



Credentialing Services (OHGCS)

445 Hutchinson Avenue, Suite 550, Columbus, OH 43235 Phone: 614.566.0010 or 800.635.7207 Fax: 614.566.0401

TO: New Applicant

RE: Initial Credentialing with one or more of the following: Riverside, Grant, Doctors, Dublin and Grady Hospitals

Thank you for your interest in applying for privileges with our OhioHealth Hospitals. There are a few things in this packet I want to bring to your attention that I hope will help make your credentialing process go more smoothly.

- Please note in the attached packet we request 2 additional references that are separate from the 3 listed on your CAQH Online Application*
 - Do not duplicate these as the hospitals require 5 professional references of practitioners that are of the same discipline as you and/or collaborating/supervising physician(s).
 - All 5 professional references must have observed you in the past 3 years.
 - In order to expedite the process please include fax numbers and e-mail addresses of all 5 references.
 - Please contact your references and let them know a request will be sent to them so they will be looking out for the requests.
- You will see a form that mentions you will need to be fingerprinted. **Do not do this on your own** as practitioners are required to have an appointment scheduled through our office to have this done.
- Please be advised of the Malpractice History Verification Form that requires your signature. In addition, it is your responsibility to forward this to all applicable insurance carriers with the past 5 years. *This must be received in our office before privileges can be obtained.*
 - Please note, if you are/have been employed by an OhioHealth entity within the past 5 years, it is your responsibility to fax the Legal Department the signed release form to fax number (614) 544-4463.
- Record of your TB Test taken within the past 12 months must be submitted.
- A professional color photograph is required as mentioned in the packet check list. You may e-mail the photograph to me, send on CD or include the original along with your packet. *Note: Do not send passport photos.*

*In addition to the paperwork in this packet we also require a completed CAQH Online Application. I have attached a New Applicant Notification Form for you to complete and then submit to me so that I may create your ID Number. Please call me or fax this form to me at 614-566-0401. If you already have a CAQH ID Number please contact the CAQH Help Desk at 888-599-1771 to obtain a personal username and password so you may log into your application. The CAQH website can be found at <https://upd.caqh.org/oas/> Once you obtain this information please log on and make sure to update your application with **all current information**, such as the practice that you will be joining, all malpractice claims, work history, etc... *Do not print the application and send to me as I will be able download directly from the website.*

I will need both components before I can release your application for processing. If you have any questions regarding this application request please don't hesitate to let me know. I work Monday through Friday from 7:00am to 4:00pm EST with Lunch around 11:00am.

Thank You,
Bonnie J. Chapman, Administrative Assistant
OhioHealth Group Credentialing Services
445 Hutchinson Avenue, Suite 550
Columbus, OH 43235-5677
Phone: 614-566-0010
Fax: 614-566-0401
E-Mail: bchapman@ohiohealthgroup.com

Note: Due to the high volume of phone calls in this office voicemails are returned within 48 hours.



OhioHealth Group

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New Initial Applicant CAQH Notification Form

DATE: _____ SPECIALIST: _____ PCP: _____

New Practitioner's First Name: _____ M.I.: _____ Last Name: _____ Degree: _____

CAQH Practitioner's 8-Digit Identification Number (if applicable): _____

If No CAQH ID is available do you need one created? YES _____ NO _____ (in process w/another insurance agency)
(The Practitioner must be credentialed by us for the ID to be created by us)

Practitioner's Social Security #: _____ Practitioner's Date of Birth (mm/dd/yy): _____

Contact Name: _____ Contact Phone Number: (____) _____ ext. _____

Contact Name's Email Address: _____
(Additional information related to below may need sent to you, such as an application packet or provider agreements)

Group Name: _____ TAX ID #: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Please check what entity/entities you are interested in having the practitioner join:

*Need to apply for Hospital Privileges? YES _____ NO _____ If yes, please check one or more of the following:
*There is an application packet required for hospital privileges in addition to a completed CAQH.

Riverside Methodist Hospital: _____ Grant Medical Center: _____ Doctors Hospital: _____

Grady Memorial Hospital: _____ Dublin Methodist Hospital: _____

*Need to join Insurance Plans? YES _____ NO _____ If yes, please check one or more of the following:
*There are provider agreements required depending on which insurance plan and/or group the practitioner will be joining.

Medical Group of Ohio (MGO): _____ OhioHealth Group / HealthReach PPO: _____

*Please return this form along with the Practitioner's CV / Resume via fax to:
Attention Bonnie Chapman --- Fax 614-566-0401 --- Phone 614-566-0010 Option 2*

OHGCS provides high quality credentialing services on behalf of the following:

American Kidney Stone Management, LTD • Doctors Hospital • Dublin Methodist Hospital • Grady Memorial Hospital
Grant Medical Center • The Medical Group of Ohio • OhioHealth Group (HealthReach & HealthReach Preferred)
OhioHealth Practice Management Services (GRMCFI) • Riverside Methodist Hospital



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OhioHealth Group Credentialing Services participates with the Council of Affordable Quality Healthcare (CAQH) Universal Credentialing Database initiative. This is an online service where practitioners can provide standardized credentialing information to multiple organizations without filling out multiple forms. Simply enter your information into the data base and authorize users to access it.

Effective January 1, 2012: OhioHealth Group Credentialing Services will be credentialing mid-level practitioners for the following entities, (Riverside Methodist Hospital, Grant Medical Center, Doctors Hospital, Dublin Methodist Hospital, Grady Memorial Hospital, The Medical Group of Ohio, OhioHealth Group (HealthReach / HealthReach Preferred products) and/or the American Kidney Stone Management Ltd. The mid-level practitioners that are eligible to participate with these organizations are defined as the following:

All Entities

- Physician Assistants
- Advance Nurse Practitioners
 - Nurse Practitioners
 - Certified Nurse Midwife
 - Certified Registered Nurse Anesthetist
 - Clinical Nurse Specialists

OhioHealth Hospitals Only:

- Massage Therapists
- Physicians (MD/DO) in training that are not otherwise eligible for membership on the Medical Staff at the hospital(s)

You must complete the CAQH on line application and contact OhioHealth Group Credentialing Services at 614-566-0010 to receive a supplemental packet that must be completed and returned to us in order to facilitate the credentialing of your application. The supplemental packet will contain the following:

- Hospital specific documents if you are applying to any of the 5 Central Ohio OhioHealth hospitals
- Provider Agreements if you are interested in participation with OhioHealth Group (HealthReach / HealthReach Preferred products). You will be required to identify your primary collaborating or supervising physician.
- Individual Mid Level Practitioner Participation Addendum (you will be required to identify your primary collaborating or supervising physician) if you are interested in participation with The Medical Group of Ohio

By signing the CAQH Standard Authorization, Attestation and Release form you understand the term “Entity” applies to any of the entities that OHGCS provides credentialing services on your behalf. This single application will allow for the processing of your application ***one time*** even when you are applying to more than one entity.

Completion of this application **DOES NOT** guarantee acceptance by any of the entities. Each participating entity to which you are applying will be given a copy of your application. The entity will give OhioHealth Group Credentialing Services the approval to go forward with processing your application if you meet their membership and credentialing criteria.

Upon completion of the credentialing process, your application, all related verifications and supporting documentation will be sent to each applicable entity. The entity will then complete the decision making portion of the application process and notify you of the results.

If you decide you would like to apply with additional entities or have questions about the status of your application, please call OhioHealth Group Credentialing Services at (614) 566-0010. Questions related to privileging should be directed to the individual hospitals or the American Kidney Stone Management, Ltd.

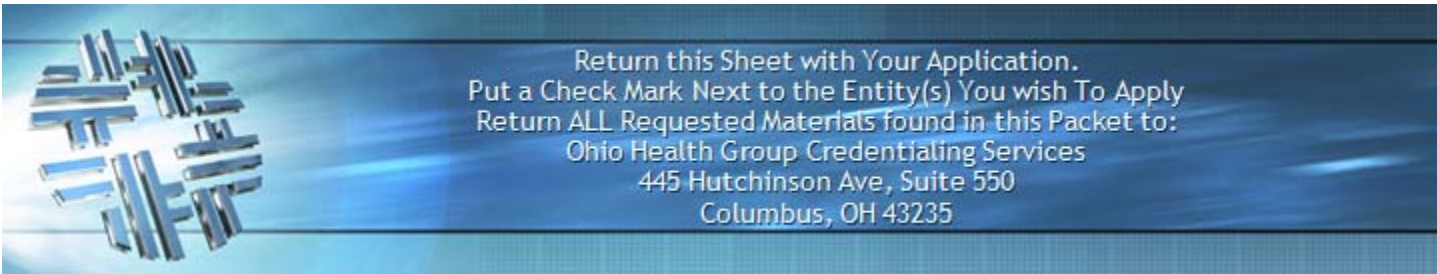
Riverside Methodist Hospital: (614) 566-3374 **Grant Medical Center:** (614) 566-8268, **Doctors Hospital:** (614) 544-1018, **Dublin Methodist Hospital:** (614) 544- 8222, **Grady Memorial Hospital:** (740) 614-1025, **The Medical Group of Ohio:** (614) 566-0113, **American Kidney Stone Management, Ltd.** (614) 447-0281

For your convenience we have included in this packet a Frequently Asked Questions document concerning CAQH and the Universal Credentialing Datasource.

If you are already a CAQH Provider, indicate your ID number below. Make sure to complete the CAQH online application in its entirety with current information and authorize OhioHealth Group Credentialing Services to retain your credentialing information, and complete the enclosed.

My CAQH Provider ID Number is: _____

If you do not have an established CAQH Identifications number, please contact our office at 614-566-0010 opt 2. Our representative will establish a CAQH number for you to submit your credentialing information on line.



OhioHealth Group Managed Care Products

- HealthReach / HealthReach Preferred** (a PPO managed care product). Applicant must be practicing in a group practice that is currently contracted with HealthReach PPO / HealthReach Preferred.



OhioHealth Hospital Medical Staffs

- Riverside Methodist Hospital** (Allied Health Practitioner membership and clinical privileges).
- Grant Medical Center** (Allied Health Practitioner membership and clinical privileges).
- Doctors Hospital** (Allied Health Practitioner membership and clinical privileges).
- Dublin Methodist Hospital** (Allied Health Practitioner membership and clinical privileges).
- Grady Memorial Hospital** (Allied Health Practitioner membership and clinical privileges).

Separate membership/privilege criteria apply to all the above

- Check box for processing fee for one hospital is enclosed. – \$290
- Check box for processing fee for two hospitals is enclosed – \$305
- Check box for processing fee for three hospitals is enclosed – \$320
- Check box for processing fee for four hospitals is enclosed. – \$335
- Check for processing fee for all five hospitals enclosed – \$350

*Application fee **MUST** be received in order for application to be processed for any of the above hospitals. Please note the application fee is a one time fee and is non-refundable once the primary source verification is completed on your application.

Make checks payable to: OhioHealth Group Credentialing Services



The Medical Group of Ohio

- By signing the enclosed MGO Mid Level Individual Practitioner Participation Addendum you are confirming that you are employed by a physician / group that participates in Health⁴.



American Kidney Stone Management, Ltd.

- Please note only CRNA's are eligible to apply.



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Frequently Asked Questions

I don't know if I have a CAQH ID, how do I find out?

Call the CAQH Help Desk at 1-888-599-1771 and they will ask you some identifying information to see if they can locate you in the Database. If you don't have an ID Number the Help Desk will not create one for you. You will be asked to contact an Insurance Company to create an ID Number. In this instance call the OhioHealth Group Credentialing Services office at 614-566-0010 to obtain an ID Number. We will need your birthday, social security number, and your primary practice address and phone number.

