Dear Doctor,

Thank you for your interest in participating in the Oklahoma State Chiropractic Independent Physicians Association. Presently we have nearly 400 chiropractic physicians enrolled in our IPA membership program statewide. OSCIPA has signed contracts with multiple managed care groups. Visit the Membership Benefits Health Plan Benefits section of our website to view a list of OSCIPA contracted carriers and networks.

Please be sure the Uniform Application and OSCIPA Credentialing Addendum is ***completed in its entirety, do not leave blanks; put N/A if not applicable.*** Print legibly, or type, and return to OSCIPA along with the following:

1. All currently valid state licenses.
2. The declaration page from your Professional Liability Insurance Policy showing you as the insured.
3. A Curriculum Vitae or Current Resume, and list all chiropractic schools attended on the Education Form.
4. A completed and signed W-9 form.
5. The Provider Agreement with original signature and date.
6. A check for initial credentialing costs of $175.00. Please make your check payable to OSCIPA and mail the entire application packet to **5350 E. 46th St., Ste. 122, Tulsa, OK 74135-6601**.

The nonrefundable credentialing fee (see item 6 above) is due upon receipt of your application. OSCIPA will verify your application elements directly from each source. The entire credentialing process for membership is completed within 45 days. Upon the credentialing committee recommendation and board approval, OSCIPA will assign an effective date to you and send notification to our contracted carriers/networks of your participation with OSCIPA. OSCIPA has been delegated to credential on behalf of the contracting carrier or network, and once the carrier/network has added you to their provider directory you may see their member's in-network. Our Provider Relations Representative will then contact you to schedule an orientation visit for you and your staff if needed and will send you your orientation packet.

Startup Membership Fee: The startup fee for new doctors is $75 per month. The criterion for this rate is determined by your state license date. If your license date falls within the last 3 calendar years, you may be eligible for the startup fee. The year that you received your license plus two additional calendar years, you will be assessed a fee of $75 per month. Continuing membership fees after the three year mark will be at the regular membership rate.

Monthly Membership Fee for IPA Members: OSCIPA's monthly IPA membership fee for most continuing members is $125.

Once your membership is finalized with OSCIPA, we encourage you to submit your claims electronically through Infinedi, L.L.C. OSCIPA has negotiated a flat rate charge of $50 per month for unlimited claims processing on your behalf with Infinedi, L.L.C. Electronic filing with Infinedi is to your advantage as well as OSCIPA's and our contracting carrier/networks. Utilization reports are compiled by use of the data submitted to Infinedi. In addition, Infinedi assists OSCIPA through the use of a comprehensive editing program. They also provide OSCIPA members with an ERA translator, another advantage of OSCIPA membership.

Yours in Health,

Larry M. Bridges, Ph.D.
OSCIPA Executive Director

Uniform Credentialing Application

63 O.S. Supp. 1998, Section 1-106.2

This form must be completed in full and typed or printed legibly (i.e. do not state "see CV"). Write "N/A" in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to:__________________________

Oklahoma State Chiropractic Independent Physicians Association

Date:______________________________

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION.

Oklahoma State Department of Health
Protective Health Services

ODH Form 606
(Rev. 03/04)

SECTION 1: PERSONAL INFORMATION

Name ____
Last First Middle Suffix

Professional Degree ____________________________________ Gender: ___ Male ___ Female

Other Name By Which You Have Been Known ____________________________________

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Other Name By Which You Have Been Known ____________________________________

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Personal NPI_______________________ Practice NPI Type II_______________________

Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___ ____________________________________
Place of Birth Citizenship

____
Visa Type Visa Number (provide copy) Expiration Date

____
Your Personal Medicare Number Your Personal Medicaid Number

SECTION 2: PROFESSIONAL DIRECTORY INFORMATION

Mailing Address For All Credentialing Correspondence: ____________________________________
Street Address

____
Suite Number City State Zip Code County

( ) ____________________ ( ) ____________________ ( ) ____________________
Phone Number Fax Number Emergency or Pager Number

( ) ____
Answering Service Number E-Mail Address Website Address

Contact Person For Credentialing Correspondence: ____________________________________

This Section continues on next page.

-Section 2 Continued-

Office Street Address: ______________________________
Street Address

____
Suite Number | City | State | Zip Code

(   ) ____________ (   ) ____________ (   ) ____________
Phone Number | Fax Number | Emergency or Pager Number

(   ) ______________________________
Answering Service Number | E-Mail Address

Office Mailing Address: ______________________________
Street Address

____
Suite Number | City | State | Zip Code

(   ) ____________ (   ) ____________ (   ) ____________
Phone Number | Fax Number | Emergency or Pager Number

(   ) ______________________________
Answering Service Number | E-Mail Address

Office Billing Address (If Different From Claims Payment Address): ______________________________
Street Address

____
Suite Number | City | State | Zip Code

(   ) ____________ (   ) ____________ (   ) ____________
Phone Number | Fax Number | Emergency or Pager Number

(   ) ______________________________
Answering Service Number | E-Mail Address

Claims Payment Address (If Different From Office Billing Address): ______________________________
Street Address

____
Suite Number | City | State | Zip Code

(   ) ____________ (   ) ____________ (   ) ____________
Phone Number | Fax Number | Emergency or Pager Number

(   ) ______________________________
Answering Service Number | E-Mail Address

Make Checks Payable To: ______________________________

SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice) ____ Subspecialty ____ % Of Time ____

Secondary Specialty ____ Subspecialty ____ % Of Time ____

Do you wish to be listed as:
___ Primary Care Provider ___ Specialist ___ Hospitalist ___ On-Call ___ Other (specify)________________________
If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

____

____

___ Yes ___ No Are you accepting new patients?

___ Yes ___ No Are you willing, in the future to accept new patients?

___ Yes ___ No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

___ Yes ___ No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?

___ Yes ___ No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: ____

Street Address ____ Suite Number ____

City ____ State ____ Zip Code ____

(   ) ____ (   ) ____ (   ) ____
Phone Number ____ Fax Number ____ Answering Service Number ____

Name: ____

Street Address ____ Suite Number ____

City ____ State ____ Zip Code ____

(   ) ____ (   ) ____ (   ) ____
Phone Number ____ Fax Number ____ Answering Service Number ____

List any restrictions on your practice (i.e. patient age and gender): ________________________________

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) ____

Institution Degree Awarded

____

Mailing Address City State Zip Code

Telephone Number: (________) ____________________________

Dates Attended (mo/day/year) From: ___ ___ **-** ___ ___ **-** ___ ___ ___ ___ to ___ ___ **-** ___ ___ **-** ___ ___ ___ ___

