA Required question: CR3, Element C, Factor 6)

Race \_\_\_\_\_

Ethnicity \_\_\_\_\_

Languages(s) Spoken \_\_\_\_\_

No provider or group will be denied an invitation to participate, or have any contract terminated, on the basis of age, sex, race, creed, color, national origin, religion, marital status, sexual orientation, disability, or type of procedure or patient (e.g. Medicaid) in which the practitioner specializes. (KHF Policy CR1C)

## Supplemental Information

Start Date \_\_\_\_\_

Part Time or Full Time \_\_\_\_\_

Taxonomy Code \_\_\_\_\_

Group NPI \_\_\_\_\_

EMR Name \_\_\_\_\_

Telemedicine: Yes ☐ or No ☐

CAQH \_\_\_\_\_

(Please ensure the CAQH is fully complete and attested within the last 6 months.)

Name of Participating Physician: \_\_\_\_\_

### **PARTICIPATING PROVIDER AGREEMENT**

This **PARTICIPATING PROVIDER AGREEMENT** (this “**Agreement**”) is entered into and made effective this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ (the “**Effective Date**”), by and between the following:

\_\_\_\_\_, an individual physician residing at \_\_\_\_\_, \_\_\_\_\_, GA  
\_\_\_\_\_ (“**Provider**”); and

**PREMIER PEDIATRIC PROVIDERS, LLC**, d/b/a **Kids Health First**, a Georgia limited liability company, with principal offices located at 2480 Briarcliff Road NE, Suite 6-334 Atlanta, Georgia 30329 (hereafter referred to as “**KHF**”),

Provider and KHF are collectively referred to herein as the “**Parties**” and each individually as a “**Party**.”

### **RECITALS**

- (1) Independent Pediatric Alliance-Greater Atlanta, LLC, a Georgia limited liability company, is a clinically-integrated network of pediatric practices and physicians (hereafter referred to as the “**Network**”) located in the metropolitan Atlanta area.
- (2) KHF provides support and administrative services for the Network with the goal of improving healthcare services offered by participating physicians and their practices to children in Atlanta and thus improving the overall health of children in Metro Atlanta.
- (3) KHF’s supporting services for the Network, and specifically for Network physicians and their medical practices, include, among other things: (i) improving record sharing among Network physicians and specialists; (ii) assisting the Network as it develops and implements best practices protocols, (iii) providing administrative assistance as needed for quality assurance efforts and programs, (iv) helping participating practices and their physicians create efficiencies to improve patient care and lower administrative costs where possible, (v) providing Network credentialing support services, (vi) creating and designing compliance tools to monitor compliance improvement efforts, and (vii) helping to design new technological tools to improve the delivery and efficiency of healthcare services.
- (4) KHF also serves as the contracting agent on behalf of the Network, its participating practices, and its participating physicians relating to agreements with third-party payers, including licensed insurers, third-party administrators, healthcare service plans, non-profit hospital service plans, managed care organizations and other similar entities (all such paying entities referred to herein “**Payers**”) that arrange and pay for the provision of healthcare services to their respective members who are enrolled in various benefit plans (each such benefit plan referred to herein as a “**Plan**” and such individual enrollees in such Plans referred to as “**Members**”);
- (5) Provider is a physician who is duly licensed, certified, accredited, or otherwise authorized to practice medicine in the State of Georgia, and, as such, Provider desires to (i) participate in the Network, (ii) participate in the supporting services offered by KHF for the Network; and (iii) provide professional healthcare services to Members.
- (6) KHF and Provider thus desire to enter into this Agreement which sets out the terms and conditions of Provider’s participation in the Network and as a provider of covered services to Members.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending to be legally bound, agree as follows:

## **ARTICLE I**

### **INCORPORATION OF RECITALS AND DEFINITIONS**

**Section 1.1 Incorporation of Exhibits.** All attached **Exhibits** are incorporated herein by reference and made a part of this Agreement.

**Section 1.2 Definitions.** The words and phrases defined above and below shall have such assigned meanings throughout this Agreement. Unless the context otherwise requires, words importing the singular include the plural and vice versa, words importing the masculine gender include the feminine and neuter and vice versa, and references to any individual, person, or entity includes an incorporated or unincorporated body, partnership, joint venture, association, authority, government, trust, and vice-versa. For the purposes of this Agreement, (i) the words “include”, “includes”, and “including” shall be deemed, throughout this Agreement unless specifically stated otherwise, to be followed by the words “without limitation”; (ii) the word “or” is not exclusive; and (iii) the words “herein”, “hereof”, “hereby”, “hereto”, and “hereunder” refer to this Agreement as a whole.

“Active Solicitation of Members” is defined in Section 8.11.

“Active Solicitation of Payers” is defined in Section 8.10.

“Agreement” is defined in the preamble above.

“Board of Managers” or the “Board” means the KHF Board of Managers as defined by KHF’s operating agreement, as amended from time to time.

“Business Day” means a day other than (i) Saturday, (ii) Sunday, or (iii) another day on which commercial banks in Atlanta are authorized or required by law to be closed.

“Coordination of Benefits” is a procedure used to process healthcare payments when a Member is covered by one or more insurers. Coordination of Benefits means the determination of which of two or more health benefit plans will apply, either as primary or secondary coverage, for Covered Services. The Coordination of Benefits is intended to preclude a Member from recovering an aggregate of more than one hundred percent (100%) of covered charges from all coverage. When the primary and secondary benefits are coordinated, determination of liability will be in accordance with the usual procedures employed by the Georgia Department of Insurance and applicable federal and state regulations.

“Copayment” or “Deductible” means charges for professional healthcare services that may be collected by Provider from a Member as payment in addition to fees paid by Payers to Provider in accordance with the terms of the agreement between the Network and such Payer and in accordance with Member’s Evidence of Coverage.

“Covered Services” means healthcare services and supplies that a Member is entitled to receive pursuant to a Plan. Such Covered Services for any given Plan are described and defined in the Plan’s documents, including disclosure forms, subscriber, and group contracts, and in a Plan’s provider manual.

“Credentialing Criteria” means the criteria established, from time to time, by KHF for the

initial credentialing and re-credentialing (as needed and determined by the Board) of Participating Providers, which may be amended from time to time by KHF in its sole discretion.

**“Effective Date”** is defined in the preamble above.

**“Grievance Procedure”** is defined in **Section 7.3**.

**“Hearing Request”** is defined in **Section 4.3(c)**.

**“Initial Participation Date”** means the date on which Provider first joined KHF.

**“KHF”** is defined in the preamble above.

**“KHF-Endorsed Initiatives”** is defined in **Section 2.15**.

**“KHF Indemnities”** is defined in **Section 6.1**.

**“KHF Trade Secret Information”** is defined in **Section 8.13**.

**“Losses”** means actions, liabilities, liens, deficiencies, judgments, losses, damages, bonds, dues, assessments, fines, penalties, taxes, fees, costs (including out-of-pocket costs of investigation, defense, and enforcement of this Agreement), expenses or amounts paid in settlement (in each case, including reasonable, out-of-pocket attorneys’ and expert fees and expenses).

**“Medical Director”** is the physician appointed to such position by the KHF Board of Managers.

**“Member”** means the person(s) entitled and eligible to receive Covered Services pursuant to a Plan.

**“Member Information”** is defined in Section 8.12.

**“Network”** is a clinically-integrated network of physicians and is further defined in the Recitals section above.

**“Participating Hospital”** means the hospital(s) with agreements with a Plan to provide hospital services to a Member.

**“Participating Facility”** means the facility(ies) with agreements with a Plan to provide facility services to a Member.

**“Participating Providers”** are those healthcare providers who have entered into an agreement with KHF to perform Covered Services to Members.

**“Party”** and **“Parties”** are defined in the preamble above.

**“Payer”** means an entity, who has entered into a Payer Agreement with KHF, responsible for the agreed upon payment for Covered Services rendered to Members. Payers may include

health insurance carriers, managed care organizations, third party administrators, other types of insurance coverage providers, health maintenance organizations, self-funded employee benefit plans, and other similar entities contracting with KHF to provide Covered Services.

**“Payer Agreement”** means an agreement with a Payer and KHF (and thus the Network) setting forth the terms and conditions under which the Network shall arrange for the provision of Covered Services to Members under Plan(s) specifically referenced in such Payer Agreement.

**“Plan”** is defined in the Recitals section above and means an arrangement under which a Payer is obligated to pay, directly or indirectly, a provider of healthcare services, in connection with such provider’s rendering of Covered Services to Members.

**“Plan Participation Notice”** is defined in **Section 2.14**.

**“Primary Hospital”** means a hospital as approved by the Board of Managers in the Atlanta metropolitan area.

**“Primary Physician”** or **“Primary Care Physician”** shall have the meaning assigned in each applicable Payer Agreement.

**“Provider”** is defined in the preamble above.

**“Provider Indemnitees”** is defined in Section 2.1(g).

**“Provider’s Practice”** means the medical corporate entity through and under which Provider practices medicine.

**“QM Committee”** is defined in Section 7.2.

**“QM Program”** is defined in Section 7.2.

**“Referral”** means the process by which Provider directs a Member to obtain Covered Services from another Participating Provider.

**“Review Procedure”** means the procedure whereby a provider or Participating Provider may request a reconsideration of various actions of KHF.