I have a CAQH ID Number but how do I get a username and password to log in?

You will need to contact the CAQH Help Desk at 1-888-599-1771 to request a username and password. Please note that your office manager will not be allowed to request this information on your behalf. The Help Desk will only release this information to the practitioner.

I don't have the Malpractice Facesheet for the Practice I'm joining and this needs faxed into CAQH. What do I do?

Please contact the OhioHealth Group Credentialing Services office at 614-566-0010 for assistance.

Do I have to update my practice information in CAQH with the new group I'm joining?

Yes. We will need to know what group you are joining and the specifics such as start date, primary and billing addresses. If there are issues with the current group's knowledge of you leaving please contact the OhioHealth Group Credentialing Services office at 614-566-0010 for assistance.

There are 2 references requested in this application and 3 references listed on CAQH. Can I use the same ones?

No. If you are applying for privileges with one or more of the OhioHealth Hospitals, it is required to have 5 references with the application. They will need to have observed you in the past 3 years and be of the same discipline as you. It would also be helpful to include fax numbers or email addresses of the references otherwise there will be a delay if we need to mail the request. Please also contact your references and let them know they will be getting a request and to respond as soon as possible. Failure to do these things will cause a delay with your application process.

I have settled claims, does this need to be listed on CAQH?

Yes. All claims against you within the last 10 years, regardless if they are pending or settled, need to be listed on the CAQH Application. *To avoid a delay in processing your application make sure you have provided enough information on all of your malpractice claims on the CAQH application.*

Who is my Credentialing Contact on CAQH?

This is the office manager at the practice you are joining. Please note that any Insurance Company you are credentialed with will contact this person regarding your credentialing process at their entity. If you are in a solo practice and do not have an office manager then enter your information in this section.

What are all the steps in completing my CAQH Application?

There are 4 steps to the application process.

1. Enter your information in all the sections of the online application.
2. Once all data entry has been entered, you will need to perform an audit of the data. If there is any information in the required fields those will need fixed before progressing any further.

3. Once the audit is complete you will need to attest the application. It is at this time the data will be “entered” and appear complete.
4. Once you attest the application you will be asked to fax supporting documents into CAQH. Follow all the steps provided by CAQH.
 - a. Print the Attestation & Release Form. Sign and Date the form.
 - b. Print your Fax Cover Sheet
 - c. Gather up your supporting documents, including the Attestation & Release form and your DEA and Malpractice Facesheet.
 - d. Complete the Fax Cover Sheet following the guidelines listed.
 - e. Fax your supporting documents into CAQH.

It will take at least 24 to 48 hours for CAQH to show receipt of your documents. When logged into your CAQH application you can click on the Activity Log to find out if all documents were received by CAQH.

I’m being told my CAQH Application is not complete, but I’ve done everything. What’s wrong?

It could be that you did not attest your application. If you don’t attest the application it will not show complete. It could also be that one or more of your supporting documents were rejected by CAQH. Looking at your Activity Log will show if all documents were accepted.

Why is my fax I sent for supporting documents being rejected by CAQH?

It’s possible the Attestation & Release form wasn’t dated, or a supporting document wasn’t readable. If a document was rejected contact the CAQH Help Desk at 1-888-599-1771 to find out why.

How do I Re-Attest my CAQH Application?

Every 120 days your CAQH application will need to be re-attested to remain in a current status. If your application doesn’t remain current it will end up in an expired status and an entity you are with will not be able to process your application. When you log into your CAQH you will see a bubble to re-attest the application. Click on this bubble and follow the steps that are prompted.

I am coming from out of state, how do I change my primary practice state to Ohio?

In the very beginning part of your application process you will see a section for the provider type and primary practice state. Make sure this is listed in Ohio. Some states have a state mandated application and in that instance we can’t credential your application until it’s an Ohio application. Please note you will be required to also sign/date and fax an updated Attestation & Release form if you are coming from out of state. ***Failure to do this will delay your credentialing process.***

The Checklist in this packet says I need to include a Professional Photograph. Is this really needed?

Yes, if you are initially applying to any of the 5 Central Ohio OhioHealth hospitals and do not have a professional photo on file with OhioHealth Media Services you are required to submit a professional photograph of yourself from the shoulders up. Please contact the OhioHealth Group Credentialing Services at 614-566-0010 for the options available but this must be included with your packet. ***Failure to do this will delay your credentialing process.***

This application packet includes a Claims History release form that needs sent to my carriers. Do I need to send this?

Yes. Verification of your malpractice claims history from the carrier is a requirement of the credentialing process when you are initially applying to any of the 5 Central Ohio OhioHealth hospitals. Please send this release form to all of your carriers you have had in the past 5 years including your Residency and Fellowship programs. ***Failure to do this will delay your credentialing process.***

Areas of Interest – Section 3 of the CAQH application: We want to encourage you to provide us with any information related to your areas of professional interest, activities, procedures and diagnosis. This information is currently being tracked in our database and may be used to better serve patients looking for specific areas of practice which is currently not recognized as a board certification (i.e. Breast surgery, holistic healing, bariatric surgery, Parkinson’s disease, etc...)



Notification of Practitioner Rights

- Practitioners have the right to be informed of the status of their credentialing or reappointment application upon request.
- Practitioners have the right to review information obtained and used for purposes of credentials evaluation with the exception of peer review statutes.
- Practitioners have the right to correct information collected from outside sources that is erroneous. Corrections to erroneous information must be made in writing and sent to OHGCS within fifteen days of notification that erroneous information has been received.
- Practitioners have the right to copy only documents in their file which they have submitted with regard to their application.
- Practitioners have the right to be credentialed in a non-discriminatory manner based upon race, gender, nationality, origin, or religion.



There are a number of required documents that must accompany your application when you submit it to OHGCS.

Failure to submit the required documentation will deem the application “incomplete” and your application will **NOT** be processed until all required documents are received.

Checklist of “Required” documents for all Entities:

- Copy of Current Resume
- Copy of DEA Registration (**if applicable**). If you are relocating from another state you will be required to update your address information on your DEA registration to reflect your practice location associated with this application. (If your DEA Registration is pending, please submit a copy to OHGCS once available.)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and applicant’s name (if pending, please submit a copy to OHGCS once available).
- Copy of wallet size Board Certification card which provides your board certification number and expiration date
- Copy of all out of state license(s)
- W-9 for verification of each tax identification number used

 **OhioHealth Group Managed Care Products (OHG)**

- Signed Provider Agreements



The Medical Group of Ohio (MGO)

- Provider Agreements: *(By signing the MGO Provider Agreements enclosed a practitioner is expressing interest in participating in services offered by this physician organization, including contracting, group purchasing, practice management, quality management, etc.)*



 **OhioHealth Mid-Level Practitioners**

In order for your application to be released to the Hospital(s) for processing, “ALL” of the required documents listed below must accompany your application

- Application fee **
 - Check for processing fee for one hospital enclosed. – \$290
 - Check for processing fee for two hospitals enclosed – \$305
 - Check for processing fee for three hospitals enclosed – \$320
 - Check for processing fee for four hospitals enclosed. – \$335
 - Check for processing fee for all five hospitals enclosed – \$350

- OhioHealth Medical Staff Office Addendum *

- Authorization Form to conduct a Criminal Background and/or Fingerprint Process *

- Legible notarized copy of applicant’s driver’s license or other government issued photo ID *

- OhioHealth Internet User Agreement *

- 5 year Malpractice Claims History Verification *

- Health Assessment (the Medical Staff Office (s) will accept a Health Assessment that was performed by another organization within the last 12 months) *

- ORB Registration / Connectivity Agreement / Confidentiality Statement of Understanding *

- Recent Portrait Quality Photograph of yourself that meets the following requirements: **
 - *Plain or studio backdrop*
 - *Attire should be suit, sport coat or lab coat*
 - *Body should be at a slight angle with head turned to lens*
 - *Lighting should be from studio light or natural*
 - *Save at a resolution of 300 pixels as a .jpg*
 - *If scanning, save at 150 dpi or higher*

*** Included in this application packet that must be completed and returned.**

**** Required documents that must be returned along with this packet.**



Medical Staff Office Addendum

Applicant Name (Print): _____

Marital Status (Optional): ___ Single ___ Married

If married, spouse's name: _____

Pager Number: _____

*Cellular Number: _____

(*Required in order to obtain remote access to OhioHealth computer systems. This number will not be released, and will only be used for OhioHealth purposes).

Preferred mailing address:
(This will be used for all
business correspondence
sent by OhioHealth entities)

Provide Names & Addresses of 2 Additional Professional References:

They must be different from the 3 names you previously used on the CAQH application. The references must have observed your work in the past 3 years. An acceptable peer reference is someone from the same discipline with essentially equal qualifications.

NOTE: Friends and/or relatives cannot be used as references.

Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone: Fax:	Phone: Fax:
Relationship:	Relationship:

1) - For RMH, GMC, Dublin and Doctors applicants only - Do you hold a direct or indirect ownership interest in an inpatient hospital located in Franklin County, Ohio or any contiguous county? (For purposes of this question, "indirect ownership" means that another person or entity may own the interest but you will receive a benefit from it, e.g., ownership by a spouse, employer, pension program or beneficial trust).

Yes No

If yes please explain: _____

2) - For RMH, GMC, Dublin and Doctors applicants only - If the answer to question 1 is "no", are you in a profit-sharing arrangement with a person or entity that holds a direct or indirect ownership interest in an inpatient hospital located in Franklin County, Ohio or any contiguous county?

Yes No

If yes please explain: _____



Notification of Criminal Background Investigation

- TO:** New Applicants applying to the following:
- Riverside Methodist Hospital
 - Grant Medical Center
 - Doctors Hospital
 - Dublin Methodist Hospital
 - Grady Memorial Hospital

To improve the safety and screening process not only for our new associates but also for new practitioners the following is set forth.

All new applicants applying to a central Ohio OhioHealth hospital are required to provide fingerprints to the OhioHealth Protective Services or Human Resources Department. The fingerprinting will be conducted only at initial application. Applicants will be required to sign a consent form for this process. Failure to sign a consent form will terminate the application process.

OhioHealth currently participates with National WebCheck as the vendor to electronically submit fingerprints to the BCII. This submission allows for a criminal records check to be completed by both BCII and the FBI. OhioHealth will accept an original background check that is performed by another National WebCheck vendor. If you utilize the services of another National Webcheck vendor other than OhioHealth you will be required to pay the vendor's fee at the time the service is performed. Reports that are completed by another National WebCheck vendor other than OhioHealth are required to have both the BCII and FBI record check completed. Results of the reports are to be submitted to:

OhioHealth Group Credentialing Services
445 Hutchinson Avenue, Suite 550
Columbus, OH 43235

OhioHealth currently provides the following designated sites to have your fingerprinting performed.

A valid driver's license is required for this process

Riverside Methodist Hospital
Protective Services / ID Badge Ctr.

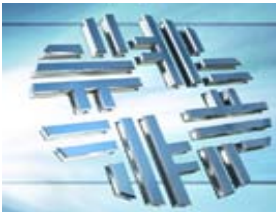
Riverside Methodist Hospital
Human Resources Department

Grant Medical Center
Human Resources Department
Doctors Hospital
Human Resources Department

Dublin Methodist Hospital
Human Resources Department

Grady Memorial Hospital
Human Resources Department

OhioHealth Group Credentialing Services will contact you to schedule an appointment at any of the above locations to conduct the fingerprinting process. It is important that you arrive at your designated location on time in order to ensure availability of designated OhioHealth personnel and to ensure timely completion of your initial application.