Graduation Date ___ ___ **-** ___ ___ **-** ___ ___ ___ ___

(2) ____

Institution Degree Awarded

____

Mailing Address City State Zip Code

Telephone Number: (________) ____________________________

Dates Attended (mo/day/year) From: ___ ___ **-** ___ ___ **-** ___ ___ ___ ___ **to** ___ ___ **-** ___ ___ **-** ___ ___ ___ ___

Graduation Date ___ ___ **-** ___ ___ **-** ___ ___ ___ ___

(3) ____

Institution Degree Awarded

____

Mailing Address City State Zip Code

Telephone Number: (________) ____________________________

Dates Attended (mo/day/year) From: ___ ___ **-** ___ ___ **-** ___ ___ ___ ___ **to** ___ ___ **-** ___ ___ **-** ___ ___ ___ ___

Graduation Date ___ ___ **-** ___ ___ **-** ___ ___ ___ ___

SECTION 5: TRAINING
Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) ____________________________

Was program successfully completed: ___ Yes ___ No

Specialty | Institution | Your Program Director

( )
Address | City | State | Zip Code | Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(2) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) ____________________________

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

( )
Address | City | State | Zip Code | Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(3) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) ____________________________

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

( )
Address | City | State | Zip Code | Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(4) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) ____________________________

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

( )
Address | City | State | Zip Code | Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1) ____ ( )______
Institution and Address City State Zip Code Phone Number

____________From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(2) ____ ( )______
Institution and Address City State Zip Code Phone Number

____________From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(3) ____ ( )______
Institution and Address City State Zip Code Phone Number

____________From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, **all hospital/health system affiliations** where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1) ____ ___ Primary ___ Secondary
Facility Name

____ ( )______
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________
Dates of Appointment (mo/day/year) Staff Category

____
Reason for Discontinuance Department or Service

(2) ____ ___ Primary ___ Secondary
Facility Name

____ ( )______
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________
Dates of Appointment (mo/day/year) Staff Category

____
Reason for Discontinuance Department or Service

This section continues on next page.

-Section 7 Continued-

(3) ______________________________ ___ Primary ___ Secondary
Facility Name

______________________________ ( )
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________________
Dates of Appointment (mo/day/year) Staff Category

____
Reason for Discontinuance Department or Service

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) ______________________________
Name and Nature of Affiliation

______________________________ ( )
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________________
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) ______________________________
Name and Nature of Affiliation

______________________________ ( )
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________________
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) ______________________________
Name and Nature of Affiliation

______________________________ ( )
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________________
Dates of Affiliation (mo/day/year) Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

____
Location Branch of Service

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

____
Location Branch of Service

SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have ever applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

Oklahoma______________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________________ ___ ___-___ ___-___ ___ ___ ___
USMLE/ECFMG Number Certification Date

SECTION 10: CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
(DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

______________________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________________ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

BOARD CERTIFICATION

Are you Board Certified? ___ Yes ___ No ______________________________
Name of Board

___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
Date Initially Certified Date Most Recently Recertified Date Certification Expires

___ Yes ___ No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

This section continues on next page.

-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification   Name of Board

___ ___ - ___ ___ - ___ ___ ___ ___ Date Initially Certified   ___ ___ - ___ ___ - ___ ___ ___ ___ Date Most Recently Recertified   ___ ___ - ___ ___ - ___ ___ ___ ___ Date Certification Expires

Subspecialty or Added Qualification   Name of Board

___ ___ - ___ ___ - ___ ___ ___ ___ Date Initially Certified   ___ ___ - ___ ___ - ___ ___ ___ ___ Date Most Recently Recertified   ___ ___ - ___ ___ - ___ ___ ___ ___ Date Certification Expires

BOARD QUALIFICATIONS

___ Yes ___ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

___ Yes ___ No Are you planning to take the exam?

___ Yes ___ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral ___ ___ - ___ ___ - ___ ___ ___ ___

Written ___ ___ - ___ ___ - ___ ___ ___ ___

Other ___ ___ - ___ ___ - ___ ___ ___ ___

Subspecialty or Added Qualification   Name of Board

Date Qualified ___ ___ - ___ ___ - ___ ___ ___ ___   Date Qualification Expires ___ ___ - ___ ___ - ___ ___ ___ ___

Classifications:

___ Yes ___ No Are you certified in CPR?   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

___ Yes ___ No Basic Life Support (BLS)   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

___ Yes ___ No Advanced Cardiac Life Support (ACLS)   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

___ Yes ___ No Health Care Provider (CoreC)   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

___ Yes ___ No Advanced Trauma Life Support (ATLS)   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

___ Yes ___ No Neonatal Advanced Life Support (NALS)   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

___ Yes ___ No Pediatric Advanced Life Support (PALS)   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

___ Yes ___ No Other____________________   Expires ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 11: OFFICE INFORMATION
Primary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

___ Solo ___ Partnership ___ Single-Specialty Group ___ Multi-Specialty Group Other (specify)________________________

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ___ Yes ___ No Reference Lab? ___ Yes ___ No On Site? ___ Yes ___ No

CLIA ID # ______________________________ CLIA Waiver # ______________________________

Does your office have the following:

___ Yes ___ No Radiology

___ Yes ___ No EKG

___ Yes ___ No Audiology

___ Yes ___ No Treadmill

___ Yes ___ No Sigmoidoscopy

___ Yes ___ No Wheelchair/handicapped access?

___ Yes ___ No Other services for the disabled?

If yes, please list:______________________________

___ Yes ___ No Other:________________________

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You ______________________________

Your Staff ______________________________

Other Resources ______________________________

Does this office meet all state and local fire, safety and sanitation requirements? ___ Yes ___ No

24-hour, seven day a week coverage is required. Please check the service you use:

_______ Answering service _______ Answering machine

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	________	________	________	________	________	________	________
To:	________	________	________	________	________	________	________

Average Appointment Scheduling Time:

New Patient_____Hours/Days/Weeks Routine Visit_____Hours/Days/Weeks Urgent Visit_____Days/Hours/Weeks

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name ______________________________ Specialty ______________________________ Telephone (______)______________

Name ______________________________ Specialty ______________________________ Telephone (______)______________

Name ______________________________ Specialty ______________________________ Telephone (______)______________

___ Yes ___ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 11: OFFICE INFORMATION
Secondary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

____ Solo ____ Partnership ____ Single-Specialty Group ____ Multi-Specialty Group ____ Other (specify) ______________________

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ____ Yes ____ No   Reference Lab? ____ Yes ____ No   On Site? ____ Yes ____ No

CLIA ID # ______________________   CLIA Waiver # ______________________

Does your office have the following:

____ Yes ____ No Radiology
____ Yes ____ No EKG
____ Yes ____ No Audiology
____ Yes ____ No Treadmill
____ Yes ____ No Sigmoidoscopy
____ Yes ____ No Wheelchair/handicapped access?
____ Yes ____ No Other services for the disabled?
If yes, please list:______________________
____ Yes ____ No Other:______________________