**“Term”** is defined in Section 4.1.

**“UM Committee”** is defined in Section 7.1.

**“UM Program”** means either the utilization management program established and administered by KHF or the utilization management program required by a Payer in a Payer Agreement or required by an entity pursuant to an Agreement with KHF.

## **ARTICLE II**

### **OBLIGATIONS OF PROVIDER**

#### **Section 2.1     Services to Plan Members.**

- (a)     **Primary Pediatric Care.** Provider agrees to provide primary care pediatric medical

services that fall within the meaning of Covered Services to Members, provided the applicable Plan has accepted Provider to provide Covered Services to its pediatric Members. Provider agrees to provide Covered Services in accordance with the terms of the applicable Payer Agreement. Provider agrees to be available to provide such Covered Services or to provide coverage for such Covered Services (at Provider's cost) twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. If Provider is, for any reason, unable to provide such services when needed, Provider, or Provider's Practice, may secure the services of a locum tenens who shall render primary care pediatric services on Provider's behalf, subject to Plan's or Payer Agreement requirements regarding such coverage. Provider shall be solely responsible for securing and paying for the services of the locum tenens. Provider shall ensure that the locum tenens looks solely to Provider for compensation and complies with the terms of this Agreement. Notwithstanding anything herein to the contrary, Provider agrees to, and Provider shall cause Provider's Practice to agree to, appoint only such locum tenens providers who currently satisfy current credentialing criteria established by the Board of Managers as of the date of services to be provided by the locum tenens.

(b) **Treatment of Members/No Discrimination.** Provider agrees to treat Members in each applicable Plan no less favorably than Provider's other patients in all respects. Provider also agrees not to discriminate against any Member on the basis of such Member's race; color; age; religious beliefs, observances, and practices; natural origin; physical disability; mental disability; medical condition; sex; sexual orientation; gender identity; or any other protected class recognized by applicable local law.

(c) **Methods and Compliance.** Provider, and not KHF, shall determine the method, details, and means of performing Covered Services for Members. Such Provider services, however, shall be performed pursuant to and consistent with state licensure requirements, applicable state and federal certification rules and regulations (including DEA requirements), applicable accreditation requirements, and consistent with the proper and applicable standard of care.

(d) **Members Cap Based Upon Percentage.** Provider shall provide Covered Services to Members under applicable Plans and Payer Agreements to which Provider is obligated or has agreed to accept under the terms of this Agreement; provided, however, that if twenty percent (20%) or more of Provider's gross revenues are attributable to a specific plan or Payer under an applicable Payer Agreement, Provider may refuse to accept additional beneficiaries under such Plan or Payer Agreement, upon ninety (90) days advance written notice to KHF, and with the consent of the KHF Board of Managers. Notwithstanding anything herein to the contrary, this subsection (d) does not apply to Medicaid and related state and federal payment programs. Nothing in this Agreement or otherwise shall require Provider to enroll or participate in Medicaid or any other federal or state payment program as a participating provider (including, but not limited to, an ordering, prescribing, and referring provider) or otherwise.

(e) **Use of Assistants.** Provider may utilize such non-professional personnel in Provider's office or Provider's Practice who are employees or contractors of Provider, or of an entity or group which employs Provider, or with which Provider is affiliated, as Provider deems necessary to perform Covered Services. KHF shall not control, direct, or supervise, in any way, such non-professional personnel in the performance of Covered Services. The services of any such non-professional personnel shall be reimbursed by the respective Plan only in accordance with the terms of this Agreement and the applicable Plan documents.

(f) **Referral/Admission Procedures.** In the event that Provider believes that a Member requires a Referral to a Participating Provider, Participating Facility, or Participating Hospital, Provider shall make such Referral in accordance with referral procedures designed, developed, and adopted by the applicable Plan or KHF ("**Referral Procedures**"). In addition, Provider shall admit Members only to an appropriate Participating Hospital unless an appropriate bed or needed service is unavailable at a Participating Hospital, in accordance with the admission procedures set forth in the Plan documents and/or procedures adopted from time to time by KHF.

(g) **Documentation.** Provider agrees to provide and maintain clinical notes in accordance with the applicable standard of care, and also in conformity to Plan requirements and the reasonable requirements of KHF. In addition, Provider or Provider's office staff shall obtain from a parent or guardian of a pediatric Member a written assignment of benefits and an authorization to release medical records as required by Plans and KHF. Provider also agrees, subject to KHF's compliance with all applicable laws, rules, and regulations, to permit the collection of data by KHF or its agents for Network and KHF compliance, clinical integration, and care improvement efforts. KHF will indemnify and defend Provider and Provider's representatives ("**Provider Indemnitees**") against, and hold each Provider Indemnitee harmless from and against, and shall pay and reimburse each of them for, any and all Losses incurred or sustained by, imposed upon, the Provider Indemnities based upon or arising out of, with respect to, or by reason of KHF's or its designees' improper collection, disclosure, storage, and use of, or access to, patient health information.

(h) **Primary Care Provider Obligations.** If Provider is designated as a Primary Care Physician by a Plan, then Provider agrees to act as the Primary Care Physician for Members who designate Provider as such. The responsibilities for serving as a Primary Care Physician will be set out in the applicable Plan document or applicable utilization management/quality improvement program documents. In addition, in the event that any Plan seeks to design and implement a patient-centered medical home for its Members, Provider agrees to comply with the terms as accepted by Provider in the applicable Plan document. Provider further agrees to comply with any requirement of KHF that Provider and Provider's Practice serve as a patient centered medical home for any Plans or other similarly designed or equivalent programs.

**Section 2.2 Compliance with Laws, Rules, and Regulations.** Provider shall at all times during the Term comply with

- (i) all applicable federal and state laws, rules, and regulations relating to the practice of medicine and required of healthcare providers in the provision of medical services;
- (ii) all applicable rules and regulations of the Georgia Composite Medical Board, and
- (iii) all rules and guidelines of the Drug Enforcement Agency and the Controlled Substances Act required of those providing medical services to others.

Provider's failure to comply with any of the above at any time during the Term shall constitute a material breach of this Agreement, and this Agreement may be terminated immediately without regard as to whether such noncompliance has been finally adjudicated.

**Section 2.3 Impact of Limitations and Restrictions.** If Provider's license to practice medicine in the State of Georgia or Provider's DEA license is terminated, suspended, limited, conditioned, restricted, revoked, or surrendered, this Agreement may be terminated at the discretion of the KHF's Board of Managers without regard to whether or not such termination, suspension, limitation, condition, restriction, or revocation has been finally adjudicated. Provider hereby agrees that, when in need of locum tenens coverage, Provider will arrange for locum tenens coverage with only those physicians (i) holding a valid license to practice medicine in the State of Georgia, and (ii) with a valid, current, non-conditioned, and unrestricted DEA license.

**Section 2.4 Required Notifications.** Provider agrees to notify KHF immediately but in no event later than within three (3) Business Days of any of the following:

- (i) Provider's failure to comply with **Section 2.2** above;
- (ii) a termination, suspension, limitation, imposition of conditions, restriction, revocation, or

surrender of Provider's license to practice medicine in the State of Georgia or Provider's DEA license;

- (iii) any disciplinary action initiated against Provider, directly or indirectly, relating to Provider's practice of medicine;
- (iv) any action taken by a federal, state, or local regulatory agency or official that directly or indirectly impacts, or could reasonably be viewed as possibly impacting, Provider's practice of medicine;
- (v) any action by any hospital with the potential to negatively impact Provider's privileges at such hospital;
- (vi) any filing of a formal civil or criminal legal proceeding against Provider, including
  - (A) any malpractice claim;
  - (B) other civil action directly or indirectly relating to Provider and Provider's practice of medicine;
  - (C) any felony charge asserted against Provider; or
  - (D) any misdemeanor charge asserted against Provider for a crime involving moral turpitude;
- (vii) any allegation, investigation, or claim of sexual molestation or violent criminal act arising out of Provider's actions in any forum and whether or not related to the practice of medicine;
- (viii) any malpractice settlement on behalf of Provider of a malpractice allegation against Provider; and
- (ix) any verdict against Provider in a civil matter relating to Provider's practice of medicine or felony criminal matter, regardless of the final adjudication of such claim.

**Section 2.5 Credentialing Criteria.** Provider shall at all times during the Term of this Agreement be in, and remain in, compliance with all Credentialing Criteria established by KHF. Provider also acknowledges and agrees that all information provided by Provider to KHF on any credentialing application or related form must be, and remain at all times, true and correct in all material respects during the Term. Any failure by Provider to provide true, accurate, and complete information to KHF shall be deemed a material breach of this Agreement. In any such instance, this Agreement may be terminated immediately by the KHF Board of Managers.

**Section 2.6 Quality Assurance.** Provider acknowledges and agrees that participation in KHF requires Provider's compliance with all quality assurance measures and processes approved by the KHF Board of Managers. Any failure by Provider to participate in such approved quality assurance measures or procedures will be considered a breach of this Agreement giving KHF the right to terminate this Agreement with Provider. Provider further agrees to comply with Plan medical directors in the review of quality of care administered to Members.

**Section 2.7 Insurance Requirements.**

- (a) **Workers' Compensation.** Provider shall provide, at Provider's or Provider's practice cost and

expense, workers' compensation insurance for Provider's agents and employees throughout the entire term of this Agreement, in accordance with the laws of the State of Georgia as the same may from time to time be amended. Provider shall provide written evidence of such coverage upon written request of KHF.