Authorization to Conduct Background Investigation

NOTICE TO APPLICANTS

An investigative report including fingerprinting and/or a criminal background check, information concerning your character, employment history, general reputation, personal characteristics, police record, education, qualifications and motor vehicle record will be obtained in connection with your application for membership and privileges at an OhioHealth facility. Upon a written request made to OHGCS, and within 5 days of the request, the name, address and phone number of the reporting agency and the nature and scope of the report will be disclosed to you.

Before any adverse action is taken, based in whole or in part on the information contained in the report, you will be provided a copy of the report, the name, address and telephone number of the reporting agency, a summary of your rights under the Fair Credit Reporting Act as well as additional information on your rights under the law.

Signature

Date

CONSENT TO OBTAINING REPORTS

Read carefully before signing

I have read the above "Notice to Applicants" and hereby authorize OHGCS to obtain investigative reports as described.

I understand that I have the right to make a written request within a reasonable amount of time to receive additional, detailed information about the nature and scope of any investigative report including the name, address and telephone number of the reporting agency.

I hereby authorize any present or former employers, educational institutions, criminal justice agencies, departments of motor vehicles or public agency, to submit information or opinions about me including data received from other sources in order that my qualifications can be evaluated. I hold said persons and/or organizations blameless and without liability for statements or opinions made regarding my character, experience or qualifications. I hereby release and hold harmless OHGCS, its predecessors, successors, assignees, trustees, directors, officers, administrators, employees and agents from any and all liability and responsibility, damages and claims of any kind whatsoever arising from this investigation of my background.

By my signature below I acknowledge that I have read and understand all of the above statements.

Print Name _____ Date _____

Signature _____

The following information is required by law enforcement agencies for positive identification purposes when checking public records. It is confidential and will not be used for any other purpose.

(Date of Birth) (Social Security Number) (Maiden or other name(s) used) Driver's License Number and State

Home Address City State Zip

DISCLOSURE QUESTION: Failure to disclose will add processing time to your application.

Have you ever pled guilty to or been found guilty of a violation of any law, other than a minor traffic violation (*Note: a DUI or DUI reduced to reckless operation is not considered a minor traffic violation*)? This background check will identify information greater than 10 years old.

No Yes If yes, please explain below and include a separate sheet if necessary.

NOTE: If you or your applicants are located in MN, OK, or CA you should always include the following in your authorization and disclosure:
" If you would like to receive a free copy of your report, please check this box."



Protecting the information assets of OhioHealth

Purpose

Patient and healthcare business are important assets of OhioHealth. It is essential that associates and/or practitioners provide for the protection of this information. This agreement informs associates and/or practitioners of the potential threats imposed by the use of the Internet and to communicate expectations of Internet use when representing OhioHealth. The requirements identified in this document ensure that the reliability and integrity of our business processes and information resources are maintained and ensure compliance with applicable rules and regulations.

Since the Internet is an open, unsecured network, system intrusion and other exploitation are common. Each associate and/or practitioner must be aware of the risks and take appropriate precautions to help protect corporate/patient information assets. There is a risk that the privacy of information sent across the Internet, such as with electronic mail, could be violated. There is a risk that OhioHealth could be compromised by illegal access to systems or websites on the Internet. There is a risk that information sent globally across the Internet may misrepresent OhioHealth and/or be in non-conformance with legal requirements.

The requirements defined below have been established to protect the resources, data and network of OhioHealth from Internet threats and risks.

Acceptable Internet Use Requirements

Access authorization - Access to the Internet is authorized by OhioHealth. Access and use is limited to business purposes at OhioHealth. Personal use is minimized. Unauthorized access or attempts to use, alter, destroy, or damage data, programs, or equipment violates applicable law or hospital policy and could result in criminal prosecution and/or civil liability. For everyone's mutual protection, all system use, including electronic mail, may be monitored to protect against unauthorized use.

Business use - All Internet use must be performed for business purposes only. Inappropriate activity includes:

- a. activities for profit, or hire;
- b. activities that waste time or computing resources;
- c. actions or activities undertaken on behalf of; or activity as an agent for, a non-OhioHealth related and unapproved organization, company, agency, or individual;
- d. activities that are illegal under or intended to circumvent, federal, state, local or foreign laws;
- e. unauthorized use of or reference to OhioHealth member companies' names or product information;
- f. activities that could lead to accusations of unethical behavior; and
- g. activities that could damage OhioHealth's professional reputation.
- h. activities that compromise privileged, confidential or proprietary information of OhioHealth and/or its patients.

Compromised Computers - Associates and /or practitioners maintain an awareness of their computers and report to the Information Security Director (566-4800) any activity that is considered suspicious (e.g. unexplained appearances of new files or directories, corrupted files, access by unauthorized staff, access to inappropriate websites by staff) or any computers that are suspected of being compromised by malicious attack or by witting or unwitting dissemination of the access logons (i.e. passwords or PINS).

Suspicious Communications - Associates and/or practitioners should log and report any suspicious communications to the Information Security Director (566-4800). Associates and/or practitioners should never divulge information to unknown sources without proper identification, authorization, and confirmation of integrity. Upon management request, the Information Security Department has the authority to suspend or terminate computer access and/or communication activities determined to be suspicious. Any individuals involved in suspicious and/or unapproved activities and/or illegal actions will be directed to cease the activity. Any failure to comply with this agreement will be reported to the senior management of the area in violation and to the Information Security Director. Depending on the nature of the violation, Protective Services, the Privacy Officer and/or Human Resources may also be notified. Noncompliance may result in legal action and may include termination of employment (if applicable).

I have read this Internet User Agreement from OhioHealth and understand my responsibility to comply with the requirements. I acknowledge that if I fail to comply, I am subject to disciplinary action that could result in termination of employment or relationship with OhioHealth.

Signature _____

Date _____



Malpractice Claims History Request Information Page

TO: Applicants of the following:

- Riverside Methodist Hospital
- Grant Medical Center
- Doctors Hospital
- Dublin Methodist Hospital
- Grady Memorial Hospital

FROM: Credentialing Services Department

SUBJECT: Malpractice Claims History

Please send a copy of the attached form to each malpractice carrier (or insurance agent) that you have had during the past 5 years including the carrier or self-indemnification fund that covered you during your residency training if applicable.

**DO NOT COMPLETE THE FORM YOURSELF. THE FORM NEEDS TO BE
COMPLETED BY YOUR AGENT/CARRIER.**

Sign the top part of the form before forwarding it to the agent/carrier. After completing the form your agent/carrier should fax it directly to our attention at 614-566-0401. It would be wise to impress upon them that failure to provide this information will result in delays in processing your application for membership and privileges at one or all of the Hospitals listed above.





OhioHealth Group
Credentialing Services (OHGCS)

445 Hutchinson Avenue, Suite 550, Columbus, OH 43235 614.566.0010 800.635.7207 Fax: 614.566.0401

MALPRACTICE CLAIMS HISTORY VERIFICATION

1. Please sign ONLY the top portion of this form. This will authorize the insurance company to release your malpractice claims history to OhioHealth Group.
2. Forward the signed release form to your insurance carrier for them to complete.

I have applied for membership on the allied health staff at one or more of the following Grant Medical Center, Doctors Hospital, Dublin Methodist Hospital, Riverside Methodist Hospital Medical Staff in Columbus, Ohio, and / or Grady Memorial Hospital in Delaware, Ohio. Please provide my claims history information for the past five (5) years to the OhioHealth Group Credentialing Services Department by completing this form and faxing it to **614-566-0401**

By signing this form I authorize release of this information.

 Printed Name of Practitioner

 Practitioner Signature

 Date

*******The following information needs to be completed by your insurance company*******

Carrier: _____

Type: ooccurrence oclaims-made oother

Policy Number: _____

Policy Amount: _____

Effective Dates: _____ Retroactive Dates: _____

Have any specific procedures been excluded from his/her coverage? YES_____ NO_____

Has your company defended this applicant in any liability suits in the past? YES_____ NO_____

Has your company paid any judgments or settlements on behalf of the Applicant for any professional liability suits in the last 5 years? YES_____ NO_____

Does the applicant currently have any pending lawsuits? YES_____ NO_____

If the answer to any of these questions is YES please provide a full explanation of details and attach your response.

 Printed name of insurance representative

 Title

 Phone

 Signature of insurance representative

 Date



HEALTH EVALUATION FOR COMMUNICABLE DISEASE

Name (please print full name)	SS#	Date of Birth	Phone (work)
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Please note: Both sections of this form must be completed

Section One: TB Documentation

Please complete this section of the form or provide chest x-ray if skin test is positive or provide TB documentation. If you had a PPD test in the past 12 months you may submit a copy of the results in lieu of having another test placed.

Date of last TB skin test Tests must be read in 48-72 hours. Test read greater than 72 hours will need to be repeated.

Date applied	Site	Manufacturer	Lot #	Exp. Date	Signature	Date read	Induration	Signature
1 st step / /	RFA/LFA			/ /		/ /		
2 nd step (if required) / /	RFA/LFA			/ /		/ /		

Section Two: Health History

Please answer the questions in this section

History of POSITIVE TB test? No Yes

If you answer No, go to question #1. If you answer Yes, answer the following:

Date of positive test Date of last chest x-ray X-ray result

- (a) BCG vaccine? No or Yes
 - (b) Treated by physician? No or Yes
 - (c) INH Therapy? No or Yes
 - (d) Traveled outside the USA? No or Yes
- If so when?

During the last year, have you experienced any of the following conditions over a prolonged period of time? (more than 2 weeks duration)	No	Yes	Resolved	If not resolved, please comment.
1. Abdominal or gastrointestinal problems such as frequent diarrhea, nausea or vomiting.				
2. Unexplained weight loss or excessive fatigue.				
3. Frequent upper respiratory symptoms such as colds, sore throat, productive cough, or pneumonia.				
4. Persistent fever or excessive sweating, especially at night.				
5. Skin problems; such as cold sores, boils, abscesses or other skin lesions of the face and hands.				
6. Communicable disease such as Hepatitis or Tuberculosis.				
7. Compromised immune system or serious illnesses.				
8. Allergies NO Yes (please list):				

Signature: Date:

(Your signature authorizes release of TB testing information to be sent to the Medical Staff office.)



OhioHealth

CONFIDENTIALITY STATEMENT OF UNDERSTANDING

This statement summarizes the responsibilities and obligations of all persons who use, create or receive confidential information belonging to OhioHealth patients and to the OhioHealth member hospitals, as set out in the Hospital SPP "Security & Confidentiality Policies & Procedures." It is the responsibility of all persons granted access to confidential information to protect the confidentiality of patient and hospital information and to make use of that information only to the extent authorized and necessary to provide patient care and/or to perform a proper Hospital, Medical Staff or Educational function. This also serves as the overall OhioHealth connectivity agreement.

I _____ (maintained by) recognize and acknowledge that all patient-identifiable information and certain of the information the OhioHealth hospitals and Ambulatory Sites maintained for business purposes is confidential. By reason of my duties, I may come into possession of this confidential information even though I may not have been directly involved in patient services or in developing the business information.

I agree that I will not, at any time during or after my employment or term of service, improperly disclose any confidential information to any person or permit any unauthorized person to examine or make copies of any reports, documents, or electronic information that comes into my possession. Additionally, as this confidential information is available only on a Need-to-Know basis, I will not access confidential information without authorization and will do so only when required to do so. I will notify OhioHealth of my departure or changes in my office staff. I understand that I am accountable for breach of access.

I recognize that the unauthorized disclosure of confidential information is totally prohibited.