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:
You ______________________
Your Staff ______________________
Other Resources ______________________

____ Yes ____ No Does this office meet all state and local fire, safety and sanitation requirements?

24-hour, seven day a week coverage is required. Please check the service you use:

________ Answering service   ________ Answering machine

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	________	________	________	________	________	________	________
To:	________	________	________	________	________	________	________

Average Appointment Scheduling Time:

New Patient______Hours/Days/Weeks   Routine Visit______Hours/Days/Weeks   Urgent Visit______Hours/Days/Weeks

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name ______________________ Specialty ______________________ Telephone (______) ____________

Name ______________________ Specialty ______________________ Telephone (______) ____________

Name ______________________ Specialty ______________________ Telephone (______) ____________

____ Yes ____ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

Attached	Item
________	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
________	Current Federal DEA Registration Certificate
________	Emergency Care Training Certificates (CPR, etc., if certified)
________	Photo Identification
________	Curriculum Vitae
________	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) ____

Signature ____ Date ______________________

NOTE:
Practitioners are reminded that each organization will require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.

Application Credentialing Addendum

For ____

Name of Doctor

Please complete this form, in type or print, in its entirety and attach to the Uniform Credentialing Application. Attach additional information on separate sheets as needed and return originals to: **Oklahoma State Chiropractic Independent Physicians Association (OSCIPA), 5350 E. 46th St., Suite 122, Tulsa, OK 74135 Attn: Credentialing**

Please attach copies of the following documents to the application:

- All currently valid state licenses
- Face sheet of Professional Liability Insurance Policy showing you as the insured
- Current copy of your Curriculum Vitae (CV)
- Completed and signed W-9 (blank copy enclosed)

Professional References

Please list two (2) peers who have personal knowledge of your current clinical abilities, ethical character, and ability to work cooperatively with others. These should be individuals who will provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time.

*****Examples of professional references are other practitioners in the same field and/or other practitioners in your specialty. None of your references should be relatives, and no more than one should be a current professional associate.**

If your training was completed within the past three (3) years, you may list your Program Director(s) as professional reference(s). If you have been out of training for more than three (3) years, it is important to name individuals who have not been listed previously in your Oklahoma Uniform Application.

(1) ____

Name Title Specialty

____

Address City State Zip

____

Phone Number Fax Number

(2) ____

Name Title Specialty

____

Address City State Zip

____

Phone Number Fax Number

Liability Insurance

1. Have you ever been denied professional liability insurance or has your coverage ever been cancelled or terminated? YES ☐ NO ☐
   If yes, please explain on a separate sheet.

2. Have there ever been, or are there currently pending, any malpractice claims, settlements, judgments, or arbitration proceedings involving your professional practice? YES ☐ NO ☐
   If yes, please complete Exhibit 1 included in this addendum packet.

3. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? YES ☐ NO ☐
   If yes, list the procedures which have been excluded and provide a full explanation on a separate sheet.

Please include Carrier information covering a minimum of five (5) years continuous coverage. If your current carrier coverage is less than five (5) years please attach previous carrier information.

BE SURE TO ATTACH A COPY OF YOUR CURRENT CERTIFICATE OF LIABILITY INSURANCE

Contractual Requirements expect minimums of $1,000,000 per occurrence/$3,000,000 aggregate

Present Carrier

____

Present Carrier Agent Name

____

Address City State Zip Phone Number

____

Name in which the policy is issued Policy Number

Policy Effective from __________________________ to ___________________________.
Calendar Date Calendar Date

All Prior Carriers during the past five years

____

Prior Carrier Name in which the policy was issued Policy Number

____

Address City State Zip Phone Number

Policy Effective from __________________________ to ___________________________.
Calendar Date Calendar Date

Disclosure Information

1. Have any of the following ever been, or are any currently in process or pending, either on a *voluntary or involuntary basis: denied, revoked, suspended, reduced, limited, cancelled, sanctioned, placed on probation, not renewed or relinquished for disciplinary reasons? **All "yes" answers for questions 1-13 require full explanation on a separate page.**

a) Medical license in any state Yes ______ No _____

b) Other professional registration or license Yes ______ No _____

c) DEA registration Yes ______ No _____

d) Oklahoma BNDD (or other state narcotics registration) Yes ______ No _____

e) Membership on any hospital or healthcare facility medical staff Yes ______ No _____

f) Clinical privileges, prerogatives, or rights on any medical staff Yes ______ No _____

g) Membership in other healthcare organizations or facilities Yes ______ No _____

h) Professional society membership or fellowship Yes ______ No _____

i) Board certification Yes ______ No _____

j) Participation in the Medicare of Medicaid program or other Government health benefits program Yes ______ No _____

2. Have you ever received a reprimand, sanction or been fined by any state licensing board? Yes ______ No _____

3. Have there ever been, or are there now, any state licensing investigations, claims, or actions against you? Yes ______ No _____

4. Has there been a gap of six (6) months or greater in your academic or professional career for the previous five (5) years? Yes ______ No _____

5. Do you have hospital medical staff privileges? Yes ______ No _____

6. Has your employment at a health care organization ever been terminated? Yes ______ No _____

7. Have you ever been charged or convicted of a felony, moral, ethical or sexual crime, or violation of any federal, state and/or local regulations other than a minor traffic offense? Yes ______ No _____

8. Are there any felony charges pending against you? Yes______ No _____

9. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconducts? Yes______ No _____

10. Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges or resigned from the medical staff or surrendered your clinical privileges while under investigation or before a recommendation or decision by a hospital's or health care facility's medical executive or governing board was rendered? Yes ______ No _____

11. Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)? Yes ______ No _____

12. Have you ever been terminated, rejected, limited or been excluded or refused membership in a managed care organization (HMO, PPO, PHO, etc.) for a stated reason? Yes ______ No _____

13. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? Yes ______ No _____

A "No" answer to the following question states you are <u>not</u> able to perform your duties.

14. Are you able to perform the essential functions of a practitioner in your area of practice? Yes ______ No _____

Disclosure Information – Health Status

If any of the questions are answered in the affirmative, please provide full explanation on a separate sheet.

1. **Do you presently have a physical or mental health condition, including drug or alcohol dependence, that affects, or that may reasonably be expected to progress within the next two years to the point of affecting, your ability to practice medicine or place your patients at increased risk?** Yes _____ No _____

2. **Have you every had any such condition in the past that is now resolved without the need of continuing therapy or medication?** Yes______ No ______

3. **Do you have any physical impairments or are you currently taking medication/therapy for a condition which could affect your ability to perform professional duties if the medication/therapy were discontinued today?** Yes______ No ______

4. **Have you at any time during the last ten years been hospitalized or received any other type of institutional care for any such condition/problem?** Yes _____ No ______

OSCIPA Authorization and Attestation

I hereby affirm and attest that all statements, answers and information contained in this application and submitted by me are true and complete to the best of my knowledge, information and belief. I understand that falsification, misrepresentation or omission of any fact(s) requested will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application.