(b) **Medical Malpractice Insurance.** Provider shall provide, unless otherwise agreed to by Provider and KHF, at Provider's sole cost and expense, throughout the Term, a policy of professional malpractice liability insurance with a licensed insurance company, reasonably acceptable to KHF, admitted to issue such policies in the State of Georgia in a minimum amount of One Million Dollars (\$1,000,000.00) per claim and Three Million Dollars (\$3,000,000.00) in the annual aggregate, or such other amounts as may be required or approved by the Board of Managers of KHF, to cover any loss, liability or damage alleged to have been committed by Provider, or Provider's agents or employees. Provider shall obtain a "tail" policy for a period of not less than five (5) years following the effective termination date of the foregoing policy in the event the policy is a "claims made" policy. The tail policy shall have the same policy limits as described above.

(c) **Other Insurance.** Provider shall provide, at Provider's sole cost and expense, throughout the entire term of this Agreement, a policy or policies of insurance covering Provider's principal place of business insuring Provider against any claim of loss, liability, or damage committed or arising out of the alleged condition of said premises, or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage as a result of the operation of a motor vehicle for business purposes by Provider, Provider's agents or employees, both in a minimum amount of One Hundred Thousand Dollars (\$100,000.00) per claim and Three Hundred Thousand Dollars (\$300,000.00) in the annual aggregate. In addition, Provider shall maintain, at Provider's sole cost and expense, any additional insurance policies (such as a cybersecurity insurance policy) reasonably required by the Board of Managers of KHF.

(d) **Notice of Changes in Insurance Coverage.** Provider shall provide KHF immediate written notice in the event any of the policies set forth in this **Section 2.7** are canceled, changed, or amended. Provider shall, from time to time, on the reasonable request of KHF, furnish to KHF written evidence that the policies of insurance required under this **Section** are in full force and effect. Further, Provider shall instruct his or her insurer to name KHF as an additional insured solely for purposes of notification of changes in certificates of coverage and amendment or termination of coverage.

**Section 2.8 Hospital Privileges.** During the Term, Provider shall be and remain at all times a member in good standing of the medical staff of at least one Primary Hospital. This obligation may be satisfied with affiliate membership at Children's Healthcare of Atlanta alone or by maintaining full privileges at another Primary Hospital. Provider shall provide KHF immediate notice in the event that such membership required herein is denied, restricted, reduced, conditioned, revoked, or not renewed for any reason. Upon notification of such event and notwithstanding any provision herein to the contrary, KHF, in its sole discretion, may immediately terminate this Agreement, without regard to whether or not such impairment of privileges or membership has been finally adjudicated.

**Section 2.9 Compliance with KHF Rules and Regulations/Clinical Integration.** Provider agrees to comply with all KHF written rules, regulations, written policies, and procedures that have been adopted by the KHF Board of Managers and provided to Provider from time to time. Furthermore, acknowledging and recognizing the critical importance of KHF's clinical integration efforts, Provider further agrees to participate fully in all clinical integration efforts of the Network. In the event that compliance by Provider with a specific clinical integration effort, in Provider's opinion, imposes a significant and commercially unreasonable burden on Provider, Provider agrees to meet with the KHF Board of Managers to present and describe in detail such burden(s). The KHF Board of Managers may waive Provider's compliance as to any specific clinical integration effort or step if the Board determines, at its sole discretion, that compliance would (i) cause such a significant and commercially unreasonable burden, and (ii) not create undesirable risk to the overall clinical integration efforts of KHF.

**Section 2.10 Roster Information.** During the Term, Provider hereby grants to KHF and each Plan that contracts with KHF a non-revocable, unlimited, worldwide, and royalty-free license to use Provider's name, address(s), phone number, fax number, and type of practice in the KHF and/or a Plan roster of Provider participants. The roster for each Plan shall be used by prospective Members, KHF physicians, KHF, prospective new physicians, and individuals and businesses considering various Plans.

**Section 2.11 Payment of Credentialing Fee.** Provider shall pay to KHF a non-refundable credentialing or re-credentialing fee in the amount(s) established by KHF from time to time in accordance with KHF rules and regulations.

**Section 2.12 Grant of Access to Information.** Provider hereby grants KHF permission to access any information relative to Provider's professional qualifications, Provider's mental or physical fitness (for the purposes of credentialing and quality assurance only), or the quality of care rendered by Provider. Provider shall provide KHF with any authorizations, consents or releases that KHF may require from Provider to obtain the information described above. In addition, Provider grants KHF permission, for and on behalf of Provider, to authorize representatives of Plans contracting with KHF to obtain the information described above. Provider hereby releases KHF, its employees and its authorized agents from any and all claims, liability and damages incurred by KHF, its employees, or its authorized agents due to any action taken by KHF pursuant to this **Section**; provided, however, that KHF will indemnify and defend Provider against and shall hold Provider harmless from and against, and shall pay and reimburse Provider for, any and all Losses incurred or sustained by, imposed upon, the Provider based upon or arising out of, with respect to, or by reason arising out of KHF's or its employees' or agents' unauthorized disclosure or access to information received pursuant to this **Section 2.12** or negligence or misconduct in using or storing such information.

**Section 2.13 Periodic Review.** For a period of eighteen (18) months following the Initial Participation Date (the "**Review Period**"), KHF shall have the right to review on a periodic basis, but no more frequently than quarterly, Provider's performance in meeting Provider's obligations hereunder. Such review shall be conducted by the Credentialing Committee and/or the Board of Managers of KHF. Notwithstanding anything herein to the contrary, if at any time during the Review Period KHF determines, in its sole and absolute discretion, pursuant to such periodic review(s) that Provider does not meet the criteria for continued participation as a Participating Physician under this Agreement, KHF may, in its sole and absolute discretion, deem such Provider to be in violation of this Agreement and terminate this Agreement immediately.

**Section 2.14 Participation in Payer Agreements.** KHF, following applicable federal and state antitrust rules and regulations, will determine appropriate terms for each potential Payer Agreement. KHF agrees to send Provider written notice, outlining the terms of each proposed Payer Agreement ("**Plan Participation Notice**"). If Provider does **not** wish to participate in such proposed Payer Agreement, Provider must notify KHF in writing within ten (10) Business Days of receipt of the Plan Participation Notice of the Provider's desire not to participate in that particular Payer Agreement. If Provider does not notify KHF within such ten (10) day period of Provider's desire not to participate in such Payer Agreement, then Provider shall be deemed to have elected to participate in and abide by the terms of said Payer Agreement. If Provider elects to participate in a Payer Agreement, then the terms of such Payer Agreement shall be incorporated herein by this reference. All notices to be given by Provider or KHF pursuant to this Section shall be given in a manner consistent with the notice requirements of this Agreement. Both Parties agree that KHF and this Agreement in no way restricts Provider from contracting directly with any Payer or Plan with which the IPA does not have a Payer Agreement. The ability of Provider to contract directly with any Payer or Plan does not, however, give Provider the right to participate in other independent practice associations or other similar negotiating arrangements.

**Section 2.15 Participation in KHF Initiatives.** KHF may, from time to time, implement various initiatives ("**KHF-Endorsed Initiatives**") to offer affordable benefits and services to its Participating Providers.

Such KHF-Endorsed Initiatives may, but are not required to, include group health benefit plans for Provider and Provider's employees, clinical research opportunities, malpractice insurance, or other benefit programs. Provider understands and agrees that the success and/or low-cost pricing of such KHF-Endorsed Initiatives will often be dependent upon the volume of participation and adherence to terms of participation by Participating Providers. In the event that the Board of Managers mandates provider participation in any given initiative, Provider agrees to comply with such Board mandate. Provider further agrees that (i) if Provider elects to participate in any of the KHF-Endorsed Initiatives, or (ii) if Provider is required to participate by mandate of the Board in any such initiative, then Provider agrees to abide by the agreed upon terms of participation for the particular KHF-Endorsed Initiative. In the event of any failure of Provider to comply with this **Section 2.15**, KHF may, in its sole and absolute discretion, deem such failure a breach of this Agreement and terminate this Agreement immediately.

**Section 2.16 Acceptance of Payment/Billing.** Except as otherwise expressly agreed in writing in any given Plan, Provider agrees to accept payments described in this Agreement, including copayments, coinsurance, deductible payments, and payments from relevant Payers as payment in full for rendering Covered Services to Members. Except as specifically provided in this **Section**, Provider hereby agrees to not bill any Member for Covered Services provided to Members. Except as expressly stated in any Plan, Provider will bill a Member for deductibles or coinsurance, if any. Provider further agrees not to bill any Member for the difference between Provider's preferred rate or regular billing rates and the amount paid pursuant to this Agreement and the applicable Payer Agreement.

**Section 2.17 Billing for Non-Covered Services.** Provider agrees to notify Members in writing and in advance of any proposed medical services that Provider has reason to believe will not be covered or for which Provider has reason to believe that otherwise required preauthorization has not been obtained or has been denied and which, as a result, will be the personal responsibility of the Member and not covered under the applicable Payer Agreement.

**Section 2.18 Coordination of Benefits.** Provider agrees to cooperate with each Plan in coordinating benefits and payments with other plans and payers that are or may be responsible for all or part of Covered Services provided to Members. Based upon information available to Provider, Provider agrees to submit bills first to the Payer that appears to be primarily responsible to pay bills for the services rendered.