I also recognize that the disclosure of, or sharing of passwords, access codes, and hardware token devices assigned to me is prohibited and that I am accountable for them and for any improper access to information gained with these privileges. My access privileges are the equivalent of my legal signature and I shall take all reasonable and necessary steps to protect my access privileges. I acknowledge that I am responsible for all actions taken using my access privileges. If I have reason to believe that the confidentiality of my access privileges has been broken, I shall immediately notify my employer or the Director of Information Services at my facility.

I understand that if I violate any of the above statements I may lose my access privileges immediately and that any violation may result in corrective action from my employer, sponsoring organization or academic institution..

I also acknowledge that violation against any of the above statements will reflect upon my employer and will result in corrective action according to Medical Staff bylaws and policies.

Applicant

Full Name (Print First Name MI, Last Name)	Practice Name / Phone
Signature	Practice Address
Social Security # (for unique identification purposes)	Phone Factor Phone Number (for remote access)
Date	Title
Email Address	Hospital affiliations

OhioHealth

Signature	Name	Title
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OhioHealth

EXECUTIVE SUMMARY - OhioHealth

STANDARD POLICY & PROCEDURE - SECURITY & CONFIDENTIALITY POLICY

It is the policy of OhioHealth to maintain procedures that address granting access to electronic information assets, coordinating statements of confidentiality used throughout the institution, and developing security access and audit control procedures and standards. This policy and the associated procedures are designed with the primary intent: *to protect the security and confidentiality of OhioHealth's patients personal health information*. Based on the need-to-know premise both caregivers and non-caregivers at OhioHealth have access to a variety of patient and/or hospital data. For the caregiver, access to patient data is essential for delivering care to the patient. For the non-caregiver, access is specified based on the roles and responsibilities described in the job description.

PHYSICIAN'S RESPONSIBILITIES

- Coordinate access requests with OhioHealth Information Services division and Medical Staff Offices.
- Access to OhioHealth information systems is granted only upon request to medical staff members and their nursing and office staff.
- Submit a Confidentiality Statement of Understanding signed by the physician in order to obtain access.
- Contact the hospital to terminate access for themselves or staff who have left office employment.
- Assure that any resident or allied health practitioner with ability to access and change the data on the physician's behalf signs a confidentiality agreement and adheres to its terms.
- Utilize OhioHealth systems (eg: email or Internet access) for business purposes only.
- Submit to and participate in periodic random audits as conducted by OhioHealth.

OHIOHEALTH'S GUIDING PRINCIPLES FOR MANAGEMENT OF INFORMATION

GOVERNANCE OVER DATA

- Patient information belongs to the patient, not the hospital.
- The hospital designates what non-patient information is proprietary and confidential.
- The hospital owns the storage devices (electronic or paper) which store hospital and patient information and serves a custodial role in protecting the security and confidentiality of the information stored within its systems.
- Data and information are managed as a hospital-wide resource for use in achieving hospital goals and objectives.

CONTROLLING ACCESS TO DATA

- Every medical staff member is responsible for protecting the confidentiality of information and reporting situations that pose a potential breach of confidentiality or security.
- The patient has the right to authorize or refuse the release of his/her patient identifiable information except in circumstances specified in state or federal law.
- Patients have access to their medical information in accordance with state and federal laws.
- Access to data is granted based on an appropriate need-to-know basis.
- Access to data is controlled through hardware and software security features and management authorization policies and procedures designed with the primary intent to protect the security and confidentiality of information.
- Access to aggregate data does not provide access to the individual data from which the aggregate data was derived.

REDISCLASURE

- As a general rule, releasing patient data to any party other than the patient will require that no redisclosure of the data be permitted and that the data be handled in a manner such that its security and confidentiality is upheld.
- Redisclosure of data must be specifically requested and approved on a case by case basis.
- Data is to be used only for the purpose for which it was requested.
- The release of proprietary data will require that no redisclosure of such data occurs without consent of the hospital.

COMPLIANCE WITH FEDERAL AND STATE STATUTES

- Data specifically addressed through federal or state statutes of regulations will be identified by the hospital and proper security and confidentiality procedures implemented.

DESIGNATION OF CONFIDENTIAL DATA

- The hospital exercises its right to designate data and records as confidential if the data is not already governed under state or federal law.

EDUCATION

- Educational programs are integral to the management of data and information within the hospital. Medical staff will be informed and educated on their roles and responsibilities in protecting the confidentiality and security of information.



What is ORB (OhioHealth Results Browser)?

ORB is a user-friendly, web-based program offered by OhioHealth, designed to give you and members of your staff access to valuable patient information as well as important business resources via a secure Internet connection.

Why do I need ORB access in my office?

- Access patient information as soon as it's available – No more waiting!
- Physicians can receive message alerts when new patient information is available
- Fax/Print results directly from ORB
- Ensure the continuous delivery of high-quality care
- Save valuable time and money

What is available in ORB?

ORB combines data from all inpatient and outpatient encounters from Riverside Methodist Hospital, Grant Medical Center, Doctors Hospital, Grady Memorial Hospital, Dublin Methodist Hospital and OhioHealth Neighborhood Care sites. ORB also offers reference information and OhioHealth contact information important to your office. You can view:

- Census/Rounding Lists
- Laboratory Results
- Cardiology
- Active Orders
- Clinical Reference Tools
- ePrescribing
- Demographic/Face Sheets
- Radiology (Reports/Images)
- Transcriptions
- Inpatient Medications
- OhioHealth Information

How do I access ORB?

You can access ORB from home, your office, or anywhere there is an Internet connection. You need:

- Internet Service Provider (ISP) (we highly recommend a high-speed ISP)
- Internet Explorer 7.0 or greater
- Adobe Acrobat 7.0 or greater

How do I get access to ORB?

Physicians with privileges at an OhioHealth facility can get access for themselves and their staff by completing an application. Physicians who do not have privileges at an OhioHealth facility can gain access to ORB with limited search capabilities (i.e. Medical Record Number or Social Security Number). To obtain an application or request training:

- Visit <https://orb.ohiohealth.com> select **Request an ORB ID** on the Home Page under **Need Assistance**.
- Call **566-eDoc (3362)** to request an application and/or training.



OhioHealth



OhioHealth

ORB Desktop

ORB also offers great business tools for you and your practice

Clinical References:

- Electronic PDR
- MDConsult
- MedlinePlus
- OVID
- PubMed
- Up To Date
- Variety of Micromedex products including Drug-Reax, Poisondex, Conversion Calculators

Important Physician Information

- Find A Doctor – search by name or specialty
- Medical Staff and CME information for Doctors Hospital, Grady Memorial Hospital, Grant Medical Center, Riverside Methodist Hospital and Dublin Methodist Hospital
- OhioHealth Unapproved Abbreviations

OhioHealth Information

- Maps and Directions to Central Ohio OhioHealth facilities (Doctors Hospital, Grady Memorial Hospital, Grant Medical Center, Riverside Methodist Hospital, Dublin Methodist Hospital and OhioHealth Neighborhood Care)
- OhioHealth Programs and Services including contact phone and fax numbers
- Insurance plans accepted by OhioHealth
- Printable hospital forms

Patient Education

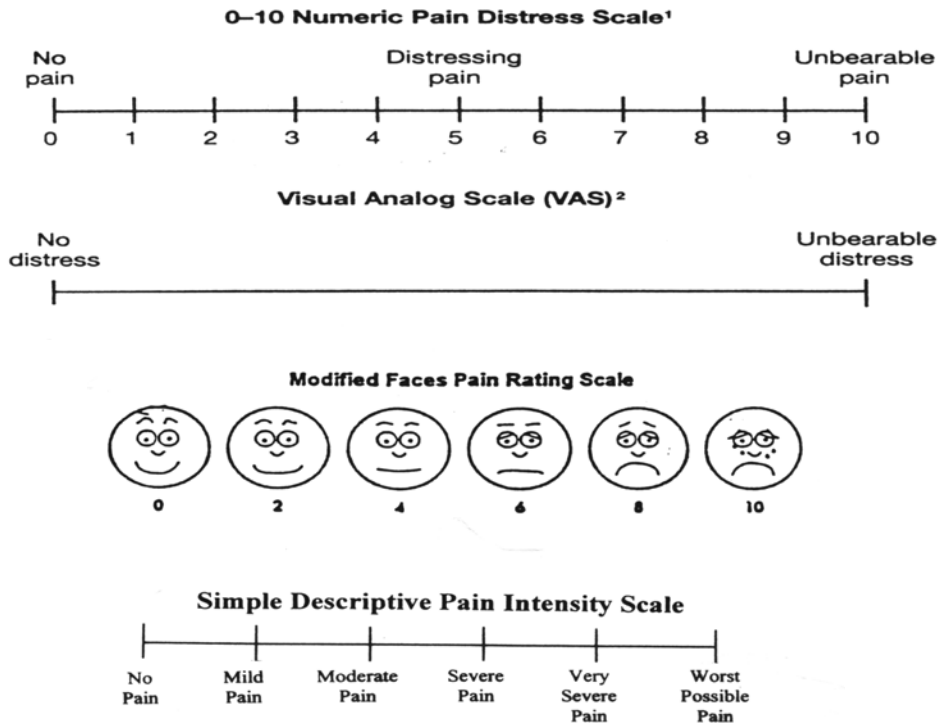
- CareNotes™ – Disease and Medication Specific printable patient education available in English and Spanish
- Printable OhioHealth teaching sheets on a variety of topics for your patients

PAIN, THE FIFTH VITAL SIGN

Pain is often called the Fifth Vital Sign. It can reveal a tremendous amount about the health status of your patient. Pain can affect the quality of life through its affect on such things as mood, activity, appetite and the ability to focus and concentrate.

To achieve adequate pain control it is necessary to understand how to assess pain. The following questions and assessment scales will help you evaluate your patient's pain.

1. **Where is your pain?** Pain can be in more than one place. Pointing to the place where it hurts is sometimes the best way to explain where it is.
2. **When did the pain start?**
3. **How bad does it hurt?** To help measure pain, there are different scales that sometimes help. The most common is a number scale with 0 meaning no pain and 10 meaning the worst pain. Below are some examples of scales. Use the scale that works best for you.



4. **What does it feel like?** Does it burn? Tingle? Ache? Is it dull or sharp?
5. **Is it worse at anytime of the day more than another?** Morning? Evening?
6. **What make the pain feel better?** What makes the pain feel worse? Does medicine make it feel better? Heat? Cold? Lying in a certain position? Does it hurt more when you're active or when you're lying still?
7. **Has the pain affected any other parts of your life?** For example, does it make it hard to sleep, eat or care for yourself or others? Has it affected your emotions? Your relationships?

WHEN PAIN EXISTS, TREATMENT IS POSSIBLE

For further education on this topic, refer to OhioHealth University through ORB.

Request for Taxpayer Identification Number and Certification

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

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: Individual/Sole proprietor Corporation Partnership Other ▶

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

Requester's name and address (optional)

City, state, and ZIP code

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. 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 2.** 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 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number								

or

Employer identification number								

List account number(s) here (optional)

Part II For U.S. Payees Exempt From Backup Withholding (See the instructions on page 2.)

Part III 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 2.)

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 get 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.

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

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515**, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

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.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. 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.

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 not be subject to backup withholding. **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 III instructions on page 2 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 Part II instructions 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 enter 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.

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

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.

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 an **LLC** that is **disregarded as an entity** separate from its owner (see **Limited liability company (LLC)** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page 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. Get **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 get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at www.irs.gov.

If you 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.

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III—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, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

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 state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give 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 MSA. 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.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% 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.

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	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	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, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

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.



EXHIBIT A
Individual Mid Level Practitioner Participation Addendum

This Individual Mid Level Practitioner Participation Addendum (“Addendum”) hereby is entered into by the undersigned Participating Mid Level Practitioner for the benefit of The Medical Group of Ohio, Ltd. (“MGO”).