I understand and agree that acceptance of this application does not constitute approval of acceptance of participating status in the Oklahoma State Chiropractic Independent Physicians Association (OSCIPA) and grants me no rights or privileges of participation until such time as I receive written notice of participating status.

I also grant permission for the OSCIPA (and any of its subsidiaries) to perform an on-site review of my practice location(s). I understand that this application process will not be considered complete without an on-site review.

In the event that I subsequently receive notice of participating status, I authorize the OSCIPA to use this information, including Sections VI and VII, to answer questions that covered persons may have about my practice. I further agree that if I receive notice of participating status, I will assume the duty of informing the OSCIPA (or its relevant subsidiaries) in a timely manner of subsequent changes in any of the information provided on or relative to this application.

I authorize individuals, organizations, previous employers, and schools to provide any information, including confidential records and separate evaluations, relating to my professional qualifications, professional liability insurance, credentials, and clinical and/or professional competence to practice medicine. This authorization is made on the condition that the OSCIPA use such information only in connection with their peer review and credentialing process.

I release from liability and hold harmless all representatives and agents of the OSCIPA for acts performed in good faith and without malice in connection with the evaluation of my competence and qualifications. I hereby further release from liability all individuals, organizations and agencies providing information to the OSCIPA under terms of this authorization.

A photocopy of this signed consent form shall be deemed to have my authorization and approval for release of the requested information to the OSCIPA.

Signed: ____

Date: ____

Additional Information

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.

EXHIBIT 1

PROFESSIONAL LIABILITY CASE REPORTING FORM

PLEASE FILL OUT A SEPARATE FORM FOR EACH JUDGEMENT, SETTLEMENT, OR PENDING CLAIM
PLEASE NOTE: THIS FORM WILL BE MORE USEFUL IF COMPLETED BY THE PHYSICIAN

Date Claim Filed: ____________________ Date of Alleged Incident: ____________________

Name of Carrier: ____

Status:

- ❑ Closed, No payment
- ❑ Closed, with Settlement
- ❑ Pending

Settlement: $____________________ Date of Settlement: ____________________

What are (were) the specific allegations by the plaintiff? ____________________

What is (was) your exact role in the patient's care? ____________________

Provide specific clinical details of the case as they occurred: ____________________

Please list all other defendants and their roles in the case: ____________________

Please detail subsequent events including patient outcome: ____________________

______________________________ ____________________

Applicant's Signature Date

EDUCATION

Please list all chiropractic schools attended.

____
Institution Degree

____
Address

____
City, State, Zip

____
Dates Attended From (month and year) To (month and year)

____
Date of Graduation (month, day and year)

****

____
Institution Degree

____
Address

____
City, State, Zip

____
Dates Attended From (month and year) To (month and year)

____
Date of Graduation (month, day and year)

IRS/W-9 Instructions

The IRS is requiring more detailed information on the W-9. The first line MUST be completed with the name you list on your tax return. The second line is to be used if your practice is under a different name. Checks will be made out to the name on the second line unless you only use the first line, indicating your tax return and business names are the same.

For example, if you file your practice with your personal tax return, the first line might have John Smith. The second line would be Smith Chiropractic and the checks would be made to Smith Chiropractic.

If you file your taxes under a corporation name, Smith Enterprises would go on the first line and Smith Chiropractic would be on the second line with the checks made out to Smith Chiropractic.

If your taxes are filed under your business name only, Smith Chiropractic would go on the first line and you can leave the second line blank. The checks would be made out to the business name.

Please contact your accountant/tax preparer to find out how your business taxes are filed. Complete a W-9 form to keep in your office ready for your signature and date whenever it is needed. You will need the correct W-9 for recredentialing and if you need to make any changes to your office information.

Please contact Elizabeth if you have any questions or concerns.

Elizabeth Hendricks
Credentialing Coordinator
OSCIPA
918-641-0444, ext. 2
918-641-0665 fax
www.oscipa.com

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ Exempt from backup withholding

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

Requester's name and address (optional)

City, state, and ZIP code

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 your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number
___ – __ – ____

or

Employer identification number
__ – _______

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

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

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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.

Note. *If 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.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 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 recipient 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 not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called “backup withholding.” Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, 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, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

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 the instructions below and the separate Instructions for the Requester of Form W-9.

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

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name” line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for “Other” and enter “LLC” in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the “Name” line. 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 the “Business name” line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the “Exempt from backup withholding” box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

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 possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	**THEN the payment is exempt for . . .**
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1]See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2]However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

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. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 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 Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. 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/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, 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. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic 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 items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 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 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), 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)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. 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

[1] 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.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal 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.)

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.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax 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. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Do not forget to include your <u>updated</u> Curriculum Vitae (CV) or a current resume. The following is an example:

Name, D.C.

Revised DATE

Work Experience

Month/Year to Present	Current Practice Location Address Phone	Current Practice
Month/Year to Month/Year	Previous Practice Location Address Phone	Reason for leaving
Month/Year to Month/Year	Previous Practice Location Address Phone	Reason for leaving

Education

Dates Attended	College Degrees Earned – Year	Date Graduated

Continuing Education, Certifications

You do not need to list every seminar, only the ones you choose to list.

Awards, Memberships, Honors

Professional References – 3

Name/Specialty
Address
Phone/Fax
Email

Your CV should be kept up to date. Mark your calendar to update your curriculum vitae annually when you renew your chiropractic license.

5350 E. 46th Street, Suite 122, Tulsa, OK 74135-6601
Phone: 918-641-0444 Fax: 918-641-0665
Email: info@oscipa.com

Please review the following checklist of required information:

- ❑ Is question #14 of the Disclosure Information checked correctly?
- ❑ 24 hour coverage is required. It can be as simple as an answering machine message with your phone number, or contacting their primary care physician, 911 or emergency room
- ❑ Photo
- ❑ Declaration page of current malpractice insurance – make sure it won't expire during credentialing.
- ❑ All state licenses
- ❑ W-9 for each office location.
- ❑ Curriculum vitae or resume with dates and addresses of employment – account for gaps of more than 30 days
- ❑ Make a copy of the entire application for your files
- ❑ Check for $175 for credentialing fee

The following is not acceptable:

- Stamped signature
- Any white out, the provider must initial corrected response
- Scratch out on application without the provider's initials
- Disclosure questions unanswered or answered NA

Please contact the Credentialing Coordinator
if you have any questions.