### **ARTICLE III** **COMPENSATION/PROVIDER PAYMENT OBLIGATION**

**Section 3.1 Compensation.** Provider shall receive payment from Payers for Covered Services rendered by Provider in accordance with the terms of the respective Payer Agreement. The amount of reimbursement to be paid to Provider shall be based on the appropriate Plan's applicable fee schedule attached to the Payer Agreement, which fee schedule Provider has agreed to accept in accordance with the terms hereof. Provider agrees not to charge Members in advance for eligible medical services except as permitted in applicable Payer Agreements. Per the terms of **Section 2.16** and **Section 2.17** above, Provider shall bill Members only for applicable Copayments, Deductibles, coinsurance, or Non-Covered Services and shall not seek any other compensation from a Member or other person acting on Member's behalf.

**Section 3.2 Timing of Invoices for Services.** Provider agrees to submit all invoices for payment from Payer in a timely manner but in no event later than such maximum time permitted under the terms of each applicable Payer Agreement.

**Section 3.3 Administrative Fee.** Notwithstanding anything herein to the contrary, Provider agrees to pay to KHF, as compensation for the services rendered by KHF hereunder, an amount determined, and as may be modified from time to time, by KHF's Board of Managers. Such fee shall be paid either (i) to KHF by

Provider within ten (10) Business Days of receipt by Provider of an invoice from KHF setting forth the amount owed by Provider under this **Section**, or (ii) pursuant to the terms of a Payer Agreement, directly to the KHF by the Payer. If Provider fails or refuses to satisfy its obligations to KHF under this **Section**, then the KHF may, in addition to and not in limitation of its other rights and remedies hereunder, charge interest on the outstanding amounts due at a rate not to exceed eighteen percent (18%) per annum or \$50.00 per month, whichever is greater.

#### **ARTICLE IV** **TERM, EXCLUSIVITY, AND TERMINATION**

**Section 4.1 Term of Agreement.** This Agreement shall become effective on the date first written above and shall be effective for a period of one (1) year thereafter, unless terminated sooner per the terms of this Agreement (the “**Initial Term**”). This Agreement will automatically renew for successive one (1) year periods on each subsequent anniversary of the Effective Date on the same terms and conditions contained herein, unless terminated sooner pursuant to the terms of this Agreement. The Initial Term plus all renewal terms are collectively referred to as the “**Term**.”

**Section 4.2 Exclusivity of Participation in Clinically-Integrated Network.** Provider acknowledges that the success of KHF and the Network and their ability to meet goals and objectives requires that Participating Providers not participate simultaneously in other clinically-integrated networks. As such, Provider agrees to participate only in a clinically-integrated network serviced by KHF during the Term. Notwithstanding anything herein to the contrary, the Board may permit, and may also require, participation in The Children’s Care Network

#### **Section 4.3     Right to Terminate.**

(a)     **Termination Without Cause.** Either Party may terminate this Agreement without cause by giving the other non-terminating Party at least one hundred twenty (120) Business Days prior written notice of the intent to terminate. Any such termination, however, shall not alleviate Provider’s obligation(s) as set out in any applicable Plan Agreement.

(b)     **Termination for Cause.** Either Party may terminate this Agreement if a material breach has occurred and has not been cured within twenty (20) Business Days of the breaching Party’s sending notice of the breach with an adequate description of the breach thus giving the breaching party the chance to cure the breach. If, however, the KHF Medical Director determines that Provider presents an imminent danger to a Member or to general public health, safety, or welfare, KHF may terminate this Agreement immediately.

(c)     **Right to a Hearing/Appeal to Board.** In the event of the termination of a Provider for cause, Provider may request a hearing in writing (a “**Hearing Request**”) that must be received by KHF within twenty (20) Business Days of the receipt of the termination notice containing the reason for Provider’s termination. If so requested in writing by Provider in the Hearing Request, within ten (10) Business Days of receipt of the Hearing Request, KHF will organize a hearing attended by Provider and representatives from the KHF Board of Managers. At such hearing, the KHF Board will present the reasons for the termination and give Provider an opportunity to respond to such reasons. The Board may decide to affirm the termination or may decide to reinstate Provider, possibly under restrictions.

(d)     **Final Decision.** Subject to Provider’s right to a hearing and appeal to the Board described above, the Parties acknowledge and agree that any decision made by KHF to terminate this Agreement pursuant to this **Article** shall be final. Provider’s right to appeal any such decision shall be governed strictly by the applicable provisions of the procedure described herein; and, except as otherwise provided by law, Provider shall have no further right to appeal the decision of KHF through any formal or informal administrative hearing

or review process, nor shall Provider have any other due process right to appeal a KHF decision to terminate this Agreement.

**Section 4.4 Termination of Provider by Plan.** Notwithstanding any other provision of this Agreement to the contrary, in the event that a Plan contracting with KHF notifies KHF that the Plan wishes to remove Provider from the Plan roster of participating physicians/providers, KHF shall have the right to immediately terminate Physician's participation in the Plan and/or this Agreement, in KHF's sole and absolute discretion.

**Section 4.5 Obligations on Termination or Non-Renewal.** Provider shall continue to provide Covered Services to a Member who is receiving Covered Services from Provider on the effective termination date of this Agreement until the Covered Services being rendered to the Member by Provider are completed (consistent with existing medical ethical/legal requirements for providing continuity of care to a patient), unless KHF or a Plan makes reasonable and medically appropriate provision for the assumption of such Covered Services by another Participating Provider. Provider shall be entitled to receive compensation for those Covered Services provided to a Member pursuant to this Section (prior to and following the effective termination date of this Agreement) in accordance with the fee schedule and compensation methodology set forth in the applicable Payer Agreement with respect to the applicable Plan(s).

## ARTICLE V

### **REPRESENTATIONS, WARRANTIES AND ADDITIONAL COVENANTS**

**Section 5.1 By KHF.** KHF hereby represents and warrants that it is a duly formed, validly existing legal entity, which was formed in accordance with, and is in good standing under, the laws of the State of Georgia.

**Section 5.2 By Provider.** Provider hereby represents and warrants that:

- (i) Provider is a physician holding an active, unrestricted license to practice medicine in the State of Georgia;
- (ii) Provider has all required licenses and permissions to prescribe medications in the State of Georgia without any restrictions;
- (iii) Provider has never been accused of, charged with, or convicted of a crime involving sexual misconduct or sexual battery involving a minor;
- (iv) Provider's license to practice medicine has never been revoked or suspending in any state or jurisdiction.

## ARTICLE VI

### **INDEMNIFICATION OBLIGATIONS**

**Section 6.1 Indemnification Obligations of Provider.** Provider shall indemnify and defend KHF and its respective Representatives (collectively the "KHF Indemnities") against and shall hold each of the KHF Indemnities harmless from and against, and shall pay and reimburse each of them for, and all Losses incurred or sustained by, imposed upon, the KHF Indemnities based upon or arising out of, with respect to, or by reason of:

- (i) the provision of services by Provider pursuant to the terms of this Agreement;
- (ii) any breach or non-fulfillment of any covenant, agreement, or obligation to be performed by Provider pursuant to this Agreement; or

- (iii) any inaccuracy in or breach of any of the representations or warranties of Provider contained in this Agreement.

**Section 6.2 Indemnification Obligations of Provider.** KHF shall indemnify and defend the Provider Indemnitees against and shall hold each of the Provider Indemnities harmless from and against, and shall pay and reimburse each of them for, any and all Losses incurred or sustained by, imposed upon, the Provider Indemnities based upon or arising out of, with respect to, or by reason of:

- (i) the provision of services by KHF pursuant to the terms of this Agreement;
- (ii) any breach or non-fulfillment of any covenant, agreement, or obligation to be performed by KHF pursuant to this Agreement; or
- (iii) any inaccuracy in or breach of any of the representations or warranties of KHF contained in this Agreement.

## **ARTICLE VII**

### **UTILIZATION & QUALITY MANAGEMENT, GRIEVANCE, AND CLINICAL RESEARCH**

**Section 7.1 Utilization Management.** A utilization management program (“**UM Program**”) has been created by KHF to establish policies and procedures for the review of the medical necessity of Covered Services, and may include preadmission, concurrent, and retrospective review and will be in addition to any utilization management program required by the provisions of a Payer Agreement or a contracting Plan. Any such UM Program will be administered by a utilization management committee (“**UM Committee**”) or similar committee of the Board of Managers of KHF. Provider shall comply with and, subject to Provider's rights of appeal, shall be bound by the UM Program. In addition, if requested, Provider agrees to serve on the UM Committee in accordance with the procedures established by KHF and contracting Plans. UM Committee members will be compensated in accordance with the compensation schedule approved by KHF’s Board of Managers.

**Section 7.2 Quality Management.** A quality management program (“**QM Program**”) will be created by KHF to establish policies and procedures for the review of the quality of Covered Services provided by Participating Providers to Members, and such will be in addition to any quality review program required by the conditions or provisions of a Payer Agreement or a contracting Plan. Any such QM Program will be administered by the QM Committee or a similar committee (the “**QM Committee**”) created by and subject to the Board of Managers of KHF. Provider shall comply with and, subject to Provider's rights of appeal, shall be bound by the QM Program. In addition, if requested, Provider agrees to serve on the QM Committee in accordance with the procedures established by KHF and contracting Plans. QM Committee members will be compensated in accordance with the compensation schedule as approved by KHF’s Board of Managers.