Background Information

A. MGO entered into that certain Participating Practitioner Group Agreement, dated of even date herewith (the “Group Agreement”), with the Participating Group (“Group”) of which Participating Mid Level Practitioner is an employee or independent contractor.

B. Participating Mid Level Practitioner is duly licensed and qualified under applicable state law to practice with the Group as a: (i) physician assistant, or (ii) certified nurse midwife, or (iii) certified nurse practitioner, or (iv) clinical nurse specialist, or (v) certified registered nurse anesthetist.

C. The Group Agreement obligates the Group to enter into an Individual Practitioner Participation Addendum with each of its Participating Practitioners, and Participating Mid Level Practitioner hereby acknowledges and agrees that he or she will be treated as though he or she is a Participating Practitioner for purposes of the Group Agreement.

Statement of Agreement

Participating Mid Level Practitioner hereby acknowledges the accuracy of the foregoing Background Information and agrees as follows:

§1. Participating Mid Level Practitioner hereby agrees that he or she will actively support the ongoing development and implementation of the H⁴ Clinical Integration Program as may be reasonably requested by MGO from time to time, and will abide by the terms, conditions, standards and requirements of the Group Agreement and the H⁴ Clinical Integration Program.

§2. Participating Mid Level Practitioner hereby agrees that he or she will fully perform and observe all obligations to be performed or observed by a Participating Practitioner under the terms and conditions of the Group Agreement, provided however, that Participating Mid Level Practitioner shall not be obligated to satisfy any financial term or condition arising under the Group Agreement. Participating Mid Level Practitioner shall only provide Covered Services as may be authorized by the following, as applicable to Participating Mid Level Practitioner: (i) his or her supervision agreement approved by the State Medical Board of Ohio, (ii) his or her standard care arrangement approved by his or her collaborating physician(s), or (iii) applicable state law.

§3. Participating Mid Level Practitioner hereby authorizes OHG or MGO to pay the Group for any CI Payments (as defined in the Group Agreement) OHG or MGO may receive from a Payor pursuant to the terms of a Clinical Integration Service Agreement.

§4. Participating Mid Level Practitioner hereby agrees this Addendum: (A) is effective as of the Effective Date of the Group Agreement; (B) will terminate upon (i) termination of the Group Agreement, (ii) earlier termination of this Addendum by MGO, whether with or without cause, or (iii) earlier

termination of his or her employment or independent contract agreement with the Group; and (C) is entered into for the benefit of MGO and that MGO shall have the right to fully enforce his or her personal obligations arising under this Addendum.

§5. Participating Mid Level Practitioner hereby acknowledges, understands and agrees that he or she will have no rights to any review, hearing or appeal as may otherwise be provided to a practitioner under MGO's Credentialing Plan or MGO's Mid Level Credentialing Policy following termination of this Addendum as provided in Section 4 above.

Participating Mid Level Practitioner:

Participating Group Name:

Signature

Print Name: _____

Group Tax ID: _____

Date: _____

Email: _____

Category of Mid Level Practitioner – Please check one:

_____ Nurse Practitioner

_____ Nurse Midwife

_____ Physician Assistant

_____ Clinical Nurse Specialist

_____ Certified Registered Nurse Anesthetist

List your Supervising or Collaborating Physician(s) below. If more than one, please list in order from most frequently supervises/collaborates to least frequently supervises/collaborates.

Please Print Clearly. Attach additional sheets if necessary:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Return To: Credentialing Dept
 OhioHealth Group
 445 Hutchinson Ave
 Ste 550
 Columbus, OH 43235
 Fax: 614.566.0401

COLLABORATING PHYSICIAN FORM

DEMOGRAPHIC INFORMATION

Mid Level Practitioner Name: _____ Specialty: _____
Specialty Trained: _____ Group NPI No: _____
Group Name: _____ Tax ID: _____
Office Address: _____ City: _____ ST: _____ Zip: _____
Office Phone: _____ Office Fax: _____

COLLABORATING PHYSICIAN INFORMATION

(IF THERE ARE MORE COLLABORATING PHYSICIANS NEEDING LISTED, PLEASE ATTACH TO THIS FORM)

Collaborating Physician Name: _____

Collaborating Physician Specialty: _____

Collaborating Physician Name: _____

Collaborating Physician Specialty: _____

Collaborating Physician Name: _____

Collaborating Physician Specialty: _____

Collaborating Physician Name: _____

Collaborating Physician Specialty: _____

Collaborating Physician Name: _____

Collaborating Physician Specialty: _____

Signature, Mid Level Practitioner

Date



**OHIOHEALTH GROUP, LTD.
OHIOHEALTH GROUP PPO PROGRAM ATTACHMENT
TO
PARTICIPATING PROVIDER AGREEMENT
(Individual Practitioner)**

PURPOSE

The terms and provisions of this PPO Program Attachment and the Agreement are applicable to services rendered by _____ ("Practitioner") to OhioHealth Group PPO, Inc. ("PPO") Program Beneficiaries. The PPO Program consists of Service Agreements with OHG, and OHG Affiliates, as well as other Payors.

I. PARTIES' OBLIGATIONS

A. Compensation and Billing

1. Practitioner's reimbursement for Covered Services shall be the rates set forth and attached hereto in Exhibit A, less applicable Copayments, Deductibles, Coinsurance, and any applicable PPO administrative fees, which shall not exceed 4%. The rates set forth in Exhibit A shall apply to all Health Care Services rendered to Beneficiaries in the PPO Program.
2. Practitioner will look solely to Payor for compensation for Covered Services except for Copayments, Deductibles or Coinsurance. Practitioner agrees, that whether or not there is any unresolved dispute for payment, that under no circumstances will Practitioner directly or indirectly make any charges or claims for Covered Services, other than for Copayments, Deductibles or Coinsurance, against any Beneficiaries or their representatives and that this provision survives termination of this Agreement for services rendered prior to such termination. Except for the collection of Copayments, Deductibles or Coinsurance, only those services that are not Covered Services may be billed directly to Beneficiaries, subject to limitations listed above. This paragraph is to be interpreted for the benefit of Beneficiaries and does not diminish the obligation of a Payor to make payments to Practitioner according to the terms of this Agreement.
3. OHG will encourage each Payor to remit any amount owing under this PPO Program Attachment and the Agreement within thirty (30) days after receipt of a complete claim from Practitioner. For purposes of this PPO Program Attachment, a "complete claim" is defined in the applicable Payor's Program Manual.

B. OHG Utilization Management

OHG may be responsible for Utilization Management pursuant to a particular Service Agreement. In that event, the following basic principles, as well as the policies, procedures and requirements in the OHG PPO Program Manual are applicable:

C. Utilization Management (Non-OHG)

Pursuant to a specific Service Agreement, a Payor may require that Utilization Management be conducted by an entity other than OHG or an OHG Affiliate. In those situations, the applicable Utilization Management policies, procedures and requirements will be available directly from the Payor.

II. RIGHTS AND OBLIGATIONS UPON TERMINATION

This Agreement provides for a method of payment of Practitioner charges incurred by the Beneficiary during the existence of this Agreement. It is not a contract for the provision of service to the Beneficiary. Termination of this Agreement terminates the method of payment with regard to services provided after the date of termination. Termination of this Agreement should in no way be construed as affecting the Practitioner's relationship with the patient other than removing this payment system.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the effective date.

PROVIDER:

OHIOHEALTH GROUP, LTD.

By: _____

By: _____

Printed Name: _____

Kathryn Savenko
Vice President of Support Services

Title: _____

Date: _____

Date: _____

EFFECTIVE DATE:

PPO: _____

EXHIBIT A

PPO Reimbursement

The reimbursement arrangement will be the lesser of the OHG PPO Fee Schedule or your usual and customary charge, less any applicable coinsurance, copayments, deductibles or PPO administrative fees.



**OHIOHEALTH GROUP, LTD.
PARTICIPATING PROVIDER AGREEMENT
(Individual Practitioner)**

THIS PARTICIPATING PROVIDER AGREEMENT (this "Agreement") is by and between **OhioHealth Group, Ltd.** ("OHG"), and _____ ("Practitioner") and is entered into as of the Effective Date set forth on the signature page hereto.

WHEREAS, OHG contracts directly or indirectly with Payors, employers, labor unions, trusts, insurers, plan sponsors and others to provide, insure, arrange for or administer the provision of Health Care Services;

WHEREAS, OHG also contracts with physicians, hospitals and other health care practitioners and providers, to provide, arrange for and/or administer, at predetermined rates, the delivery of such Health Care Services; and

WHEREAS, OHG and Practitioner desire to enter into this Agreement relating to the provision of certain Health Care Services for individuals by Practitioner.

AGREEMENT

In consideration of the mutual promises herein, the parties agree as follows:

I. DEFINITIONS

Terms set forth in this Agreement and in the Program Attachments shall have the following meanings:

Beneficiary means any person whether referred to as "Insured," "Member," "Subscriber," "Participant," "Enrollee," "Dependent," or otherwise who is eligible to receive Covered Services pursuant to a Service Agreement.

Beneficiary Services Program means the program developed and implemented by OHG or a Payor to process and consider questions, complaints, and other appropriate matters raised with respect to the Covered Services provided to Beneficiaries under a Service Agreement.

Complete Claim means, unless otherwise defined by applicable law, a properly completed claim for payment for Covered Services received by Payor or Payor's designee, meeting OHG's billing standards, that requires no further information, documentation, adjustment, or alteration by Participating Provider in order to be processed or paid. In order to constitute a Complete Claim, claim must be submitted on UB-92 or CMS-1500 form, as applicable, or successor forms, using standard code sets and methodology, such as CPT, ICD-9 and HCPCS. For a complete description of the information that must be included in a complete claim, refer to the applicable Program Manual.

Coinsurance means a payment that a Beneficiary is required to make to a Participating Practitioner or Provider for Covered Services under a Service Agreement, which is calculated as a percentage of the contracted reimbursement rate of such services.

Copayment or Deductible means a payment that a Beneficiary is required to make to a Participating Practitioner or Provider under a Service Agreement, which is calculated as a fixed dollar payment.

Covered Services means those Health Care Services provided to a Beneficiary in accordance with a Service Agreement.

Designated Hospital means the acute care hospital designated by Practitioner as his or her primary admitting institution, if applicable.

Effective Date means the date set forth on the signature page.

Emergency Medical Condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency Services mean medical, surgical, hospital, and related health care services and testing, including ambulance services, required to treat an Emergency Medical Condition in accordance with the provisions of Section 1753.28 of the Ohio Revised Code.

Health Care Services means those services including diagnostic, therapeutic, evaluative and preventive services that are generally and customarily provided to patients by acute general hospitals, outpatient facilities or by physicians, surgeons, dentists and other medical personnel, wherever performed.

Medically Appropriate means services or supplies which under the provisions of this Agreement or an applicable Program Attachment, are determined by OHG or another Payor to be required for the treatment or evaluation of a medical condition, are consistent with the diagnosis and which could not have been omitted under generally accepted medical standards or provided in a less intensive setting. Except as otherwise provided in a Service Agreement, Covered Services must be Medically Appropriate.

Non-Covered Services means Health Care Services that are not designated as Covered Services under a Service Agreement and are not designated as benefits to Beneficiaries, and/or Health Care Services that are determined to not be Medically Appropriate under the Utilization Management criteria applicable under the Service Agreement.

OHG Affiliate means any direct or indirect subsidiary of OHG.