Elizabeth Hendricks
918-641-0444, ext. 2
elizabeth@oscipa.com

National Provider Identifier (NPI)

If you don't have your number yet, the website is https://nppes.cms.hhs.gov/

1. Click on the National Provider Identifier (NPI) link in the middle of the page.
2. On the bottom left of this page under Additional Resources, click on the NPI Application/Update Form link for a hard copy of the application.
3. There are 2 pages of instructions along with the application.
4. The provider taxonomy code is 111N00000X
5. You may call 1-800-465-3203 to request a paper application.

If you are not using your social security number for your tax id number, you will need to apply for an organization NPI. Follow the above steps only follow the instructions for an organization. If you begin your practice using your SSN and switch to an EIN at a later date, you will need to apply for an organization NPI at that time.

If you are having trouble finding the website, use a search engine (Google, etc.) and search for the National Provider Identifier.

When you have your NPI, add it to page 2 in the Uniform Credentialing Application.

Please call 918-641-0444 if you have any questions about applying for your NPI.

OKLAHOMA STATE CHIROPRACTIC INDEPENDENT PHYSICIANS ASSOCIATION PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement ("Agreement") is made and entered into, effective the _________ day of ________________________, 20______, by and between the Oklahoma State Chiropractic Independent Physicians Association ("OSCIPA"), a nonprofit corporation of the State of Oklahoma and the undersigned, provider, who is duly licensed and authorized to practice as a Chiropractic Physician by the Oklahoma Board of Chiropractic Examiners ("Participating Provider").

RECITALS

WHEREAS, OSCIPA is organized for the purpose of arranging and managing a Independent Physicians Association (IPA) comprised of Participating Providers who, by agreement with OSCIPA, provide Medical/Chiropractic Services to Enrollees; and

WHEREAS, the undersigned agrees to provide Medical/Chiropractic Services and wishes to participate in the OSCIPA IPA;

NOW, THEREFORE, the parties mutually agree as follows:

ARTICLE I
DEFINITIONS

1.1 **"Benefit Agreement(s)"** means the written agreement entered into by a Third-Party Payor or Network and a group's representative or with individuals under which the Third-Party Payor or Network provides, indemnifies, underwrites and/or administers health care benefits.

1.2 **"Covered Services"** means those services for which benefits are available to an Enrollee from a Participating Provider under an Enrollee's Benefit Agreement provided, indemnified, underwritten and/or administered by a Third-Party Payor or Network.

1.3 "**Enrollee(s)"** means any person entitled to receive Medical/Chiropractic Services pursuant to the terms of Third-Party Payor or Network provided, indemnified, and/or underwritten or administered contracts referencing Participating Providers of OSCIPA.

1.4 **"Maximum Reimbursement Allowance"** means a compensation arrangement in which a participating providers agrees to accept the Schedule of Allowances as his total fee for covered services.

1.5 **"Medical/Chiropractic Services"** means services provided by a Participating Provider and an eligible benefit under the Benefit Agreements.

1.6 **"Medically Necessary"** means services or supplies which, under the terms of this Agreement, are determined to be:

A. Appropriate for the symptoms and diagnosis or treatment of the Enrollee's condition, illness, disease, or injury; and

B. Provided for the diagnosis or the direct care and treatment of the Enrollee's condition, illness, disease or injury; and

C. In accordance with standards of good chiropractic practice; and

D. Not primarily for the convenience of the Enrollee, or the Enrollee's provider or another provider; and

E. The most appropriate supply or level of service that can safely be provided to the Enrollee.

1.7 **"Participating Provider(s)"** means a licensed Chiropractic Physician who has entered into an Agreement with OSCIPA to provide Medical/ Chiropractic Services to Enrollees.

1.8 **"Reference Manual"** means the OSCIPA Reference Manual, as updated from time to time, that provides a source of information to which the Participating Provider is referred.

1.9 **"Third-Party Payor or Network"** means an insurance company, health maintenance organization, third-party administrator, preferred provider organization, or any other entity, including any division, subsidiary or authorized affiliate, which has contracted with OSCIPA for the delivery of Medical/Chiropractic Services by Participating Providers.

1.10 **"Usual Charge"** means the fee most commonly charged, by the Participating Provider, for services provided to most patients. As used in this Agreement, Usual Charge does not apply to the Participating Provider's Medicare and Medicaid patients.

1.11 **"Written Waiver"** means a document signed by the Enrollee, or his/her representative stating that one or both of them shall be responsible for payment denied as a non-covered service by the Third-Party Payor or Network.

ARTICLE II
RELATIONSHIP BETWEEN
OSCIPA AND THE PARTICIPATING PROVIDER

2.1 **Independent Contractor.** OSCIPA has negotiated and entered into this Agreement with the Participating Provider for itself and on behalf of the Enrollees who are covered by the provisions of the Benefit Agreements. The Participating Provider is an independent contractor who has entered into this Agreement as a Participating Provider of Medical/Chiropractic Services and is not, nor is intended to be, the employee, agent or other legal representative of OSCIPA in the performance of this Agreement. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent between OSCIPA and the Participating Provider, or any relationship contrary to that of independent contractors for the purposes of this Agreement.

2.2 **No Third-Party Rights.** Nothing in this Agreement is intended to be construed, or be deemed to create any rights or remedies for any third party, including, but not limited to, an Enrollee.

ARTICLE III
GENERAL AGREEMENT OF PARTIES

3.1 Participating Provider hereby agrees to:

A. **Services.** The Participating Provider shall provide Medical/Chiropractic Services to the Enrollee in the same manner and equal in quality and promptness

as services are provided to the Participating Provider's other patients. Services shall be rendered in accordance with generally accepted standards of medical/chiropractic care in the community and without regard to race, sex, national origin, health status or religious conviction.

B. **Referrals.** If the Participating Provider is unable to deliver the Enrollee's required services, the Enrollee should be referred to another Participating Provider. In the event that services required by an Enrollee are not available from any Participating Provider, referrals may be made to non-participating providers in accordance with the individual Third-Party Payors or Networks referral requirements. The Participating Provider will furnish referred physicians' complete information on treatment procedures and diagnostic tests performed prior to said referral.

C. **Records.** The Participating Provider shall maintain medical/chiropractic records on each Enrollee for whom services are rendered and to maintain such other records with respect to the value of and nature of the Medical/Chiropractic Services performed as may reasonably be required by OSCIPA or Third-Party Payor or Network. Such information shall be provided upon request and without charge. OSCIPA, on occasion, may request to review such information in the Participating Provider's office rather than requesting that information be forwarded via mail.