**Section 7.3 Grievance Procedure.** A grievance procedure (the “**Grievance Procedure**”) may be established for the processing of any patient complaint regarding Covered Services, in the sole and absolute discretion of KHF and contracting Plans. Provider shall comply with and, subject to Provider's rights of appeal, shall be bound by such Grievance Procedure.

**Section 7.4 Disenrollment.** A disenrollment procedure may be established for the disenrollment of any Member. Such disenrollment procedure shall be in accordance with all state and federal statutes and regulations governing health maintenance organizations, preferred provider organizations and/or provider

sponsored organizations, and that of contracting Plan(s).

**Section 7.5 Clinical Research.** From time to time, KHF may enter into agreements to participate in Clinical Research programs on behalf of the Provider. Such programs will be primarily for the clinical integration of the Provider with other Participating Providers in an effort to improve the quality of pediatric healthcare delivered to Members. Provider agrees to participate in such programs that are approved by KHF's Board of Managers. Notwithstanding anything herein to the contrary, if participation in such Clinical Research creates a significant administrative burden on Provider, Provider may appeal to the KHF Board of Managers for an exception to this requirement.

**Section 7.6 Material Participation.** Subject always to the terms and conditions of this Agreement, Provider agrees to:

- (i) participate in the clinical integration programs of KHF;
- (ii) publically support the programs and initiatives of KHF;
- (iii) regularly attend KHF meetings;
- (iv) have a general willingness to participate in positions of leadership when called upon;
- (v) provide access to information and data collected by Provider for KHF clinical integration purposes; and
- (vi) submit information reasonably requested by KHF as soon as reasonably possible, but in no event later than twenty (20) Business Days of KHF's written request.

## **ARTICLE VIII**

### **MISCELLANEOUS PROVISIONS**

**Section 8.1 Notices.** Notices required or permitted to be given hereunder by either Party to the other may be given by:

- (i) personal delivery in writing to the other Party;
- (ii) by registered or certified mail, postage prepaid, with return receipt requested addressed to the physical address first listed above in connection with each Party; or
- (iii) by email properly addressed to the email address given by either Party to the other; however, such notice will be effective only if receipt is confirmed by the receiving party in writing.

Each Party may change such Party's addresses by written notice given in accordance with this Agreement. Notices will be deemed delivered

- (A) on the date delivered, if delivered by hand;
- (B) on or before the third Business Day after sending, if sent by registered or certified mail;
- (C) on the Business Day immediately following the date on which the notice was sent, if sent by email; or

- (D) on the Business Day immediately following the date on which the notice was sent, if sent by facsimile.

**Section 8.2 Entire Agreement.** This Agreement supersedes any and all agreements, either written or oral, between the Parties with respect to the subject matter contained herein and contains all of the covenants and agreements between the Parties with respect to the rendering of Covered Services. Each Party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, have been made by either Party, or anyone acting on behalf of either Party, which are not embodied herein. The Parties also acknowledge and agree that no other agreement, statement, or promise relating directly to the subject matter herein and not contained in this Agreement shall be valid or binding.

**Section 8.3 Severability.** If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law and their implementing regulations to be invalid, void, or unenforceable, the remaining provisions will nevertheless continue in full force and effect.

**Section 8.4 Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of Georgia without regard to its conflict of law provisions.

**Section 8.5 Assignment.** This Agreement shall be binding upon, and shall inure to the benefit of, the Parties to it, and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, neither Provider nor KHF 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.

**Section 8.6 Independent Contractor.** Provider is, and shall always be, construed to be an independent contractor practicing Provider's profession, and Provider shall not be deemed to be or construed to be an agent, servant, or employee of KHF.

**Section 8.7 Confidentiality.** The terms of this Agreement and the terms of all Payer Agreements, in particular the provisions regarding compensation, are confidential and shall not be disclosed except as necessary to the performance of this Agreement or as required by law.

**Section 8.8 Waiver.** The waiver of any provision herein, or waiver of any breach of any provision herein, must be set forth specifically in writing and signed by the waiving Party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

**Section 8.9 Headings.** The subject headings of the **Articles** and **Sections** of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of its provisions.

**Section 8.10 No Third-Party Beneficiaries.** Nothing in this Agreement, express or implied, is intended or shall be construed to confer upon any person, firm, or corporation other than the Parties hereto and their respective successors or assigns, any remedy or claim under or by reason of this Agreement or any term, covenant or condition hereof, as third-party beneficiaries or otherwise, and all of the terms, covenants and conditions hereof shall be for the sole and exclusive benefit of the Parties hereto and their successors and assigns.

**Section 8.11 Specific Non-Solicitation of Payers.** During the term of this Agreement, and for an additional period of two (2) years after the effective date of the expiration or termination of this Agreement for whatever reason, Provider shall not, directly or indirectly, engage in the Active Solicitation of Payers under contractual obligation with KHF without KHF's prior written consent. For purposes of this Agreement, "**Active Solicitation of Payers**" means any in-person, telephonic, or written communications with a Payer, or advertisement placed by or requested by Provider and directed to a Payer, that KHF may reasonably interpret to

be intended to persuade a Payer to discontinue a relationship with KHF. Nothing herein shall be construed as prohibiting Provider from contracting individually with a Payer.

**Section 8.12 Non-Solicitation of Members.** During the term of this Agreement, and for an additional period of two (2) years after the effective date of the expiration or termination of this Agreement for whatever reason, Provider shall not directly or indirectly engage in the Active Solicitation of Members or any employer of Members without KHF's prior written consent. For purposes of this Agreement, "**Active Solicitation of Members**" means any in-person, telephonic, or written communications with a Member or an employer of a Member, or advertisement placed by or requested by Provider and directed to a Member or an employer of a Member, that KHF may reasonably interpret to be intended to persuade a Member or an employer of a Member to discontinue a relationship with KHF, to dis-enroll from a Plan contracting with KHF, or to persuade a Member to change Plans within KHF. Nothing herein shall be construed as prohibiting Provider from providing health care services to a Member where Provider is not otherwise in violation of this **Section**.

**Section 8.13 Proprietary Information.** Provider shall maintain all Member information including, but not limited to, the Member's name, address, telephone number (collectively, "**Member Information**"), and all other "**KHF Trade Secret Information**" as confidential. For purposes of this Agreement, "**KHF Trade Secret Information**" shall include, but shall not be limited to: all KHF programs and initiatives, KHF Payer Agreements and the information contained therein regarding KHF, Plans, employer groups, the financial arrangements between any hospital and KHF or any Payer or Plan and KHF, and all manuals, policies, forms, records, files (other than patient medical files) and lists of KHF. Provider shall not disclose or use any Member Information or KHF Trade Secret Information for any reason either during the Term or after the date of termination of this Agreement; provided, however, Provider may use Member Information or other medical information of a Member if medically necessary for the proper treatment of such Member or upon express prior written permission of KHF, appropriate Payers, and the Member or in connection with Provider's participation in KHF.

**Section 8.14 Confidentiality.** KHF shall abide by the "**Privacy Notice and Notice of Information Practices**" attached hereto as **Exhibit C**. Such Notice may be revised from time to time as necessary to comply with state and federal privacy laws. Provider shall abide by the Confidentiality and Non-Disclosure Agreement attached hereto as **Exhibit D**.

**Section 8.15 Amendment.** KHF may unilaterally amend this Agreement to conform with applicable federal or state laws, rules, or regulations by sending a copy of the amendment to Provider at least sixty (60) days prior to its effective date. Unless applicable laws and/or regulatory authorities direct otherwise, the signature of Provider will not be required. Any other amendments to this Agreement shall require the written consent of Provider and KHF.

**Section 8.16 Compliance with Privacy Security Laws.** In order to fulfill its duties and obligations under this Agreement, KHF will need to access and utilize patient information from time to time. The parties acknowledge Provider's obligations under state and federal law to protect and safeguard patient information and agree to abide by the terms of the HIPAA Business Associate Addendum attached hereto as **Exhibit E**.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date and year first above written.

**PREMIER PEDIATRIC PROVIDERS, LLC**

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

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

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

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

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

## **Exhibit E**

### **HIPAA Business Associate Agreement**

Pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), [NAME OF COVERED ENTITY], a medical practice with a principal address at \_\_\_\_\_, GA \_\_\_\_\_ (the “Covered Entity”) and PREMIER PEDIATRIC PROVIDERS, LLC, d/b/a Kids Health First, a Georgia limited liability company, with principal offices located at 2480 Briarcliff Road NE, Suite 6-334 Atlanta, Georgia 30329 (hereafter referred to as “KHF”), enter into this **Business Associate Agreement (“BAA”)** as of this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_ (the “Effective Date”) that addresses the HIPAA requirements with respect to “business associates”, as defined under the privacy, security, breach notification, and enforcement rules at 45 C.F.R. Part 160 and Part 164 (“HIPAA Rules”). A reference in this BAA to a section in the HIPAA Rules means the section as in effect or as amended.