Participating Hospital means a hospital that has a direct or indirect contractual agreement with OHG with respect to the particular Program under which the Beneficiary is covered and to which a Participating Practitioner may admit Beneficiaries for care and treatment in accordance with Program Requirements.

Participating Practitioner means an individual health care practitioner who is licensed under the laws of the State in which the individual is providing Health Care Services and has a direct or indirect contractual arrangement with OHG to provide Covered Services to Beneficiaries.

Participating Provider means a hospital, ambulatory care facility, home health care agency or any other organization, including a group or network of Participating Practitioners that provides Health Care Services and has a direct or indirect contractual arrangement with OHG to provide Covered Services to Beneficiaries.

Payor means an entity which funds, administers, offers or insures Covered Services pursuant to a Service Agreement, and which has agreed to act as a Payor in accordance with this Agreement.

Performance Improvement Plan means the plan developed in conjunction with a Participating Provider or Participating Practitioner prior to termination of the Participating Provider or Participating Practitioner for failure to meet OHG's Quality Management and/or Utilization Management standards.

Program means a Preferred Provider Organization (PPO) or other type of health care or administrative services which are provided by or arranged by OHG, an OHG Affiliate, or another entity which has contracted with OHG to access OHG's Participating Practitioner and Participating Provider Network and which are specifically described in applicable Program Attachments, Program Requirements and Program Manuals.

Program Attachment means a document signed by the parties and attached to this Agreement for each Program in which Practitioner shall be participating, that sets forth certain terms and conditions applicable to such Program.

Program Manual means a manual developed by OHG or another Payor for Providers and Practitioners that sets forth operational policies, procedures and requirements governing a particular Program.

Program Requirements means the rules and procedures that establish conditions to be followed by Participating Practitioners and Providers with respect to Programs. Any reference to Program Requirements includes the information in this Agreement, the Program Attachments, and the Program Manuals distributed by OHG.

Quality Management means the processes established and operated by OHG or its designee relating to the quality of Covered Services.

Service Agreement means an agreement between OHG, an OHG Affiliate, or another entity which has contracted with OHG to access OHG's Participating Practitioner and Participating Provider Network and an employer, insurer, labor union, trust or other organization or entity that specifies Health Care Services to be provided to or for the benefit of, or arranged for or reimbursed to the Beneficiaries, the terms and conditions under which those services are to be provided or reimbursed, and is consistent with applicable Program Requirements.

Utilization Management means the processes to review and determine whether certain Health Care Services provided or to be provided to Beneficiaries are in accordance with Program Requirements.

II. OBLIGATIONS OF PRACTITIONER

A. Provision of Services

1. Practitioner shall act in accordance with the terms of this Agreement and applicable Program Attachments and Program Requirements.
2. Practitioner shall provide those Covered Services to Beneficiaries which Provider is qualified by law to provide in a manner consistent with the norms of practice and with professional and ethical obligations. Practitioner shall render Covered Services in the same manner, in accordance with the same standards, and with the same availability, as offered to other patients. Practitioner shall not differentiate or discriminate in the treatment of any Beneficiary because of race, ethnicity, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, disability, handicap or source of payment. Unless otherwise provided for in the Program Requirements for a particular Program, Practitioner shall participate in all Programs for which Program Attachments are attached hereto.
3. Practitioner shall provide Covered Services at locations approved by OHG. Locations shall not be eliminated or changed without sixty (60) days' prior written notice to OHG.
4. As applicable, Practitioner shall designate one or more Participating Hospitals where Practitioner will admit Beneficiaries under his or her care unless otherwise approved by OHG or its designee. Practitioner shall admit Beneficiaries only to Participating Hospitals except in the case of an Emergency Medical Condition or as otherwise described in applicable Program Requirements or as otherwise required by law.
5. Practitioner shall refer Beneficiaries to and/or use Participating Practitioners and Participating Providers for the provision of Covered Services except in the case of an Emergency Medical Condition, as otherwise described in applicable Program Requirements or as otherwise required by law.
6. If a Practitioner is designated as a primary care physician under a Program Attachment the Practitioner shall arrange for on-call coverage to assure that appropriate care will be available to Beneficiaries as provided in such Service Agreement.

B. Compliance and Participation

1. Practitioner shall be bound by and comply with the provisions of applicable state and federal laws and regulations.
2. Upon request, Practitioner shall participate in, and cooperate with OHG's credentialing and recredentialing requirements and such other activities as OHG deems reasonably necessary in

connection with its efforts to obtain and maintain NCQA, JCAHO, and/or appropriate accreditation, including without limitation, periodic site reviews of offices, records, premises and operations of Practitioner.

3. Practitioner shall comply with the requirements of, and shall participate in, such Quality Management and Utilization Management programs developed or implemented by OHG or a Payor (as agreed to by OHG), as such programs may be clarified, amended or supplemented from time to time, and the decisions, rules and regulations established under such programs, including without limitation, precertification of elective admissions and procedures, referral processes and reporting of clinical encounter data.
4. Practitioner shall comply with the requirements of, and shall participate in a Performance Improvement Plan developed or implemented by OHG or a Payor's designee (as agreed to by OHG), following written notice to Practitioner of a failure to meet OHG's or Payor's standards for quality or utilization in the delivery of Health Care Services as described in Section 1753.09 of the Ohio Revised Code.

C. Books and Records

1. Provider shall create and maintain adequate medical records regarding professional services provided to Beneficiaries in accordance with accepted medical records documentation and storage procedures and applicable laws, regulations and Program Requirements and to maintain the confidentiality of such records in accordance with applicable federal and state laws. All such records shall be maintained for the period of time required by applicable law. Upon prior written request, and to the extent permitted by law, Provider shall provide to OHG, to a Payor, to their designees, to appropriate state and federal authorities and their agents (involved in assessing the quality of care or investigating grievance or complaints from Beneficiaries) and to Beneficiaries, copies of medical records and information relating to the treatment and services Provider provided to Beneficiaries. Provider may charge a fee of twenty-five cents (\$0.25) per page, not to exceed twenty-five dollars (\$25.00) per medical record unless prohibited by the terms and conditions of the applicable Program Requirements and applicable state and federal law. Medical records and information provided pursuant to this paragraph 1 shall be kept confidential by the recipient and disclosed only as permitted under pertinent state and federal law. The provisions of this paragraph 1 shall survive termination of this Agreement or any Program Attachment.
2. Practitioner shall cooperate with OHG, or its designee, to facilitate the information and record exchanges necessary for Quality Management, Utilization Management, or other programs required for OHG's operations. Practitioner shall also cooperate with OHG, or its designee, in the development and maintenance of statistical data, records and procedures in support of Quality Management, Utilization Management and other applicable Program Requirements.
3. Practitioner agrees to cooperate in connection with any transfers of Beneficiaries' medical records required when Practitioner ceases rendering services to a Beneficiary whether during the term of this Agreement or after termination of this Agreement or a Program Attachment. Practitioner agrees to provide first copies of such records at no charge. If any additional copies are needed, Practitioner can bill according to Section II.C.1 or applicable state or federal law.

III. OBLIGATIONS OF OHG

A. Payor Contracting

1. OHG shall contract, directly or indirectly, with Payors who agree to pay in accordance with this Agreement for Covered Services rendered by Practitioner and other Participating Providers and Practitioners. Practitioner acknowledges and agrees that Practitioner shall only have the right to participate in those Programs for which Program Attachments have been signed by the parties and attached hereto and that OHG is under no obligation to include Practitioner in all Programs provided or arranged by OHG or OHG Affiliates.
2. OHG shall, upon specific request by Practitioner, identify to Practitioner the Payor responsible for payment of Covered Services rendered by Practitioner under particular Programs.

B. Procedures, Communications and Other Administrative Duties

1. OHG shall require Payer to establish a system of Beneficiary identification and procedures for verification by Practitioner (through written or telephone request) of Beneficiary eligibility to receive Covered Services and whether certain services to be rendered to a Beneficiary are Covered Services, which system and procedures shall be communicated to Practitioner. Beneficiary identification cards and such other mechanisms or procedures instituted by OHG or a Payor do not guarantee eligibility and Beneficiary eligibility determinations are not a guarantee of participation or coverage, both must be determined in accordance with the terms of applicable Program Requirements.
2. OHG shall from time to time communicate current Program Requirements to Practitioner, which shall include, without limitation, specific information regarding Covered Services and applicable Coinsurance, Copayments and Deductibles.
3. OHG shall provide Payors and Beneficiaries with information identifying Practitioner as a Participating Practitioner and explaining, with particularity, the availability of Health Care Services from Practitioner and the economic benefits of the use by Beneficiaries of Participating Practitioners and Providers.
4. OHG shall list the name, address, telephone number and specialty (ies) of Practitioner in a directory or listing of Participating Practitioners and Providers which shall be kept reasonably updated and may be furnished to Payors and Beneficiaries from time to time. OHG may also list the name, address, telephone number and specialty (is) of Practitioner in other materials or publications deemed by OHG, in its sole discretion, to be reasonably necessary or desirable for the conduct of OHG's business. Practitioner authorizes OHG and other Payors to utilize the directory or listing information in any marketing activities undertaken by OHG or the Payors. Upon termination of the relationship between OHG and Practitioner, Practitioner shall not engage in any activity that implies a continuing relationship with OHG or any of the Programs.

C. Beneficiary Services Program

1. OHG shall require Payers to develop and implement a Beneficiary Services Program for each Program, designed to process and consider questions, complaints and other matters raised by Beneficiaries with respect to Covered Services rendered. In the event an issue arises under a Beneficiary Services Program involving Practitioner, Practitioner agrees to participate in and cooperate with the procedures of the Beneficiary Services Program and shall comply with all final determinations made by Payers pursuant thereto.

D. Performance Feedback

1. OHG may, but shall not be obligated to, provide feedback for Practitioner's own use in assessing and enhancing performance with regard to quality of care, patient satisfaction and efficient practice. In doing so, OHG may perform surveys and analyze costs in comparison with regional

and national peers and benchmarks. OHG may also from time to time review a sample of medical records and provide performance feedback on past treatment.

IV. Compensation and Billing

A. Payment to Practitioner

1. Practitioner shall receive payments for Covered Services as set forth in this Agreement and applicable Program Attachments. Compensation arrangements and rates for Covered Services are set forth in applicable Program Attachments. Such compensation arrangements and rates shall constitute payment in full from the applicable Payer for all services provided to Beneficiaries pursuant to this Agreement.

B. Billing

1. For any Covered Service, Practitioner shall bill for Covered Services according to the following:
 - a. Practitioner shall submit claims on the appropriate claim form for all Covered Services within one hundred eighty (180) days of the date those services are rendered. Claims received after this one hundred eighty (180) day period may be denied for payment and Practitioner shall hold OHG and the Payor financially harmless for the payment of such claims. Practitioner shall submit claims to the location designated on the Beneficiary's identification card or described in the applicable Program Attachments.
 - b. Any amount owing under this Agreement shall be paid within the time period set forth in a Program Attachment after receipt of a Complete Claim from Practitioner, taking into consideration any requests from OHG, the applicable Payor, or their designees for additional information and whether or not the claim involves coordination of benefits. For purposes of this Agreement, a complete claim shall include but is not limited to all of the following: (i) the date on which the Covered Service was performed; (ii) a description of the Covered Service and, if applicable, the descriptive terms and identifying code from the most recent edition of the AMA's Physicians' Current Procedural Terminology; and (iii) the name of the individual providing the Covered Service, if applicable. For a complete description of the information that must be included in a complete claim refer to the applicable Program Manual.
2. Practitioner may bill an individual directly for any services provided following the date the individual ceases to be a Beneficiary. Neither OHG nor any other Payor has any obligation under this Agreement to pay for services rendered to individuals who no longer are Beneficiaries.
3. Unless prohibited by applicable Program Requirements, if a Practitioner provides Health Care Services to a Beneficiary that are not Covered Services under the Program in which the Beneficiary is enrolled and benefits are not available under the Program, Practitioner may bill the Beneficiary the Practitioner's usual and customary fee for the Health Care Services, provided the Practitioner notifies the Beneficiary in advance of his or her personal obligation for payment for Health Care Services that are not Covered Services under the Program. However, if a Health Care Service has been determined not to be Medically Appropriate under the utilization management criteria or other Program Requirements applicable to the Program, the Practitioner may, unless otherwise prohibited by applicable Program Requirements, bill the Beneficiary for the service only if, in advance of the service being performed: (i) the Beneficiary has been informed that the Health Care Service has been determined under the Program not to be Medically Appropriate; and (ii) the Beneficiary agrees in writing to be financially responsible for the cost of the Health Care Service.
4. Subject to the foregoing provisions of paragraph 3 above, upon failure of OHG or a Payor to reimburse Practitioner for Covered Services provided to a Beneficiary, Practitioner may, unless otherwise prohibited by law or applicable Program Requirements, directly bill the Beneficiary for such services.