D. **Usual Charge.** The Participating Provider agrees to accept, as payment in full for such services, the lesser of the Participating Provider's Usual Charge or the Maximum Reimbursement Allowance. Deductible, co-insurance, and non-covered amounts may be collected from the Enrollee so long as the total amount collected from the Enrollee and either the Third-Party Payor or Network or OSCIPA does not exceed the lesser of the Participating Provider's Usual Charge or the Maximum Reimbursement Allowance. The Participating Provider is required not to collect any amounts from the Enrollee except the deductible, co-insurance, and non-covered amounts until the Third-Party Payor or Network has adjudicated the claim and notified the Participating Provider and the Enrollee as to the amount due from the Enrollee.

E. **Written Waiver.** The Participating Provider shall not charge Enrollee for non-covered services unless the Participating Provider has obtained a Written Waiver. Such a waiver shall be obtained prior to services being rendered. The Written Waiver shall clearly state that the Enrollee, or his/her representative shall be responsible for the non-covered service.

F. **Claims.** The Participating Provider will look solely to the Third-Party Payor or Network for payment of all amounts due except deductible, co-insurance, office visit co-payments, and non-covered amounts that may be collected directly from the Enrollee. However, OSCIPA claims must be filed electronically to a claims processing clearinghouse approved by OSCIPA. Non-compliance with this provision may constitute grounds for immediate termination of this Agreement.

G. **Name Publication.** The Participating Provider will allow OSCIPA or the applicable Third-Party Payor or Network to publish and distribute directories listing the Participating Provider's name, address and phone number as a member of OSCIPA.

H. **Offset.** The Participating Provider shall permit the Third-Party Payor or Network to exercise the right of offset, if any, deducting from future payment amounts paid in error. The Third-Party Payor or Network shall provide notice of the amounts offset, the name of the Enrollee on whose behalf payments were in error and relevant services dates.

I. **Utilization Management.** The Participating Provider will comply and participate in all utilization management procedures established by OSCIPA and/or a Third-Party Payor or Network.

J. **Collection.** The Participating Provider will collect all deductible and co-insurance amounts owed by Enrollee, neither waiving nor rebating any portion thereof, or provide other such incentives as a means of advertising, attracting new patients or maintaining existing patients. Non-compliance with this provision may constitute grounds for immediate termination of this Agreement.

K. **Incorrect Payments.** The Participating Provider will immediately notify Third-Party Payor or Network upon receipt of duplicate payments, over-payments or otherwise incorrect payments.

L. **Quality Assurance.** The Participating Provider will cooperate with quality assurance activities the Third-Party Payor or Network. The Participating Provider will also adhere to OSCIPA's quality assurance activities as defined in the Reference Manual. All such quality assurance activities of both the Third-Party Payor or Network and OSCIPA are considered to be confidential and will not be released to any other party except where required by applicable state or federal laws.

M. **Codes.** The Participating Provider assures their office, in which Enrollee will be received, screened and treated, meets all applicable state and local fire, safety and sanitation codes.

N. **Insurance.** The Participating Provider shall maintain a minimum of $1,000,000 for each claim and $3,000,000 aggregate insurance for the professional liability and comprehensive general liability risk at all times while this Agreement is in effect. Upon request by OSCIPA or designated Central Verification Organization (CVO), the Participating Provider shall provide OSCIPA or designated Central Verification Organization (CVO) with copies of insurance facesheet.

O. **License.** The Participating Provider will maintain a valid and unrestricted license to practice chiropractic care in the State of Oklahoma. The Participating Provider will notify OSCIPA of any changes in the status of his/her license to practice within thirty (30) days of such changes.

P. **Credentialing.** The Participating Provider will adhere to OSCIPA's credentialing/recredentialing requirements as provided in the Reference Manual.

Q. **Network Access Fee.** The Participating Provider agrees to pay all billed network access fees within thirty (30) days of the date of invoice.

3.2 OSCIPA hereby agrees to:

A. **Third-Party Payor or Network.** Contract with Third-Party Payor or Network for the purpose of marketing the services of the Participating Providers of OSCIPA.

B. **Name Publication.** Provide Third-Party Payors or Networks a listing of Participating Provider's demographic information in order to allow Third-Party Payors or Networks to notify their Enrollees of OSCIPA's members.

C. **Enrollee Identification.** Provide current list of Third-Party Payors or Networks.

D. **Reference Manual.** Provide the Participating Provider with the OSCIPA Reference Manual which includes OSCIPA's administrative processes.

E. **Maximum Reimbursement Allowance.** Review Maximum Reimbursement Allowance for each procedure at least annually.

ARTICLE IV
UTILIZATION MANAGEMENT

Utilization Management is intended to assure that the services provided to Enrollee are Medically Necessary and appropriate for the diagnosis and treatment to their condition.

4.1 TREATMENT GUIDELINES

A. **Treatment Frequencies.** Medically Necessary services may be provided in the frequencies determined by the applicable Third-Party Payors or Networks Utilization Management guidelines for a specific diagnosis.

B. **Additional Treatment.** Treatment in excess of the frequencies determined by the Third-Party Payor or Network may not be eligible for reimbursement.

C. **Prior Authorization.** Authorization may be required prior to treatment as determined by the applicable Third-Party Payors or Networks Utilization Management guidelines. Generally, the following information is necessary in order to obtain such authorization

(1) Date and history of onset;
(2) Subjective complaints;
(3) Examination findings;
(4) Diagnosis;
(5) Type of chiropractic techniques and conjunctive therapy to be utilized;
(6) Progress notes;
(7) Prognosis;
(8) Dates and findings of all x-rays; and
(9) Extenuating circumstances.

4.2 OTHER UTILIZATION MANAGEMENT GUIDELINES

A. **Denied Amounts.** Payment may be denied for all treatment exceeding established guidelines which have not received Prior Authorization, if required. The Participating Provider may not charge such denied amounts to the Enrollee.

B. **Billing Codes.** ICD-9-CM codes for diagnosis and appropriate CPT or HCPCS codes shall be used for billing purposes.

C. **Committee Guidelines.** The Participating Provider will follow guidelines deemed appropriate by the OSCIPA Quality Assurance Committee, and approved by the OSCIPA Board.

D. **Appeals.** Any appeals regarding Utilization Management should be directed to the applicable Third-Party Payor or Network and handled according to their specific appeal procedures.

ARTICLE V
GENERAL PROVISIONS

5.1 **Liability.** Neither party to this Agreement, OSCIPA nor the Participating Provider nor any agent, employee or other representative of a party, shall be liable to third parties for any action or omission of the other party in performance of this Agreement and the terms and provisions hereunder. This provision does not otherwise require the Participating Provider to indemnify OSCIPA for alleged acts of corporate negligence on the part of OSCIPA.

5.2 **Non-Assignment.** This Agreement or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.

5.3 **Negotiation.** OSCIPA and the Participating Provider agree that their authorized representatives will timely meet and negotiate in good faith to resolve any problems or disputes that may arise in performance of the terms and provisions of this Agreement.