## **ARTICLE I**

### **PREAMBLE AND DEFINITIONS.**

- 1.1 This BAA is intended to ensure that Business Associate will establish and implement appropriate safeguards for the Protected Health Information (“PHI”) (as defined under the HIPAA Rules) that Business Associate may receive, create, maintain, use, or disclose in connection with the functions, activities, and services that Business Associate performs for Covered Entity.
- 1.5 The functions, activities, and services that Business Associate performs for Covered Entity are defined in **Participating Practice Provider Agreement** by and between [NAME OF COVERED ENTITY] and KFH (the “Underlying Agreement”).
- 1.6 Pursuant to changes required under the Health Information Technology for Economic and Clinical Health Act of 2009 (the “HITECH Act”) and under the American Recovery and Reinvestment Act of 2009 (“ARRA”), this BAA also reflects federal breach notification requirements imposed on Business Associate when “Unsecured PHI” (as defined under the HIPAA Rules) is acquired by an unauthorized party, and the expanded privacy and security provisions imposed on business associates.
- 1.7 Unless the context clearly indicates otherwise, the following terms in this BAA shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, disclosure, Electronic Media, Electronic Protected Health Information (“ePHI”), Health Care Operations, individual, Minimum Necessary, Notice of Privacy Practices, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured PHI, and use.
- 1.8 A reference in this BAA to the Privacy Rule means the Privacy Rule, in conformity with the regulations at 45 C.F.R. Parts 160-164 (the “Privacy Rule”) as interpreted under applicable regulations and guidance of general application published by the HHS, including all amendments thereto for which compliance is required, as amended by the HITECH Act, ARRA, and the HIPAA Rules.

## **ARTICLE II**

### **GENERAL OBLIGATIONS OF BUSINESS ASSOCIATE.**

- 2.1 Business Associate agrees not to use or disclose PHI, other than as permitted or required by this BAA or as Required By Law, or if such use or disclosure does not otherwise cause a Breach of Unsecured PHI.

- 2.2 Business Associate agrees to use appropriate safeguards, and comply with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by the BAA.
- 2.3 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate as a result of a use or disclosure of PHI by Business Associate in violation of this BAA's requirements or that would otherwise cause a Breach of Unsecured PHI.
- 2.4 The Business Associate agrees to the following breach notification requirements:
- (a) Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI not provided for by the BAA of which it becomes aware within five (5) calendar days of "**discovery**" within the meaning of the HITECH Act. Such notice shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed in connection with such Breach. In addition, Business Associate shall provide any additional information reasonably requested by Covered Entity for purposes of investigating the Breach and any other available information that Covered Entity is required to include to the individual under 45 C.F.R. § 164.404(c) at the time of notification or promptly thereafter as information becomes available. Business Associate's notification of a Breach of Unsecured PHI under this Section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA, the HIPAA Rules and related guidance issued by the Secretary or the delegate of the Secretary from time to time.
  - (b) In the event of Business Associate's use or disclosure of Unsecured PHI in violation of HIPAA, the HITECH Act, or ARRA, Business Associate bears the burden of demonstrating that notice as required under this **Section 2.4** was made, including evidence demonstrating the necessity of any delay, or that the use or disclosure did not constitute a Breach of Unsecured PHI.
- 2.5 Business Associate agrees, in accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, to require that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.
- 2.6 Business Associate agrees to make available PHI in a Designated Record Set to Covered entity as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.524.
- (a) Business Associate agrees to comply with an individual's request to restrict the disclosure of their personal PHI in a manner consistent with 45 C.F.R. § 164.522, except where such use, disclosure, or request is required or permitted under applicable law.
  - (b) Business Associate agrees that when requesting, using, or disclosing PHI in accordance with 45 C.F.R. § 164.502(b)(1) that such request, use, or disclosure shall be to the minimum extent necessary, including the use of a "**limited data set**" as defined in 45 C.F.R. § 164.514(e)(2), to accomplish the intended purpose of such request, use, or disclosure, as interpreted under related guidance issued by the Secretary from time to time.

- 2.7 Business Associate agrees to make any amendments to PHI in a Designated Record Set as directed or agreed to by the Covered Entity pursuant to 45 C.F.R. § 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.526.
- 2.8 Business Associate agrees to maintain and make available the information required to provide an accounting of disclosures to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.528.
- 2.9 Business Associate agrees to make its internal practices, books, and records, including policies and procedures regarding PHI, relating to the use and disclosure of PHI and Breach of any Unsecured PHI received from Covered Entity, or created or received by the Business Associate on behalf of Covered Entity, available to Covered Entity (or the Secretary) for the purpose of Covered Entity or the Secretary determining compliance with the Privacy Rule (as defined in Section 8).
- 2.10 To the extent that Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate agrees to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).
- 2.11 Business Associate agrees to account for the following disclosures:
- (a) Business Associate agrees to maintain and document disclosures of PHI and Breaches of Unsecured PHI and any information relating to the disclosure of PHI and Breach of Unsecured PHI in a manner as would be required for Covered Entity to respond to a request by an individual or the Secretary for an accounting of PHI disclosures and Breaches of Unsecured PHI.
  - (b) Business Associate agrees to provide to Covered Entity, or to an individual at Covered Entity's request, information collected in accordance with this **Section 2.11**, to permit Covered Entity to respond to a request by an individual or the Secretary for an accounting of PHI disclosures and Breaches of Unsecured PHI.
  - (c) Business Associate agrees to account for any disclosure of PHI used or maintained as an Electronic Health Record (as defined in **Section 5**) ("**EHR**") in a manner consistent with 45 C.F.R. § 164.528 and related guidance issued by the Secretary from time to time; provided that an individual shall have the right to receive an accounting of disclosures of EHR by the Business Associate made on behalf of the Covered Entity only during the three (3) years prior to the date on which the accounting is requested Entity.
  - (d) In the case of an EHR that the Business Associate acquired on behalf of the Covered Entity as of January 1, 2009, paragraph (c) above shall apply to disclosures with respect to PHI made by the Business Associate from such EHR on or after January 1, 2014. In the case of an EHR that the Business Associate acquires on behalf of the Covered Entity after January 1, 2009, paragraph (c) above shall apply to disclosures with respect to PHI made by the Business Associate from such EHR on or after the later of January 1, 2011 or the date that it acquires the EHR.
- 2.12 Business Associate agrees to comply with the "**Prohibition on Sale of Electronic Health Records or Protected Health Information**", as provided in Section 13405(d) of Subtitle D (Privacy) of ARRA, and the "**Conditions on Certain Contacts as Part of Health Care Operations**", as provided in Section 13406 of Subtitle D (Privacy) of ARRA and related guidance issued by the Secretary from time to time.

- 2.13 Business Associate acknowledges that, effective on the Effective Date of this BAA, it shall be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. § 1320d-5 and 1320d-6, as amended, for failure to comply with any of the use and disclosure requirements of this BAA and any guidance issued by the Secretary from time to time with respect to such use and disclosure requirements.

### **ARTICLE III**

#### **PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE.**

- 3.1 Business Associate agrees to receive, create, use, or disclose PHI only in a manner that is consistent with this BAA, the Privacy Rule, or Security Rule (as defined in **Section 5**) and only in connection with providing services to Covered Entity; provided that the use or disclosure would not violate the Privacy Rule, including 45 C.F.R. § 164.504(e), if the use or disclosure would be done by Covered Entity. For example, the use and disclosure of PHI will be permitted for **“treatment, payment and health care operations”**, in accordance with the Privacy Rule.
- 3.2 Business Associate may use or disclose PHI as Required By Law.
- 3.3 Business Associate agrees to make uses and disclosures and requests for PHI consistent with covered entity’s Minimum Necessary policies and procedures.
- 3.4 Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by the Covered Entity.
- 3.5 Except as otherwise provided in this BAA, Business Associate may use PHI for its management services purposes (including collecting and analyzing data (without patient identifying characteristics) in ways designed to improve healthcare delivery and lower the cost of healthcare delivery). Also, Business Associate is authorized to use PHI to de-identify the information in accordance with 45 C.F.R. § 164.514(a)-(c).

### **ARTICLE IV**

#### **OBLIGATIONS OF COVERED ENTITY.**

- 4.1 Covered Entity shall:
- (a) Provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with the Privacy Rule, and any changes or limitations to such notice under 45 C.F.R. § 164.520, to the extent that such changes or limitations may affect Business Associate’s use or disclosure of PHI.
  - (b) Notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI under this BAA.
  - (c) Notify Business Associate of any changes in or revocation of permission by an individual to use or disclose PHI, if such change or revocation may affect Business Associate’s permitted or required uses and disclosures of PHI under this BAA.

- 4.2 Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy and Security Rule if done by Covered Entity, except as provided under **Section 3** of this BAA.

## **ARTICLE V**

### **COMPLIANCE WITH SECURITY RULE.**

- 5.1 Business Associate shall comply with the HIPAA Security Rule, which shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. Part 160 and Subparts A and C of Part 164, as amended by ARRA and the HITECH Act. The term “**Electronic Health Record**” or “**EHR**” as used in this BAA shall mean an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized healthcare clinicians and staff.
- 5.2 In accordance with the Security Rule, Business Associate agrees to:
- (a) Implement the administrative safeguards set forth at 45 C.F.R. § 164.308, the physical safeguards set forth at 45 C.F.R. § 164.310, the technical safeguards set forth at 45 C.F.R. § 164.312, and the policies and procedures set forth at 45 C.F.R. § 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by the Security Rule. Business Associate acknowledges that, effective on the Effective Date of this BAA, (a) the foregoing safeguards, policies, and procedures requirements shall apply to Business Associate in the same manner that such requirements apply to Covered Entity, and (b) Business Associate shall be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. § 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the safeguards, policies, and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements;
  - (b) Require that any agent, including a Subcontractor, to whom it provides such PHI agrees to implement reasonable and appropriate safeguards to protect the PHI; and
  - (c) Report to the Covered Entity any Security Incident of which it becomes aware.