C. Resolution of Disputes

1. For each Program, OHG shall require Payer to develop a procedure for resolving disputes between Practitioner and Payor arising out of Health Care Services provided to a Participant under the Payor's Program, including but not limited to fees for Covered Services. In the event of a dispute, OHG shall require Payer to notify Practitioner of the applicable procedure and Practitioner agrees to participate in and cooperate with the procedure established by the Program Requirements. Practitioner shall submit any disputed paid claims for reconsideration to Payor within 12 months of the original date of payment.

D. Coordination of Benefits

1. OHG shall require Payer and Practitioner to agree to cooperatively exchange information relating to coordination of benefits with regard to any Beneficiary for whom Practitioner is providing services.
2. With respect to those services reimbursed on a fee-for-service basis:
 - a. Certain claims for services rendered to Beneficiaries are claims for which another Payor may be primarily responsible under coordination of benefit rules. Practitioner may pursue and process any such coordination of benefits claims and, in so doing, shall comply with the primary Payor's billing rules, including, but not limited to, any of the primary Payor's limitations on billing Beneficiaries.
 - b. When a Payor is other than primary under applicable coordination of benefits rules, Payor will pay no greater amount than that which, when added to amounts payable to Practitioner from other sources under the applicable coordination of benefit rules, equals one hundred percent of the Practitioner's reimbursement for Covered Services pursuant to this Agreement.
 - c. When Payor is primary under applicable coordination of benefit rules, Payor will pay amounts due pursuant to this Agreement without regard for the obligations of any secondary Payors.

E. Review of Records

1. Upon reasonable notice and during regular business hours, Payer or its designee shall have the right to inspect, review and make copies of, at Payer's expense, all medical and billing records maintained by Practitioner with respect to all payments received by its Practitioner from all sources for Covered Services rendered to Beneficiaries during the term of this Agreement. Payer or its designee shall have the right to conduct periodic audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement, provided that advance notice of any audit is provided to Practitioner and the audit is conducted during normal business hours of the Practitioner. Payor or its designee shall conduct any audits within 12 months of the original date of payment. Payer or its designee shall provide Practitioner with the results of any such audits and any amounts determined to be due and owing as a result of such audits shall be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder. The audits conducted by Payer or its designee pursuant to this paragraph may include the use of statistical sampling techniques. This provision shall survive the termination of this Agreement or any Program Attachment.

F. Prompt Pay

1. Payors who have contracted with OHG to access Participating Practitioners shall make or arrange for payment for all Complete Claims for Covered Services submitted by Participating Practitioners in accordance with the compensation rates set forth in the applicable Program Attachment. This Agreement is subject to the requirements of O.R.C. Section 3901.38 or any successor statute that may

hereinafter be enacted, which the parties acknowledge shall apply to Participating Practitioners' Claims for Covered Services. If Payor fails to pay claims for Covered Services rendered by Participating Providers within the time requirements and parameters specified within said O.R.C. Section 3901.38 or successor statute that may hereinafter be enacted shall not prejudice any other rights or remedies available to Participating Practitioners at law or in equity on account of Payors failure to comply with such requirements or parameters. Further, if Participating Practitioners do not receive payment under this Agreement for Covered Services rendered within 30 calendar days after Payor's receipt of a Complete Claim, the Participating Practitioners may impose interest on the unpaid amount based upon 18% APR. The obligation for payment under this Agreement for Health Services rendered to a Beneficiary is solely that of the Payor. This excludes claims that have been suspended due to the need to determine Medical Necessity, or the extent of Payor's payment liability, if any, because of issues such as coordination of benefits, subrogation, or verification of coverage.

V. CREDENTIALING

- A. OHG shall be responsible for the credentialing and recredentialing of Practitioner in accordance with the criteria set forth in the Program Manuals.
- B. Practitioner shall promptly notify OHG of any situation of which he or she is aware including, but not limited to, license suspension, restriction or revocation; any disciplinary action or censure by the DEA, Medicare or Medicaid, state licensing board, professional society, specialty board, professional organization or similar entity; an indictment or conviction for any felony criminal offense; hospital privileges limited, restricted, suspended or terminated, or any other adverse action taken by a hospital or medical staff; any confirmed substantive negative quality issues, or an unfavorable malpractice judgment.
- C. OHG agrees to provide Practitioner with prompt written notice of any adverse credentialing action.
- D. Practitioner shall complete and submit to OHG a Practitioner Application, in the form provided by OHG, and agrees to inform OHG in a timely manner of any changes to any Practitioner Application submitted to OHG.

VI. ADDITIONAL RIGHTS AND OBLIGATIONS OF THE PARTIES

A. Insurance, Indemnification and Liability

- 1. Throughout the term of this Agreement, Practitioner shall maintain, at his or her expense, general and professional liability coverage in a form and amount acceptable to OHG. Unless otherwise determined by OHG, the minimum limits for both coverages shall be \$1 million/\$3 million. Upon OHG's request, Practitioner shall provide OHG with certificates evidencing such coverage. In the event Practitioner has a "claims made" policy, and changes professional liability insurance carriers during the term of this Agreement, such party shall either acquire appropriate "tail" insurance from the prior carrier or "prior acts" coverage from the new carrier, and shall provide OHG with a certificate or other appropriate evidence of such continuous coverage, upon request.
- 2. Each party agrees to indemnify and hold harmless the other party and its directors, managers, officers, employees and agents from any and all actions, causes of actions, claims, damages or losses of any kind, including reasonable attorney's fees, incurred by such other party to the extent resulting from the intentional or reckless acts or omissions of the first party or its employees or agents. For purposes of this paragraph 2, neither party nor its employees or agents shall be considered agents of the other party.
- 3. No manager, officer, committee member, employee or agent of OHG or an OHG Affiliate shall be liable in damages to Practitioner for any action taken or recommendation made within the scope of the functions of such person's position with OHG or an OHG Affiliate, if such person acts without malice, and in the reasonable belief that such action or recommendation is warranted by the facts known to such person, after reasonable effort to obtain the facts of the matter.

B. Confidentiality

1. OHG and Payor shall maintain the confidentiality and privacy of information contained in the medical records of Beneficiary and shall require Practitioner to do so as a material condition of this Agreement. Except for dissemination of such information as required (a) by applicable state and federal law, (b) by any applicable agreement with another authorized provider, third party Payor, governmental agency, or (c) by OHG or Payor and its Quality Management and Utilization Management programs, Practitioner shall not disclose such information to any third party without the prior written consent of the Beneficiary. These confidentiality obligations shall not terminate with the expiration or termination of this Agreement.
2. The parties acknowledge that, as a result of this Agreement, each may have access to certain trade secrets and other confidential and proprietary information of the other. Each party shall hold, and cause its employees and agents to hold, such trade secrets and other confidential and proprietary information, including the terms and conditions of this Agreement, in confidence and shall not disclose such information, and shall take precautions to ensure that its employees and agents do not disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party except as may be required by law and except as may be required to fulfill the rights and obligations set forth in this Agreement. With respect to OHG, such confidential and proprietary information shall include, without limitation, the Program Attachments and Program Requirements. The provisions of this paragraph 1 shall survive the termination of this Agreement and any Program Attachments.
3. Nothing in paragraphs 1 and 2 above shall be construed to prohibit:
 - a. communications necessary or appropriate for the delivery of Health Care Services;
 - b. communications to Beneficiaries regarding available treatment alternatives regardless of the provisions or limitations of the Beneficiary's coverage;
 - c. communications to Beneficiaries regarding applicable rights to appeal coverage determinations; or
 - d. communications to Beneficiaries identifying the type of reimbursement arrangement under which Practitioner is compensated for Covered Services under this Agreement (i.e. fee-for-service, capitation, etc.), excluding any communications with regard to the applicable rates of reimbursement.

C. Representations and Warranties of the Parties

1. Practitioner represents and warrants to OHG as follows:
 - a. that the information set forth in the Practitioner Application submitted to OHG is true and correct. Practitioner shall promptly notify OHG of any changes in the information contained in any such Application within thirty (30) days of such change;
 - b. that only Practitioner will be allowed to provide Covered Services;
 - c. that Practitioner shall during the term of this Agreement: (i) be duly licensed to provide Health Care Services, under the laws of the state in which the Practitioner is providing Covered Services; (ii) have a current and valid DEA license, if applicable; (iii) be a member in good standing, with appropriate clinical privileges, on the medical staff of the Practitioner's Designated Hospital, if applicable; and (iv) regularly provide OHG evidence of renewals of the foregoing matters;
 - d. that Practitioner currently maintains general and professional liability insurance coverage in the minimum amounts required by this Agreement, and will promptly notify OHG of any material modification, cancellation or restriction of such coverage;

- e. that Practitioner will provide written notice to OHG within ten (10) days after Practitioner learns of any report that is filed with the National Practitioner Data Bank regarding Practitioner;
 - f. that Practitioner shall immediately give OHG written notice of any written claim or lawsuit against Practitioner arising out of any act or omission of Practitioner or any employee, agent or contractor of Practitioner, relative to the rendering of Health Care Services to a Beneficiary;
 - g. that Practitioner decisions regarding the delivery of Health Care Services to beneficiaries shall be based only on appropriateness of care and service; and
 - h. that Practitioner is not compensated by OHG for utilization review denials of coverage or service and does not receive financial incentives for denials of coverage or service;
2. OHG represents and warrants to Practitioner as follows:
- a. that OHG is a duly organized limited liability company in good standing under the law of the State of Ohio, and is empowered and duly authorized to enter in this Agreement;
 - b. that OHG is currently, and for the duration of this Agreement shall remain, in compliance with any and all applicable laws and regulations of the federal government and of the State of Ohio;
 - c. that Utilization Management decision making is based only on appropriateness of care and service; and
 - d. that Practitioners or other individuals conducting utilization review are not compensated for denials of coverage or service; financial incentives for making Utilization Management decisions do not encourage denials of coverage or service.
3. OHG makes no representations or guarantees concerning the number of Beneficiaries it can or will refer to Practitioner under this Agreement.