5.4 **Notice.** Notice given under this Agreement shall be in writing and sent by first-class mail, certified mail, return receipt requested, or by private carrier to the following address, unless such party has provided notice of another address. Such notices shall be effective when mailed.

"OSCIPA"	**"PARTICIPATING PROVIDER"**
Oklahoma State Chiropractic	
Independent Physicians Association	________________________________,DC
ATTN: Executive Director	____________________________________
5350 E. 46th St., Suite 122	____________________________________
Tulsa, OK 74135-6601	____________________________________

5.5 **OSCIPA Name.** OSCIPA reserves right to, and control the use of, the words Oklahoma State Chiropractic Independent Physicians Association and all Oklahoma State Chiropractic Independent Physicians Association symbols, trademarks, and service marks presently existing or hereafter established. The Participating Provider agrees that he/she will not use such words, symbols, trademarks, or service marks in any manner without the prior written consent and approval of OSCIPA and will cease any and all usage upon termination of this Agreement.

5.6 **Secondary Payments.** In cases where Enrollee may have other third-party insurance or coverage that assumes responsibility for primary payment, the terms of this Agreement are still applicable to any secondary payments made by either OSCIPA or a Third-Party Payor or Network.

5.7 **Administrative Fees.** OSCIPA will charge a network access fee for services rendered under the terms of this Agreement as provided in the Reference Manual. Such fees are subject to modification in accordance with paragraph 5.8 below.

5.8 **Modification.** OSCIPA may modify this Agreement from time to time and further agrees that no such modification shall become effective until sixty (60) days after written notice has been mailed to the Participating Provider. This sixty (60) day period may be waived for changes mandated by state or federal law.

5.9 **Term.** The term of this Agreement shall be for a period of twelve (12) months, commencing on the effective date of execution by OSCIPA, and continuing from year-to-year thereafter.

5.10 **Termination.** Either party may terminate this Agreement by giving at least thirty (30) days prior written notice. If the termination is initiated by OSCIPA, the other party can request a Right to Hearing if such request has been made in writing and within thirty (30) days from notice of termination. Either party may terminate this Agreement immediately in the event of a material breach of this Agreement. Nothing in this Agreement shall be construed to limit either party's remedies at law.

5.11 **Terms and Provisions.** The terms and provisions of this Agreement shall be deemed to be severable one from the other, and determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Agreement, or any of them, in accordance with the intent and purpose of the parties hereto.

5.12 **Independent Contract.** The undersigned hereby acknowledges and agrees to the terms and conditions of this Agreement, including the Reference Manual. Further, the undersigned agrees that the terms and conditions of the OSCIPA Agreement hereby suspends any existing agreements to which the undersigned is a party with any Third-Party Payor or Network upon the effective date of the OSCIPA Participating Provider Agreement. During the term of this Agreement, no provision of any suspended agreement (e.g., Physician or Provider Group, Provider, and/or Specialist Physician Agreement) shall be controlling as long as the OSCIPA Participating Provider Agreement remains in effect.

5.13 **Choice of Law.** This Agreement, including its attachments and any other documents incorporated by reference, constitutes the entire understanding of the parties hereto and supersedes any and all written or oral agreements, representations, or understandings, and shall be binding upon both parties hereto.

5.14 **Attorney's Fees.** Upon the breach of any covenant contained herein, the aggrieved party shall have the right to pursue such action in law or in equity as such party deems appropriate. The prevailing party in such action shall be entitled to recover the reasonable and necessary costs, expenses, and attorney's fees associated therewith.

5.15 **Arbitration.** The parties agree to submit any claim arising out of a dispute in relations to this Agreement to binding arbitration governed by the rules and procedures of the American Arbitration Association. Claims may include, but are not limited to, allegations of breach of contract, concealment, misrepresentation, negligence and/or

fraud. Upon submission of a dispute to the American Arbitration Association, the parties agree to be bound by the rules of procedure and decision of the American Arbitration Association. The parties understand that by entering into this Agreement, they are giving up their constitutional right to have any claim decided in a court of law before a jury, and instead, are accepting the use of binding arbitration.

IN WITNESS WHEREOF, this Agreement has been duly executed by the authorized representatives of OSCIPA and Participating Physician effective as of the date set forth below by OSCIPA's executed date.

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*Any information entered into this application or its attachments which subsequently is found to be false will result in non-acceptance of this application or termination of the Oklahoma State Chiropractic Independent Physicians Association Participating Provider Agreement.

The undersigned parties agree to the terms of the Oklahoma State Chiropractic Independent Physicians Association Participating Provider Agreement, Form No. 12/2000, incorporated herein by reference as if set forth in full to become effective the first day of the month following receipt and acceptance by The OSCIPA.

---

*PARTICIPATING PROVIDER USE ONLY

____

Participating Provider Original Signature

____

Participating Provider Name (typed or printed)

Date signed _____/_____/_____

OKLAHOMA STATE CHIROPRACTIC INDEPENDENT PHYSICIANS ASSOCIATION USE ONLY

____

Authorized Signature Accepting for Oklahoma State Chiropractic Independent Physicians Association

____

Authorized Signature Name (type or printed)

Date signed _____/_____/_____

5350 E. 46th Street, Suite 122
Tulsa, OK 74135-6601
Toll Free: (877) 940-3044
Office: (918) 641-0444
Fax: (918) 641-0665
Email: info@oscipa.com

November 8, 2011

Dear Doctor:

OSCIPA is the exclusive chiropractic network in Oklahoma for Aetna, Inc. This means that all OSCIPA members are now eligible to participate in ALL of Aetna's networks.

Attached is an Individual Provider Addendum that you need to date and sign if you would like to join Aetna. This addendum, provided by Aetna, simply confirms you as a contracted member of OSICPA which will now make you eligible to be an in-network provider for Aetna.

Please return the original addendum to OSCIPA. Upon acceptance into OSCIPA and receipt of the membership fee, I will forward the original signed addendum to Aetna so they can begin their process of adding you to their network. This process will take approximately 3 weeks. I will scan a copy to your file and keep a hard copy, as well. Please make a copy for yourself.

If you have any questions, please don't hesitate to call me at 641-0444, option 2.

Sincerely,

Elizabeth Hendricks
Credentialing Coordinator

INDIVIDUAL PROVIDER ADDENDUM

The undersigned health care provider ("Provider"), a member of OSCIPA ("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., an Oklahoma 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 further agrees that if the Member is enrolled in an HMO, then in no event, including but not limited to non-payment by the HMO, insolvency of the HMO or breach by the HMO of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons acting on Member's behalf for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles. Provider further agrees that this provision shall be construed for the benefit of Members, shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider or Entity and a Member or any person acting on behalf of a Member, and shall survive the termination of the Agreement, regardless of the cause giving rise to termination.