## **ARTICLE VI**

### **INDEMNIFICATION.**

- 6.1 Business Associate shall indemnify, defend, and hold harmless the Covered Entity, its sponsor, if different from Covered Entity, and sponsor’s and Covered Entity’s affiliates (“**Indemnified Parties**”), from and against any and all losses, expense, damage, or injury (including, without limitation, all costs and reasonable attorneys’ fees) that the Indemnified Parties may sustain as a result of, or arising out of (a) a breach of this BAA by Business Associate or its agents or Subcontractors, including but not limited to any unauthorized use, disclosure, or breach of PHI, (b) Business Associate’s failure to notify any and all parties required to receive notification of any Breach of Unsecured PHI pursuant to **Section 2.4**, or (c) any negligence or wrongful acts or omissions by Business Associate or its agents or Subcontractors, including without limitations, failure to perform Business Associate’s obligations under this BAA, the Privacy Rule, or the Security Rule.

- 6.2 Notwithstanding the foregoing, nothing in this Section shall limit any rights any of the Indemnified Parties may have to additional remedies under the Underlying Agreement or under applicable law for any acts or omissions of Business Associate or its agents or Subcontractors.

## **ARTICLE VII**

### **TERM AND TERMINATION**

- 7.1 This BAA shall be in effect as of the Effective Date and shall terminate on the earlier of the date that:
- (i) either party terminates for cause as authorized under **Section 7.2**, or
  - (ii) all of the PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity. If it is not feasible to return or destroy PHI, protections are extended in accordance with **Section 7.3**.
- 7.2 Upon either party's knowledge of material breach by the other party, the non-breaching party shall provide an opportunity for the breaching party to cure the breach or end the violation; or terminate the BAA. If the breaching party does not cure the breach or end the violation within a reasonable timeframe not to exceed ten (10) days from the notification of the breach, or if a material term of the BAA has been breached and a cure is not possible, the non-breaching party may terminate this BAA, upon written notice to the other party.
- 7.3 Upon termination of this BAA for any reason, the parties agree that upon termination of this BAA for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:
- (a) Retain only that PHI that is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities.
  - (b) Return to Covered Entity or, if agreed to by Covered Entity, destroy the remaining PHI that the Business Associate still maintains in any form.
  - (c) Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to ePHI to prevent use or disclosure of the PHI, other than as provided for in this **Section 7**, for as long as Business Associate retains the PHI.
  - (d) Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out in **Sections 2 and 3** above which applied prior to termination.
  - (e) Return to Covered Entity or, if agreed to by Covered Entity, destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.
- 7.4 The obligations of Business Associate under this **Section 7** shall survive the termination of this BAA.

**ARTICLE VIII**  
**MISCELLANEOUS.**

- 8.1 The parties agree to take such action as is necessary to amend this BAA to comply with the requirements of the Privacy Rule, the Security Rule, HIPAA, ARRA, the HITECH Act, the HIPAA Rules, and any other applicable law.
- 8.2 The respective rights and obligations of Business Associate under **Section 6** and **Section 7** of this BAA shall survive the termination of this BAA.
- 8.3 This BAA shall be interpreted in the following manner:
- (a) Any ambiguity shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Rules.
  - (b) Any inconsistency between the BAA's provisions and the HIPAA Rules, including all amendments, as interpreted by the HHS, court, or another regulatory agency with authority over the parties, shall be interpreted according to the interpretation of the HHS, the court, or the regulatory agency.
  - (c) Any provision of this BAA that differs from those required by the HIPAA Rules, but is nonetheless permitted by the HIPAA Rules, shall be adhered to as stated in this BAA.
- 8.4 This BAA constitutes the entire agreement between the parties related to the subject matter of this BAA, except to the extent that the Underlying Agreement imposes more stringent requirements related to the use and protection of PHI upon Business Associate. This BAA supersedes all prior negotiations, discussions, representations, or proposals, whether oral or written. This BAA may not be modified unless done so in writing and signed by a duly authorized representative of both parties. If any provision of this BAA, or part thereof, is found to be invalid, the remaining provisions shall remain in effect.
- 8.5 This BAA will be binding on the successors and assigns of the Covered Entity and the Business Associate. However, this BAA may not be assigned, in whole or in part, without the written consent of the other party. Any attempted assignment in violation of this provision shall be null and void.
- 8.6 This BAA may be executed in two or more counterparts, each of which shall be deemed an original. This BAA also may be executed electronically by the parties.
- 8.7 Except to the extent preempted by federal law, this BAA shall be governed by and construed in accordance with the laws of the state of Georgia.

## **EXHIBIT A**

### **ENCOUNTER DATA**

The following information shall be included:

Enrollee's full name and address.

Enrollee's identification number (Social Security or Insurance I.D. number).

Enrollee's date of birth.

Enrollee's gender.

Enrollee's Plan affiliation.

Diagnostic code and description (ICD-9/CPT Code).

Date of service.

Place of service.

Procedures, services or supplies furnished and the charges.

Physician's name (not name of physician group).

Physician's address and telephone number.

Coordination of Benefit



## **EXHIBIT B**

### **Conflict of Interest and Disclosure Statement**

Decisions by the officers, committees and others on behalf of Kids Health First Pediatric Alliance, d/b/a Kids Health First Pediatric Alliance ("Kids Health First")) have far reaching significance and consequences. Statements, publications and recommendations have implications for the practice of pediatrics and the health of children throughout the southeast. Although it is assumed that all officers, committee members and others acting on behalf of Kids Health First act honestly and with integrity when making recommendations concerning Kids Health First's policies and actions, there are potential and real conflicts of interest which may impact on an individual's opinion or may appear to make that opinion self-serving.

Potential conflicts of interest are situations, which might not allow for impartial or objective determinations. These situations include, but are not limited to, serving as an advisor, Board of Directors member, Committee member or in other leadership or advisory position with a competing entity or the existence of relationships with products, devices, government, or companies such as pharmaceutical, health plan / payor, insurance companies, formula or equipment manufacturers. This would also include the receipt of research support or lecture honoraria from such companies.

Kids Health First does not wish to exclude individuals who are experts in given fields from participation in policy formulation and recommendations, merely because they have conflicts due to their expertise. However, the validity of Kids Health First recommendations and its reputation are based on the confidence in its integrity and the belief by members and the public alike that policies are unbiased and based only on concerns for the best interests of the IPA and its members.

Kids Health First Pediatric Alliance has the following policy concerning disclosure of potential and real conflicts of interest:

1. Kids Health First Pediatric Alliance wishes all points of view to be vigorously and actively expressed in the formulation of policies and recommendations at all levels in the organization.
2. The policies of Kids Health First Pediatric Alliance, the statements of its committees, and all other Kids Health First communications on matters relating to the health and well-being of infants, children, adolescents and young adults as well as to the practice of pediatrics, the recommendations of its task forces, etc., should be as free as possible from personal bias and outside influence not related to the best interests of the IPA and its members.
3. It is expected that all Kids Health First officers, members of the Board Of Directors, members of committees and task forces, consultants and others acting on behalf of Kids Health First will **openly** disclose to the IPA

any real and potential conflicts of interest. When a real or potential conflict exists which may affect objectivity, the appropriate committee, task force, or other body within the IPA should immediately be informed of the outside interest that gives rise to the conflict, and the interested individual should disqualify him/herself from participation in voting on any Kids Health First policy statement or other communication of the IPA which could be influenced by the outside interest; provided, that the

interested individual shall be entitled to participate in the discussions on that matter after making full disclosure of the conflict to the committee or other body within Kids Health First that has the matter under consideration.

4. If the chairperson of the affected committee, task force or other body finds that the circumstances surrounding the conflict warrant the imposition of greater restrictions than those outlined in paragraph 3, the interested individual may be excluded from some or all of the discussions on the matter or required to resign from the committee or other body with Kids Health First that has the matter under consideration. If the chairperson finds that the conflict is de minimis (not likely to have any impact on the Kids Health First matter in question), the chairperson may waive some or all of the restrictions set forth in paragraph 3. In the event of a dispute respecting the appropriate restrictions in any situation involving a real or potential conflict of interest with a Kids Health First matter, the Board of Directors of Kids Health First shall have the final authority to determine how that conflict should be managed or resolved.

#### VOLUNTARY DISCLOSURE STATEMENT KIDS HEALTH FIRST

I declare that if I have any direct or indirect financial interests, or any personal, family or other relationships which conflict (or have the appearance of conflicting) with my duties, responsibilities, and exercise of independent judgment as an officer, employee, or agent of Kids Health First, as a member of a committee, task force, or other body of Kids Health First, or as a representative of Kids Health First to other public, private or governmental organizations, I shall voluntarily disclose that a conflict (potential or real) exists, will abstain from voting and from drafting any Kids Health First policy statement or other Kids Health First communication on the Kids Health First matter which could be influenced by the conflict, and will take such other actions as may be deemed necessary or appropriate by Kids Health First's Board of Directors under the circumstances then present to manage the conflict of interest. I have read the Kids Health First policy entitled "Conflict of Interest and Disclosure Statement" and I agree to comply with its terms.

