

Medisaver.com Participating Medical Provider Census Form

This form must be completed by EACH participating provider, and accompanied by appropriate documentation

For Employees and Affiliates please photocopy this form BEFORE entering information

Please TYPE or PRINT complete answers to each item

Personal Information

Last Name _____ First Name _____ M.I. _____
Tax I.D. Number _____ Social Security Number _____ DEA Number _____
License #1 _____ State _____ License #2 _____ State _____ License #3 _____ State _____
Medical School _____ City _____ State _____ Country _____
Year Grad _____ Specialty _____ Board Eligible/Certified _____ Date _____
Hospital Affiliations _____
Malpractice Insurance Carrier _____ Policy # _____ Policy Limits _____ Expiration Date _____
3rd party notification required. Please have your carrier confirm when in effect.
Please list other Managed Care programs in which you participate _____

Billing Information

Billing Name _____
Billing Address _____
City _____ State _____ Zip Code _____ Phone _____

Office Information

Office #1 Street Address _____ City _____
State _____ Zip Code _____ Phone Number _____ Fax Number _____ Contact _____
Sunday _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____
Please Fill in Office Hours Above
Foreign Languages spoken at this office _____ E-Mail _____
Office #2 Street Address _____ City _____
State _____ Zip Code _____ Phone Number _____ Fax Number _____ Contact _____
Sunday _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____
Please Fill in Office Hours Above
Foreign Languages spoken at this office _____ E-Mail _____

Practice Information

Yes _____ No _____ Physician Assistant _____ Yes _____ No _____ Technician _____ Other Patient Care Staff _____
Average Wait Time for: First Appointment _____ Follow up Visit _____ Waiting Room _____
Yes _____ No _____ Type: _____ Do you Do In Office Testing? _____ Yes _____ No _____ Type _____ Do you Perform in Office Procedures? _____
Yes _____ No _____ Do you accept per capita payment? _____ Yes _____ No _____ Would you consider per capita payment? _____

If other doctors are affiliated, write names and complete a census form for each

If other doctors are employed, write names and complete a census form for each

(Please use the space at the bottom of the page or a second sheet for explanations or comments)

Do you now have, or have you ever had, any malpractice cases or lawsuits filed against you? _____

Have you ever been disciplined by a State board? _____

Has your license ever been suspended or revoked? _____

Have you ever been refused participation in or asked to leave a Managed Care plan? _____

Number of years of practice in the United States: _____

Hours of continuing education in the last 2 years: _____

Number of years that you have been in practice: _____

Please use this space for awards, honors, memberships or publications, and/or explanations from above:

We MUST BE INFORMED of any change in the above information, including change in malpractice carrier or liability limits. You MUST send copies of appropriate documentation, including, but not limited to, license, board certification or eligibility, and proof of malpractice coverage. Current and/or pending malpractice suits should be accompanied by appropriate explanations. The Medicare Providers.com Participating Provider Network is open to ALL providers who meet its selection criteria and are willing to abide by its rules, regardless of race, creed, color, religion or national origin. Providers agree to treat all patients equally without regard to race, creed, color, religion, national origin or source of payment.

Please Mail Completed Form and required documentation to:
Medisavers, c/o National Health Plan, G.P.O. Box 2319,
New York, NY 10116

For Additional Information Call Provider Relations: 800-647-2677
Fax: 212-629-0749 • E-mail: Director@Medisaver.com

PARTICIPATING PROVIDER AGREEMENT

This agreement, between MEDISAVR.COM, and _____ ("Provider") sets forth the rights and responsibilities of the parties hereto.

Relationship

The Provider is duly licensed and qualified to practice in their field of _____ in the state(s) of _____.

MEDISAVR.COM and the Provider desire that the Provider become a member of the Associated Physician Program for the purpose of providing professional care and treatment to eligible members and dependents of groups serviced by MEDISAVR.COM.

Provider enters into this agreement as an independent contractor and no employer/employee relationship exists or is intended. Provider will at all times maintain the Provider/patient relationship and will be solely responsible for determining and administering the care and treatment of the patient.

Rights and Responsibilities

Both MEDISAVR.COM and the Provider will be bound by the procedures and requirements. These procedures and requirements will remain in effect during the term of this agreement, unless modified in writing.

The census form completed by the Provider is also part of this agreement, and the Provider warrants that all information contained therein is true and complete, and recognizes that MEDISAVR.COM enters into this agreement in reliance thereon. The Provider will promptly advise MEDISAVR.COM upon material change in any information which is contained in the census form.

Reimbursement

All reimbursement for services rendered by the Provider under this agreement will be at MediCare rates.

Fees

The Provider does not pay any fees or dues for participating, nor are there any referral fees, or costs of any kind.

Billing and Payment

Billing and payment will be governed by the rules and guidelines. These rules and guidelines will remain in effect during the term of this agreement, unless modified in writing.

Term

This association is purely voluntary, and may be terminated by either party upon ninety (90) days written notice to the other party.

Provider

Date _____

National Health Plan

Procedures and Requirements

1. Patients will be referred by MEDISAVR.COM directly to the Provider, either by a staff member or MEDISAVR.COM's computerized physician locator system. Referrals may also be introduced via phone call from a staff member of MEDISAVR.COM's Provider Relations Department.
2. Should a referral to any other Provider be required, the Provider or patient **must** call MEDISAVR.COM and specify the type of specialist/Provider required. MEDISAVR.COM will furnish the patient with a participating Provider. The Provider is **not** to refer the patient directly to another specialist/Provider. If the Provider does so, the Provider will be responsible for ensuring that MEDISAVR.COM, the patient, the member, and the member's sponsoring group have no more expense than would have been incurred had a participating Provider been used.
3. Many of our participating groups require second surgical opinions. Therefore, MEDISAVR.COM **must** be called in advance of all elective surgery. There will be no coverage and no liability to MEDISAVR.COM, the patient, the member, or the member's sponsoring group if advance approval of elective surgery is not obtained. This waiver applies to the participating Provider, the hospital, and related ancillary services, such as, but not limited to, anesthesia and diagnostic testing.
4. MEDISAVR.COM enforces its pre-admission program. The Provider **must** call prior to any elective hospitalization, inpatient or outpatient. If approved, the admission must be at a participating hospital, where feasible. If this procedure is not followed, the waiver in effect in paragraph three (3) above will apply equally.
5. The requirements of paragraphs two (2), three (3), and four (4) above are waived in life-threatening situations.
6. The requirements of paragraphs three (3) and four (4) do not apply to the National Consumer Alliance and its participants. The requirements of paragraph two (2) remain in effect.
7. For cases requiring medical, utilization or other review, the Provider will promptly supply copies of medical records, operative reports, or other documentation to MEDISAVR.COM or its designated agent.

Billing and Payment

1. All fees for services covered by this agreement will be paid either by MEDISAVR.COM's client group benefit program or by MEDISAVR.COM, using the clients' monies, directly to the Provider. The Provider understands and agrees that under whatever method or manner he receives payment, payment is not made with MEDISAVR.COM's own funds, but with funds supplied to it by MEDICAREPROVIDERS.COM's clients. The Provider understands and agrees that MEDISAVR.COM is neither a guarantor or insurer of payment to the Provider and that the Provider must ultimately seek payment from the patient. All disputes wherein claims payments may be withheld must be resolved by the Provider and the patient. If payment is not made by MEDISAVR.COM and is then sought by the Provider from the patient, the Provider shall be entitled to a fee based upon his usual and customary charges from the patient. The Provider will neither seek nor accept payment from the eligible patient or member for any covered service. MEDISAVR.COM is NOT an insurance company.
2. There is usually no co-payment or cost sharing for covered services rendered to eligible members and dependents of groups participating in MEDISAVR.COM's Associated Physician Program. The fees listed in Attachment B as amended from time to time, will be accepted in full payment by the Provider. If a co-payment is in effect, it will be so indicated on the participant's identification card. If no co-payment is indicated, the Provider will not ask the participant for money. If a co-payment is indicated, the Provider will accept only that amount from the participant.
3. MEDISAVR.COM has two claims systems, electronic and paper, which apply to different groups.

For those groups whose claims may be filed electronically, the Provider will file claims AFTER services have been rendered, via an ordinary touch-tone telephone, follow the computer prompts and enter the information accurately. The system will return an authorization code if the patient is eligible and covered for the services rendered. Payment will be transmitted electronically, directly to the Provider's bank account, within ten (10) business days. The Provider must provide the patient with a statement showing the services rendered and the usual and customary fees filed electronically. [It is recommended (but not required) that the Provider submit the claim while the patient is still present in the office.] In the event that a claim is rejected, the Provider may charge the patient at his/her usual and customary fee for services rendered.

For those groups whose claims are filed on paper, the Provider shall ensure that s/he has an adequate supply of claim forms, which will be provided by MEDISAVR.COM upon request. AFTER services have been rendered, the Provider must complete and sign Section Two (2) of the claim form. The form must be properly completed or it will be returned for inclusion of required information. The Provider's usual and customary fee for service must be entered on the form, **not** the amount provided under the agreement. "Clean" claims will be processed within ten (10) business days, and payment will be mailed within thirty (30) working days. A "clean" claim is one that is complete as received and requires no further information or documentation. Other claims will be processed promptly upon receipt of needed information or documentation. No claim will be paid unless it is properly completed. In the event that a claim is rejected, the Provider may bill the patient at his/her usual customary fee for services rendered.

4. In cases where there is other coverage, and that coverage is primary, the Provider **must** bill the other coverage first. (All Providers **must** accept Medicare assignment for individuals covered by Medicare.) If the other coverage pays less than the amount provided under this agreement, then the Provider will be paid the difference between the amount paid by the other coverage and the amount provided under this agreement. Documentation of the first coverage's payment must be submitted to MEDISAVR.COM along with the claim for co-ordinated benefit payment.
5. In cases where there is other coverage, and that coverage is secondary, MEDISAVR.COM will pay the amount allowed under this agreement. The Provider may then seek the balance of his/her usual and customary charges from the Provider of the other coverage.
6. In cases involving No-Fault, Worker's Compensation, and liability, additional information, forms, or liens may be required before a claim can be processed. MEDISAVR.COM will make every effort to see that claims are processed as promptly as possible, though it has no control over any other payors.