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:____________________________

Oklahoma State Chiropractic
Independent Physicians Association
Back To A Better Life

5350 E. 46th Street, Suite 122
Tulsa, OK 74135-6601
Toll Free: (877) 940-3044
Office: (918) 641-0444
Fax: (918) 641-0665
Email: larry@oscipa.com

Date: August 18, 2010

To: OSCIPA Provider

From: Larry M. Bridges, Ph.D.

RE: Medicare Advantage Requirements

Dear OSCIPA Member:

Please sign (Next to By) the attached addendum under the OSCIPA Provider heading on page 3. Also print your name, include your title and fill in the date you signed it. You may fax it back to us at 1-918-641-0665 or mail it back to us in the attached envelope. (We only need page 3!)

The purpose of this addendum is to ensure to our Medicare Advantage Affiliates that OSCIPA and its members will comply with certain Medicare requirements. The Health Industry Collaboration Effort, Inc. (ICE), a volunteer, multidisciplinary team of providers, health plans, associations, state and federal agencies in collaboration with and approval from the Centers for Medicare & Medicaid Services (CMS) Region IX has developed this attached addendum for use by Delegated Entities (OSCIPA) and their members (you) to ensure compliance with Medicare Advantage requirements.

I have signed an attestation form indicating that we have implemented this plan of action in accordance to the above guidelines. This is a vital part of our credentialing program and your signature documents must be received as we are subjected to affiliate audits that will be looking for these signed documents.

Your quick response on this will be appreciated!

Addendum to the Oklahoma State Chiropractic Independent Physicians Association (OSCIPA) Participating Provider Agreement

In accordance with Page 7, Article 5.8, Modification OSCIPA hereby amends the OSCIPA Provider Agreement with the following addendum: This will add contract language required by the Centers for Medicare & Medicaid Services, (CMS) for participation in all of the OSCIPA Medicare Advantage (MA) programs.

Whereas, CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization and all OSCIPA Providers to comply with the Medicare laws, regulations, and CMS instructions, including but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Pub. L. 108-73) (MMA); and

Whereas, OSCIPA Providers desires to provide services to Medicare beneficiaries who enroll in the Medicare Advantage program; and

Whereas, OSCIPA desires that OSCIPA Providers provide services to Medicare beneficiaries who enroll in the Medicare Advantage program; and

Whereas, OSCIPA Providers and OSCIPA agree to comply with the terms and conditions specified by CMS in the form of this Addendum to the Agreement between OSCIPA Providers and OSCIPA; and

Whereas, OSCIPA Providers and OSCIPA previously entered into an OSCIPA Participating Provider Agreement upon the OSCIPA execution date.

NOW, THEREFORE, the parties agree as follows:

DEFINITIONS

Agreement means the agreement between OSCIPA and OSCIPA Providers that specifies the contractual relationship between the OSCIPA and OSCIPA Providers for the provision of services to Enrollee.

Centers for Medicare & Medicaid Services ("CMS") mean the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit means completion of audit by the Department of Health and Human Services, the General Accounting Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Final Contract Period means final contract period between CMS and the Medicare Advantage Organization with whom the First Tier Entity has entered into an Agreement.

Medicare Advantage Organization ("MAO") means a health plan that has entered into a contract with CMS to provide services to Medicare beneficiaries under the Medicare Advantage program.

Medicare Advantage ("MA") is an alternative to the traditional Medicare program in which private

plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Member means an individual who has enrolled in or elected coverage through a Medicare Advantage Organization. A Member is also known as an Enrollee.

REQUIRED PROVISIONS

OSCIPA Providers and OSCIPA agree to the following:

1. OSCIPA Providers agrees to retain and to grant the Department of Health and Human Services (HHS), the Comptroller General or their designees the right to inspect, evaluate, and audit any pertinent information, including books, contracts, medical records, patient care documentation, and records of subcontractors or related entities for a period of (10) years from the end of the Final Contract Period or Completion of Audit, whichever is later, for Members enrolled in a Medicare Advantage Organization.. This increase in the duration of the record retention period applies to all new records as well as to all records required to be retained under any prior addendum as of the date first written above. [42 CFR 422.504 (e) (4)].

2. OSCIPA Providers agrees to abide by all Federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, safeguard the privacy of the beneficiary's information, and maintain records and information in an accurate and timely manner. [42 CFRs 422.118 and 422.504 (a)(13)].

3. OSCIPA Providers agrees to hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the Medicare Advantage Organization, OSCIPA, or OSCIPA Providers. In no event, including but not limited to, nonpayment or breach of an agreement by the Medicare Advantage Organization, OSCIPA, OSCIPA Providers, or other intermediary, or the insolvency of the Medicare Advantage Organization, OSCIPA, OSCIPA Providers, or other intermediary, shall OSCIPA Providers bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. OSCIPA Providers shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or co-payments, as specified in the Medicare Advantage Organization Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided that, pursuant to CMS instructions, the Member was informed in advance of the cost and elected to have non-covered services rendered. [42 CFRs 422.504(g) and (i)(3)(i)].

4. OSCIPA Providers agrees that its performance or other activity are consistent and comply with the First Tier Entity's contractual obligations with the Medicare Advantage Organization, which includes the OSCIPA agreement that its performance or other activity are consistent and comply with the Medicare Advantage Organization's contractual obligations with CMS . [42 CFRs 422.504(i)(3)(iii) and 422.504(i)(4)].

5. OSCIPA Providers agrees to comply with CMS reporting requirements as specified in Sec 422.310 (risk adjustment data) and Sec 422.516 (informational data). [42 CFR 422.504(a)(8)].

6. OSCIPA Providers agrees to comply with all Medicare laws, regulations, and CMS instructions, including but not limited to, all CMS accountability provisions, which may be more fully documented in the Medicare Advantage Organization's policies and procedures. [42 CFRs 422.504(i)(3)(ii) and 422.504(i)(4)(v)].
7. OSCIPA Providers agrees that cost sharing for dual eligible Members is limited to the Medicaid (including Medi-Cal) cost sharing limits; and that for those dual-eligible Members the Downstream Provider will accept the Medicare Advantage Organization or First Tier Entity payment as payment-in-full or will separately bill the appropriate state source for any amounts above the Medicaid (or Medi-Cal) cost sharing.

Except as provided in this Addendum, all other provisions of the Agreement between OSCIPA and OSCIPA Providers not inconsistent herein shall remain in full force and effect. This Addendum shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Addendum as of the date set forth below each signature.

OSCIPA:		OSCIPA Provider:	
By:	[signature]	By:	
Print Name:	LARRY L. BRIDGES	Print Name	
Title:	Executive Director	Title:	
Date:	August 18, 2010	Date:	