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(Signature)

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(Print name)

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(Date)

### **EXHIBIT C**



### **Privacy Notice and Notice of Information Practices**

Independent Pediatric Alliance-Greater Atlanta, LLC & Premier Pediatric Providers, LLC and its affiliates (collectively, the IPA) respect you and your right to privacy. We want you to know about our IPA's policies and procedures for protecting the privacy of your nonpublic personal information that we receive, and your rights regarding such information.

This Notice explains our policies and practices as of July 1, 2001, regarding the nonpublic personal information about individuals who are members of the IPA contained in our records in accordance with the Gramm-Leach-Bliley Act ("GLBA") and the Privacy of Consumer Financial Information Regulation promulgated by the Federal Trade Commission pursuant to GLBA. We reserve the right to amend, modify or supplement this privacy policy at any time in accordance with applicable law. If we make changes to our privacy policy we will provide you with a copy of a revised Notice as required by applicable law. This Notice applies to individuals who are current and former members of the IPA.

#### **What Kind of Information We Collect About You**

We collect nonpublic personal information about you from the following sources:

- Information provided by you directly to us, such as your address, social security, license and certification numbers and credentialing information.
- Information that we receive from nonaffiliated third parties, such as NPDB, FSMB, OIG, State of Georgia, your insurance carrier(s).

#### **2. What We Do With Information We Collect About You**

We may disclose information about you to our affiliates and use that information for purposes related to our providing services to you. Generally, we will not disclose the nonpublic information about you in our records to any organization not affiliated with the IPA without your prior authorization. However, as required or permitted by law, we may disclose your information in our records to certain nonaffiliated third parties.

#### **3. Who Has Access To Your Information In Our Records**

We maintain appropriate physical, electronic and procedural safeguards to protect against unauthorized access to your nonpublic personal information contained in our records. Access to such information is restricted to individuals who need to know the information to service your account or to provide products and services to you. We will educate our employees about the terms of this Notice and the importance of confidentiality and consumer privacy. Employees who gain unauthorized access to your nonpublic personal information in our records or otherwise violate our privacy policy will be subject to our disciplinary process, which may include termination of employment.

Should you have any questions about this policy statement please don't hesitate to contact our Privacy Officer at 770.333.0033.



## **EXHIBIT D**

### **CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT**

This Confidentiality and Non-Disclosure Agreement is hereby incorporated in the Participating Physician Agreement entered into by the Professional whose name appears on the signature page of said Agreement (“Professional”) and Premier Pediatric Providers, L.L.C. d/b/a Kids Health First Pediatric Alliance (“Company”), a Georgia Corporation, both collectively known as “Parties”.

### **RECITALS**

WHEREAS, Company and Professional have agreed to enter into a Participating Physician Agreement for their mutual advantage and such Agreement requires the exchange of confidential and proprietary information, including trade secrets, business plans, marketing plans, financial data and technological information not generally known to the public (collectively “Confidential Information”); and

WHEREAS Company and Professional seek to ensure that the Confidential Information they exchange will be used only for the purposes described in the preceding sentence.

NOW, THEREFORE, in consideration of the foregoing, the Parties hereby agree as follows:

1. Company is desirous of protecting the confidentiality of its Trade Secrets, Intellectual Property, Methods of Business, Employee Agreements, Customer and Client Lists, Financial Information, and all Proprietary Information (collectively “Information”). This includes, but is not limited to, all oral, written, or electronic data, reports, records or materials.
2. Information shall not include, and all obligations as to non-disclosure by the undersigned shall cease to be any part of, such information to the extent that such information: (i) is, or becomes, public other than as a result of acts by the undersigned; (ii) can be shown to be already known to the undersigned at the time of its disclosure hereunder; (iii) is independently obtained by the undersigned from a third party having no duty of confidentiality to the Company; (iv) is independently developed by the undersigned without use of any information supplied hereunder; or (v) is obligated to be disclosed pursuant to applicable law, regulation or legal process.
3. Information is being furnished, or will become accessible to the Professional, solely in connection with the Professional’s duties under the Participating Physician Agreement and all such Information shall be treated as “secret” and “confidential” and no portion of it shall be disclosed to others, except to those employees and agents whose knowledge of the information is required to comply with the terms and conditions of the Agreement, and who shall assume the obligations of confidentiality under this Agreement. The undersigned hereby assumes full responsibility for the compliance of such employees or agents to the terms of this Agreement.

4. The undersigned further agrees that it will not interfere with any business of Company through the use of any information or knowledge acquired under this Confidentiality and Non-Disclosure Agreement nor use any such information for its own account.
5. It is understood that the Company is the intended party and beneficiary whose rights are being protected and may enforce the terms of this Confidentiality and Non-Disclosure Agreement. In the event of a dispute the venue shall be Cobb County, Georgia. The prevailing party shall be entitled to recovery of all reasonable costs including attorney's fees, court costs, costs on appeal, and interest from date of breach. Any and all disputes shall be resolved by binding arbitration in accordance with the rules of the American Arbitration Association.
6. Professional specifically agrees that disclosure of any Information may cause irreparable harm to the Company, and that money damages alone would be inadequate to compensate Company. Professional hereby grants to Company the right to injunctive, or other equitable relief, to restrain any breach or threatened breach of this Agreement.
7. All information shall be promptly returned, or destroyed, as directed by Company.
8. The respective obligations of the parties under this Agreement shall survive for a period of five years following the date hereof.



## **EXHIBIT E**

### **HIPAA BUSINESS ASSOCIATE ADDENDUM**

This Business Associate Addendum (“Addendum”) is attached as an Exhibit to and made part of the Participating Physician Agreement by and between the parties thereto. For purposes of this Addendum, the IPA shall be referred to as the “Business Associate” and the Professional shall be referred to as the “Covered Entity.” The meanings of defined terms are set forth in Section C below.

#### **A. HIPAA BUSINESS ASSOCIATE PRIVACY OBLIGATIONS.**

##### ***1. Obligations and Activities of Business Associate.***

- a. Business Associate agrees not to use or disclose Protected Health Information other than as permitted or required by the Addendum or as required by law.
- b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Addendum.
- c. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Addendum of which it becomes aware.
- d. If Business Associate maintains Protected Health Information in a Designated Record Set, Business Associate agrees to provide access, at Covered Entity’s request, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
- e. If Business Associate maintains Protected Health Information in a Designated Record Set, Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Entity direct or agree to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, within 10 days after receipt by Business Associate of such request.
- f. Business Associate agrees to make available to Covered Entity, or to the Secretary, internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity in the time and manner designated by the Secretary or within 5 business days of receipt of Covered Entity’s written request, for purposes of determining Covered Entity’s compliance with the Privacy Rules.
- g. Business Associate agrees to document disclosures of Protected Health Information not provided for by this Addendum of which Business Associate becomes aware and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual

for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

- h. Business Associate agrees to provide to Covered Entity or an Individual, in time and manner requested by Covered Entity, but in no event more than 10 business days from such request, information documented in accordance with Section A.1(g) of this Addendum, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

## **2. *Permitted Uses and Disclosures by Business Associate***

Except as otherwise limited in this Addendum, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rules if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity.

## **B. HIPAA BUSINESS ASSOCIATE SECURITY OBLIGATIONS.**

- 1. ***Security Safeguards.*** On or before April, 2005, Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by the Security Rules.
- 2. ***Reporting.*** In accordance with the requirements of the Security Rules, Business Associate shall promptly report to Covered Entity any security incident of which it becomes aware.

## **C. GENERAL.**

### **1. *Definitions.***

- a. **Designated Record Set** means a group of records maintained by or for Covered Entity that is (1) medical records and billing records maintained by or for a Healthcare Provider; (2) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a Health Plan; or (3) used by the Covered Entity to make decisions about Individuals. Records include any item, collection or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for Covered Entity.
- b. **Privacy Rules** means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
- c. **Protected Health Information** has the same meaning as the term “protected health information” in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- d. **Secretary** means the Secretary of the Department of Health and Human Services or his designee.
- e. **Security Rules** means the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160, 162 and 164.
- f. Terms used but not otherwise defined in this Addendum shall have the same meaning as those terms in the Privacy Rules.

## **2. *Term and Termination***

- a. *Term.* The obligations of this Addendum shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.
- b. *Termination for Cause.* Upon Covered Entity's knowledge of a material breach by Business Associate of the terms of this Addendum, Covered Entity may either:
  - i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Addendum and the Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
  - ii. Immediately terminate this Addendum and the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or
  - iii. If neither termination nor cure is feasible, report the violation to the Secretary.
- c. *Effect of Termination.*
  - i. Notwithstanding any other provision in the Agreement to the contrary, except as provided in subsection (c)(ii) below, upon termination of this Agreement for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
  - ii. In the event that Business Associate reasonably determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall maintain the Protected Health Information in a manner consistent with this Addendum and extend the protections of this Addendum to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

- 3. ***Subcontractors.*** Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information.

## **4. *Miscellaneous***

- a. *Regulatory References.* A reference in this Addendum to a section in the Privacy Rules or Security Rules means the section of the Privacy Rules or Security Rules, as applicable, as in effect or as amended, from time to time.
- b. *Amendment.* The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy

Rules, Security Rules and/or the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

- c. *Survival.* The respective rights and obligations of Business Associate under Section C.2 of this Addendum shall survive the termination of this Addendum and the Agreement.
- d. *Interpretation.* Any ambiguity in this Addendum shall be resolved to permit Covered Entity to comply with the Privacy Rules and Security Rules.