D. Operational Policies and Procedures

In addition to the Program Manuals, OHG or its designee may issue and deliver to Practitioner, additional operational policies or procedures for the purpose of implementing or clarifying this Agreement or Program Attachment, and may supplement or withdraw such policies or procedures as needed. Ninety (90) days after the delivery of any such policies, procedures or supplement thereto to Practitioner which materially modify existing policies or procedures in Program Manuals or otherwise ("Implementation Date"), the provisions thereof shall become fully binding on Practitioner as if expressly set forth in this Agreement. If such policies, procedures or supplements thereto are not acceptable to Practitioner, Practitioner may give written notice of termination of this Agreement or the affected Program Attachment to OHG no later than thirty (30) days after receipt of such policies, procedures or supplements thereto, in which case this Agreement or the affected Program Attachment shall terminate effective as of the Implementation Date, unless OHG otherwise agrees to continue this Agreement or the affected Program Attachment without the proposed policies, procedures or supplements thereto. Failure to provide such notice within said thirty (30) day period shall be deemed to be acceptance of the policies, procedures or supplements thereto. In the event the provisions of any such policies, procedures or supplements are inconsistent with the terms of this Agreement or a Program Attachment, the terms of this Agreement or the Program Attachment shall prevail.

VII. TERM AND TERMINATION

A. Term of Agreement

This Agreement shall begin on the Effective Date and shall continue for a period of one year. Thereafter, this Agreement shall automatically renew for successive one year periods, unless terminated as set forth below.

B. Termination

1. For Cause. Practitioner or OHG may terminate this Agreement at any time for cause. Cause for termination includes, but is not limited to, the following:
 - a. Failure of Practitioner to comply or cooperate with OHG's Credentialing, Quality Improvement, Quality Management, Utilization Management Programs and/or a Performance Improvement Plan developed for Practitioner. In the event the termination decision is based upon the failure of the Practitioner to meet OHG's standards for quality or utilization in the delivery of Health Care Services, OHG will notify Practitioner of the termination decision, the reasons for the decision and of the opportunity to participate in a Performance Improvement Program. Practitioner agrees to assist OHG in developing and implementing a suitable Performance Improvement Program. If the Practitioner fails to comply with the Performance Improvement Program, OHG may promptly terminate the Practitioner, subject to the appeal rights set forth in the Program Requirements.
 - b. Other material breach of this Agreement by either party.
 - c. Any material addition or alteration by OHG of policies and procedures governing the provision of Covered Services to Beneficiaries (in accordance with Section VI.D) or amendment by OHG of this Agreement (in accordance with Section VIII.D) if such action is unacceptable to Practitioner; provided that Practitioner gives OHG notice of rejection of such action within thirty (30) days of receipt by Practitioner of OHG's notice concerning the addition, alteration or amendment and OHG does not elect to continue this Agreement without such addition, alteration or amendment, as set forth in Section VI.D or Section VIII.D hereof.
 - d. Insolvency of either party.
 - e. Failure by Practitioner to maintain licenses, certifications, permits or approvals required to perform Practitioner's duties under this Agreement or to comply with applicable laws, regulations or Program Requirements.
 - f. Failure by OHG to maintain licenses, certifications, permits or approvals required to perform OHG's duties under this Agreement or to comply with applicable laws or regulations.
 - g. Commission or omission of any act or any conduct or allegation of conduct for which OHG's or Practitioner's license or certification may be subject to revocation or suspension, whether or not actually revoked or suspended, or if OHG or Practitioner is otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction over such party.
 - h. Any material misrepresentation or falsification of any information submitted by Practitioner to OHG.
 - i. Failure of Practitioner to maintain required liability coverage protection.
 - j. Commission or omission of any act or conduct by Practitioner which is detrimental to a Beneficiary's health or safety.

Unless otherwise provided in applicable Program Attachments to this Agreement, termination for any other reason set forth above shall be upon thirty (30) days' prior written notice to the other party by the terminating party unless said reason for termination is cured to the satisfaction of the terminating party within said thirty (30) day period, in which case this Agreement shall not terminate. Notwithstanding the foregoing, OHG shall have the right to immediately terminate this Agreement for cause, upon written notice thereof to Practitioner if OHG in good faith determines that such immediate termination is necessary to avoid imminent risk of harm to a Beneficiary or Beneficiaries.

2. Without Cause. This Agreement or any individual Program Attachment to this Agreement (unless otherwise provided in the Program Attachment) may be terminated at any time without cause or prejudice upon ninety (90) days' prior written notice by either party. Termination of any individual Program Attachment will not have the effect of terminating the entire Agreement and all remaining provisions of this Agreement and remaining Program Attachments to this Agreement will remain in full force and effect.

C. Rights and Obligations Upon Termination

Upon termination of this Agreement for any reason, the rights of each party hereunder shall terminate, except as provided in this Agreement and any Program Attachments to this Agreement. Any such termination shall not release Practitioner or OHG from obligations under this Agreement or any Program Attachment occurring prior to the effective date of termination. Practitioner shall accept compensation and rates outlined in Section IV.A.1 and applicable Program Attachments for services rendered to Beneficiary prior to the effective date of termination as payment in full.

VIII. MISCELLANEOUS

A. Independent Contractor Relationship

1. This Agreement is not intended to create nor shall it be construed to create any relationship between OHG and Practitioner other than that of independent entities contracting for the purpose of effecting provisions of this Agreement. Neither party nor any of their agents, employees or representatives shall be construed to be the agent, employer, employee or representative of the other.
2. Nothing in this Agreement, including Practitioner's participation in the Quality Management and Utilization Management process, shall be construed to interfere with or in any way affect Practitioner's obligation to exercise independent professional judgment in rendering Health Care Services to Beneficiaries.

B. Assignment and Delegation of Duties

Neither OHG nor Practitioner may assign duties, rights or interests under this Agreement or any Program Attachment unless the other party shall so approve by written consent, provided, however, that any reference to OHG herein shall include any successor in interest and that OHG may assign its duties, rights and interests under this Agreement or any Program Attachment in whole or in part to an OHG Affiliate or may delegate any and all of its duties in the ordinary course of business.

C. Interpretation

The validity, enforceability and interpretation of this Agreement shall be governed by any applicable federal law and by the applicable laws of the State of Ohio.

D. Amendment

1. This Agreement or a Program Attachment (unless otherwise provided for in the Program Attachment) may be materially amended by OHG by giving ninety (90) days prior written notice to

Practitioner of the proposed amendment. If an amendment is not acceptable to Practitioner, Practitioner may give written notice of termination of this Agreement or the applicable Program Attachment to OHG no later than thirty (30) days after receipt of the written notice of amendment, in which case this Agreement or the applicable Program Attachment shall terminate effective as of the effective date of the proposed amendment, unless OHG otherwise agrees to continue this Agreement or the applicable Program Attachment without the proposed amendment. Failure to provide such notice within said thirty (30) day period shall be deemed to be acceptance of the amendment.

2. Non-material amendments to this Agreement or a Program Attachment may be made by giving 15 days prior written notice to the Practitioner of the proposed amendment.
3. Notwithstanding the foregoing provisions of this Section VIII.D, in the event that state or federal law or regulation should change, alter or modify the present services, levels of payments to OHG, standards of eligibility of Beneficiaries, or any operations of OHG, such that the terms, benefits and conditions of this Agreement or a Program Attachment must be changed accordingly, then upon notice from OHG, Practitioner shall continue to perform services under this Agreement or the Program Attachment as modified.
4. OHG may, from time to time, invite Practitioner to participate in future Programs. Practitioner may agree to participate in future Programs by executing a new Program Attachment. If Practitioner refuses any future Program that OHG offers, OHG may terminate this Agreement based on the Practitioner's refusal upon written notice to the Practitioner no sooner than 180 days after the refusal.
5. Except as provided above, amendments to this Agreement must be agreed to in advance in writing by OHG and Practitioner.

E. Program Attachments

The Program Attachments hereto are a part of this Agreement and their terms shall supersede those of other parts of this Agreement in the event of a conflict.

F. Third Party Beneficiaries

Except to the extent otherwise specifically provided in this Agreement or a Program Attachment to this Agreement, nothing herein contained is intended to confer upon any person, other than the parties hereto, any rights, remedies, obligations or liabilities under or by reason of this Agreement.

G. Entire Contract

This Agreement together with all Program Attachments and documents referred to herein contain all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied, regarding the subject matter of this Agreement and the Program Attachments.

H. Notice

Any notice required hereunder shall be in writing and shall be deemed to have been made three (3) days after deposited in the United States mail, postage prepaid, to OHG and Practitioner at the addresses set forth below each party's signature or to such other address as shall have been given in writing by either party to the other.

I. Enforceability and Waiver

The invalidity and unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

J. Regulatory Approval

In the event that OHG has not been licensed or has not received any applicable regulatory approval for use of this Agreement or a Program Attachment prior to the execution of this Agreement or the Program Attachment, this Agreement and/or the Program Attachment, as the case may be, shall be deemed to be a binding letter of intent. In such event, this Agreement and/or the Program Attachment, as the case may be, shall become effective on the date that such regulatory approval is obtained. If OHG is unable to obtain such licensure or approval after due diligence, OHG shall notify Practitioner and both parties shall be released from any liability under this Agreement and/or the Program Attachment, as the case may be; provided however, that if such licensure or approval is obtained upon the condition of OHG's amendment of this Agreement and/or the Program Attachment, as the case may be, then this Agreement and/or the Program Attachment, as the case may be, shall continue and OHG shall amend the Agreement and/or the Program Attachment, as the case may be, pursuant to Section VIII.D.2 hereof.

K. Dispute Resolution

1. The parties shall first attempt to resolve any disputes that may arise between the parties in accordance with the dispute resolution procedures described in applicable Program Requirements.
2. Should the dispute not be resolved through the aforementioned process, the parties shall refer the dispute, controversy or question arising under this Agreement to an arbitrator selected by the parties. The proceeding shall be governed by the Rules of the American Arbitration Association then in effect, and shall be held in Franklin County, Ohio. If the parties are unable to agree upon such an arbitrator within thirty (30) days after either party has given the other party written notice of its desire to submit the dispute, controversy or question for decision, then either party may apply to the American Arbitration Association for the appointment of an arbitrator or, if such Association is not then in existence or does not desire to act in the matter, each party shall appoint an arbitrator of its choice. The appointed arbitrators will select a third arbitrator and the panel of three arbitrators will hear the parties and settle the dispute, controversy or question. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this provision to the prevailing party. If the arbitrator does not award fees to the prevailing party, each party shall assume its own costs, but the compensation and expenses of the arbitrator(s) and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the parties. Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s). Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction.

L. Ohio Mandated Insurance Fraud Warning

The State of Ohio Department of Insurance requires the following provisions in this provider contract:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

THIS AGREEMENT CONTAINS A BINDING DISPUTE RESOLUTION PROVISION THAT MAY BE ENFORCED AGAINST THE PARTIES.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the effective date.

PROVIDER:

OHIOHEALTH GROUP, LTD.

By: _____

By: _____

Printed Name: _____

Kathryn Savenko
Vice President of Support Services

Title: _____

Date: _____

Date: _____

Address: _____

Address: 445 Hutchinson Avenue, Suite 550
Columbus, Ohio 43235

Phone: _____

County: _____

NPI: _____

Federal Tax ID No.: _____

EFFECTIVE DATE:

PPO: _____

OTHER: _____

List your Supervising or Collaborating Physician(s) below. If more than one, please list in order from most frequently supervises/collaborates to least frequently supervises/collaborates.

Please Print Clearly. Attach additional sheets if necessary:

1. _____
2. _____
3. _____
4. _____

SCHEDULE A

CARDS ISSUED BY TPAS MAY CARRY THE TPA NAME OR THE EMPLOYER'S NAME, BUT WILL ALSO DISPLAY THE HEALTHREACH LOGOS. BELOW ARE VARIATIONS, BUT NOT LIMITED TO, OHIOHEALTH GROUP HEALTHREACH PPO LOGOS:

