



**Network Provider
Infusion Therapy
Contract**

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SIGNATURE PAGE



Network Infusion Therapy Provider Contract

It is hereby agreed between the Office of Management and Enterprise Services Employees Group Insurance Division (EGID), and the Infusion Therapy Provider named on the signature page, that the Infusion Therapy Provider shall be a Provider in the EGID's network of providers.

This Contract is entered into for the purpose of defining the conditions for reimbursement by EGID to the Infusion Therapy Provider. It in no way is meant to impact on the Infusion Therapy Provider's decision as to what is considered appropriate infusion therapy treatment.

I. RECITALS

- 1.1 The Employees Group Insurance Division (EGID) is a statutory body created by 74 O.S. 2012, § 1301 et seq., as amended, to administer and manage certain insurance benefits for employees of the State of Oklahoma.
- 1.2 The Infusion Therapy Provider is a Medicare and/or Joint Commission certified Infusion Therapy Provider and satisfies additional credentialing criteria as established by EGID.
- 1.3 The intent of this Contract is to provide access to enhanced quality infusion therapy, utilizing managed care components, at an affordable, competitive cost to EGID and its members.
- 1.4 Failure to abide by any of the following provisions may result in non-renewal of the Contract or may be cause for termination.

II. DEFINITIONS

- 2.1 "Allowable Fee" means the maximum charge payable to an Infusion Therapy Provider for a specific procedure in accordance with the provisions in Article VI of this Contract. The Infusion Therapy Provider shall charge the usual and customary fee unless the fee schedule limits otherwise.
- 2.2 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating Providers and other health care providers.
- 2.3 "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)).
- 2.4 HELP/Wellness (Health Education Lifestyle Planning) means the program established to actively promote responsible behavior and the adoption of lifestyles that are in the best interest of the Plan member's good health.

- 2.5 “Infusion Therapy” means the services provided by a Network Infusion Therapy Provider that are covered by the Employees Health Insurance Plan.
- 2.6 “Medical” means belonging to the study and practice of medicine for the prevention, alleviation or management of a physical or mental defect, illness, or condition.
- 2.7 “Medically Necessary” means services or supplies that, under the provisions of this Contract, are determined to be:
- a) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
 - b) provided for the diagnosis and treatment of the medical condition, and
 - c) within standards of acceptable, prudent medical practice within the community, and
 - d) not primarily for the convenience of the member, the member’s Infusion Therapy Provider or another provider, and
 - e) any condition which, if left untreated, could deteriorate into a life threatening situation, and
 - f) the most appropriate supply or level of service that can safely be provided.
- 2.8 “Members” means all persons covered by the Group Insurance Plans, including active, retired, or vested employees, survivors and others on approved leave or disability and their covered dependents eligible at the time of service.
- 2.9 “Network Provider” means an Infusion Therapy Provider who has entered into this Contract with EGID, to accept scheduled reimbursement for covered infusion therapy services provided to members.
- 2.10 “Prior Authorization” means a function performed by EGID, or its designee, to review for medical necessity in identified areas of practice as defined at 7.1 of this Contract, prior to services being rendered.
- 2.11 “Employees Health Insurance Plan” means the HealthChoice benefit plan designed to enhance the quality of care and to financially incentivize members to use Network Providers.
- 2.12 “Third Party Payor” means an insurance company or other entity making payment directly to the Infusion Therapy Provider on behalf of EGID.

III. RELATIONSHIP BETWEEN THE EGID AND THE INFUSION THERAPY PROVIDER

- 3.1 EGID has negotiated and entered into this Contract with the Infusion Therapy Provider on behalf of the individuals who are members of the Employees Health Insurance Plan. The Infusion Therapy Provider is an independent contractor who has entered into this Contract to become a Network Provider and is not, nor is intended to be, the employee, agent or other legal representative of EGID in the performance of the provisions of this Contract. Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of the independent contractor for the purposes of this Contract.
- 3.2 EGID and the Infusion Therapy Provider agree that all of the parties hereto shall respect and observe the provider/patient relationship that will be established and maintained by the Infusion Therapy Provider. The Infusion Therapy Provider may choose not to establish a provider/patient relationship if the Infusion Therapy Provider would have otherwise made the decision not to establish a provider/patient relationship had the patient not been a member. The Infusion Therapy Provider

reserves the right to refuse to furnish services to a member in the same manner as he would any other patient.

- 3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies in any third party, including but not limited to, a member or a Network Provider other than the Infusion Therapy Provider named in this Contract.

IV. INFUSION THERAPY PROVIDER SERVICES AND RESPONSIBILITIES

- 4.1 The Infusion Therapy Provider agrees to provide quality infusion therapy services in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the Infusion Therapy Provider shall provide services to members that are medically necessary and covered under the Health Insurance Plan.
- 4.3 The Infusion Therapy Provider agrees to make reasonable effort to refer covered members to those Network Providers, with which EGID contracts, for medically necessary services that the Infusion Therapy Provider cannot or chooses not to provide. Failure of the Infusion Therapy Provider to use Network Providers will result in a review pursuant to the credentialing plan.
- 4.4 The Infusion Therapy Provider shall provide patient progress update reports to EGID by phone, mail or fax. This may result in a change of the approved length of services.
- 4.5 The Infusion Therapy Provider shall participate in the prior authorization procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from those reviews subject to rights of reconsideration, review and appeal.
- 4.6 The Infusion Therapy Provider shall accurately complete the Network Provider Application that is attached to and made part of this Contract. The Infusion Therapy Provider shall notify EGID's Network Manager of any change in the information contained in the Application within 15 days of such change, including resolved litigation listed as "pending" on the original Application.
- 4.7 The Infusion Therapy Provider shall reimburse EGID for any overpayments made to the Infusion Therapy Provider within 30 days of the Infusion Therapy Provider's receipt of the overpayment notification.
- 4.8 The Infusion Therapy Provider shall submit to a patient record audit upon 48 hours advance notice.
- 4.9 The Infusion Therapy Provider shall participate in HELP/Wellness promotions sponsored by EGID, at EGID's allowable under the terms of the promotion.

V. EGID SERVICES AND RESPONSIBILITIES

- 5.1 EGID agrees to pay the Infusion Therapy Provider compensation pursuant to the provisions of Article VI.
- 5.2 EGID agrees to grant the Infusion Therapy Provider the status of "Network Provider" and to identify the Infusion Therapy Provider as a Network Provider on informational materials disseminated to members.

- 5.3 EGID agrees to continue listing the Infusion Therapy Provider as a Network Provider until this Contract terminates.
- 5.4 EGID agrees to periodically provide The Infusion Therapy Provider access to a list of all Network Providers.
- 5.5 EGID agrees to provide appropriate identification cards for members.
- 5.6 EGID agrees to adhere to confidentiality of patient's records and to only release pertinent clinical information in accordance with state and federal guidelines.
- 5.7 EGID shall give a 48 hour notice prior to an audit.
- 5.8 EGID shall maintain a prior authorization program in order to aid its members in making decisions that will maximize medical benefits and reduce their financial risk.

VI. COMPENSATION AND BILLING

- 6.1 The Infusion Therapy Provider shall seek payment only from EGID for the provision of infusion therapy services except as provided in paragraphs 6.3, 6.4, and 6.9. The payment from the Employees Health Insurance Plan shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 EGID agrees to pay the Infusion Therapy Provider's designated per diem value or billed charge for each procedure or the fee set by EGID for that procedure, whichever is less.
 - a) EGID may reduce the payment by any deductibles, and coinsurance.
 - b) EGID shall have the right to categorize what shall constitute a procedure. EGID and the member's financial liability shall be limited to the procedures allowable as determined by EGID, paid by applying appropriate coding methodology, whether the Infusion Therapy Provider has billed appropriately or not. The per diem rates do not include any professional component fees which are considered for payment according to separately billed CPT codes.
 - c) The Infusion Therapy Provider agrees not to charge more for medical services to members than the amount normally charged (excluding Medicare) by the Infusion Therapy Provider to other patients for similar services. The Infusion Therapy Provider may, however, contract with other third party payors for services. The Infusion Therapy Provider's usual and customary charges may be requested by EGID and verified through an audit.
- 6.3 The Infusion Therapy Provider agrees that the only charges for which a member may be liable and be billed by the Infusion Therapy Provider shall be for infusion therapy services not covered by Employees Health Insurance Plan, or as provided in paragraphs 6.4 and 6.9. The Infusion Therapy Provider shall not waive any deductibles and coinsurance required by EGID, except during times of HELP/Wellness promotions, when the copayment/coinsurance is waived by EGID.
- 6.4 The Infusion Therapy Provider shall not collect amounts in excess of Plan limits unless the member has exceeded his/her annual or lifetime maximum.
- 6.5 The Infusion Therapy Provider shall refund within 30 days of discovery to the member any overpayments made by the member.

- 6.6 In a case in which EGID is primary under applicable coordination of benefit rules, EGID shall pay the amounts due under this Contract. In a case in which EGID is other than primary under the coordination of benefit rules, EGID shall pay only those amounts not payable from other sources pursuant to the applicable coordination of benefit rules, up to EGID's maximum liability under the terms of this Contract.
- 6.7 The Infusion Therapy Provider shall bill EGID on forms acceptable to EGID within 60 days of providing the infusion therapy services. The Infusion Therapy Provider shall use the current CPT codes with appropriate modifiers and ICD codes, when applicable. The Infusion Therapy Provider shall furnish, upon request at no cost, all information, including progress notes, signed physician's orders, and treatment plans required by EGID to verify and substantiate the provision of infusion therapy services and the charges for such services if the member and the Infusion Therapy Provider are seeking reimbursement through EGID.
- 6.8 EGID shall reimburse the Infusion Therapy Provider within 30 days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. EGID will not be responsible for delay of reimbursement due to circumstances beyond EGID's control.
- 6.9 The Infusion Therapy Provider shall not charge the member for infusion therapy services denied during the prior authorization procedures described in Article VII, unless the Infusion Therapy Provider has obtained a written waiver from that member. Such a waiver shall be obtained only upon the denial of prior authorization and prior to the provision of those infusion therapy services. The waiver shall clearly state that the member shall be responsible for payment of infusion therapy services denied by EGID.
- 6.10 EGID shall have the right at all reasonable times and, to the extent permitted by law, to inspect and duplicate all medical and billing records relating to medical services rendered to covered members at no cost to EGID or the member.

VII. UTILIZATION REVIEW

- 7.1 The Infusion Therapy Provider shall adhere to and cooperate with EGID's prior authorization procedures. These procedures do not guarantee a member's eligibility or that benefits are payable, but assure the Infusion Therapy Provider that the professional services to be provided are covered under the Plan. Failure to obtain prior authorization shall result in the Infusion Therapy Provider's reimbursement being penalized by 10% if medical necessity is confirmed retrospectively and, if not confirmed, there shall be no reimbursement.
- 7.2 The prior authorization requirements are intended to maximize insurance benefits assuring that infusion therapy services are provided to the member at the appropriate level of care. In no event is it intended that the prior authorization procedure interfere with the Infusion Therapy Provider's decision regarding the patient's care.
- 7.3 EGID shall maintain review procedures and screening criteria that take into account professionally acceptable standards for quality medical care in the community. EGID or its designee shall consider all relevant information concerning the member before medical necessity is approved or denied.
- 7.4 EGID shall not retrospectively deny any previously approved care. The Infusion Therapy Provider and/or its designee shall update EGID, or its designee, as the member's condition or diagnosis changes.

Updated information may result in a change of the originally approved length of stay.

- 7.5 Upon the member's request, EGID shall reconsider any non-approved services. The Infusion Therapy Provider may submit a formal written appeal to EGID.
- 7.6 The Infusion Therapy Provider shall request prior authorization from EGID before providing infusion therapy services. The Infusion Therapy Provider shall be prepared to give the following information:
- a) patient's name
 - b) member's name
 - c) member's social security number
 - d) patient's age and sex
 - e) diagnosis and brief description of case
 - f) scheduled date services are to begin
 - g) treatment plan – to include physician's letter of medical necessity, signed physician's orders and estimated duration of service. The written plan must be submitted to EGID.

VIII. LIABILITY AND INSURANCE

- 8.1 Neither party to this Contract, EGID nor the Infusion Therapy Provider, nor any agent, employee or other representative of a party, shall be liable to third parties for any negligent act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.
- 8.2 The Infusion Therapy Provider shall maintain a minimum of \$1,000,000 per occurrence of insurance coverage for professional liability.

IX. MARKETING, ADVERTISING AND PUBLICITY

- 9.1 EGID shall encourage its members to use the services of the Network Infusion Therapy Provider.
- 9.2 EGID shall have the right to use the name, office address, telephone number and specialty of the Infusion Therapy Provider for purposes of informing its members and prospective members of the identity of the Network Providers.
- 9.3 The Infusion Therapy Provider, upon prior approval of EGID, shall have the right to publicize the Infusion Therapy Provider's status in EGID's network of providers.

X. DISPUTE RESOLUTION

- 10.1 EGID and the Infusion Therapy Provider agree that their authorized representatives will meet in a timely manner and negotiate in good faith to resolve any problems or disputes that may arise in performance of the terms and provisions of this Contract. Nothing in this Article shall interfere with either party's rights under Article XI.

XI. TERM AND TERMINATION

- 11.1 The term of this Contract shall commence on the effective date on the signature page, and shall remain in effect until terminated by either party subject to 11.2.

- 11.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 12.2
- 11.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.
- 11.4 This Contract shall terminate with respect to an Infusion Therapy Provider upon:
- a) the loss or suspension of the Infusion Therapy Provider's Medicare or Joint Commission certification; or
 - b) failure to maintain the Infusion Therapy Provider's professional liability insurance in accordance with this Contract.
- 11.5 Following the effective date of termination, this Contract shall be of no further force or effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this Contract.
- 11.6 Following termination of this Contract, EGID shall continue to have access to the Infusion Therapy Provider's records of care and services provided to members for five years from the date of provision of the services to which the records refer as set forth in Paragraph 6.10.

XII. GENERAL PROVISIONS

- 12.1 This Contract or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.
- 12.2 At any place within this Contract that notice is required, it is the intention of the parties that only those with regard to termination by either party of participation in the Contract must be sent by certified mail, a return receipt requested, at no other time when notice is required by this Contract is there an obligation by either party to use certified mail. The Network Newsletter serves as the primary method by which providers receive all other notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.
- 12.3 Notwithstanding the provisions of Paragraph 12.1 of this Contract, EGID may appoint an Administrator to administer any of the terms of the Network Contract referenced herein, and any and all duties or acts required of EGID under this Contract and to receive any notices required by this Contract.
- 12.4 This Contract, together with its exhibits, contains the entire agreement between EGID and the Infusion Therapy Provider relating to the rights granted and the obligations assumed by the parties concerning the provision of medical services to members. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract not expressly set forth in this Contract are of no force or effect.

- 12.5 This Contract, or any part, section or exhibit of, or attached to it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of EGID and the Infusion Therapy Provider.
- 12.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract that is not in conformity with existing or future legislation shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.
- 12.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and the determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this entire Contract, or any one of them, in accordance with the intent and purpose of the parties hereto.
- 12.8 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.
- 12.9 As mandated by HB1086, the Transparency, Accountability, and Innovation in Oklahoma State Government 2.0 Act of 2011, all payments disbursed by the Office of the State Treasurer must be made solely through electronic funds transfer (EFT). Provider/facility hereby agrees to accept EFT payments by July 1, 2013. Provider acknowledges that all health and dental claims received after July 1, 2013, regardless of the date of service, will be denied pending receipt of additional information if EFT payment information is not on file as of July 1, 2013.



**Network Provider Facility Credentialing Information
Contract Applications**

HealthChoice requires all three addresses on the respective pages of the application.

1. **Service Address** – This address is used for the location where health care services are performed and/or the physical location of the provider. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all HealthChoice Network Providers.
2. **Mailing Address** – Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.
3. **Billing Address** – This address is used for submitting all claims to HealthChoice for processing and appears in box 33 of the CMS-1500 claim form or box 2 on the UB-04. If box 2 is not used by the facility, the billing address appears in Box 1 of the UB-04. Claims will be paid exclusively to the billing address.

Each address must have a corresponding phone number, email address, fax number and contact person.

Insurance Certificate/Face Sheet must have name of the applicant listed as the insured. The insurance limits must be at the levels required in the contract and must indicate clearly the coverage type(s) stated in the contract. Product liability coverage in lieu of professional/medical liability is acceptable for DME only.

W-9 forms must be signed and list only the Tax ID number for each location listed on the application which will be used on claim forms

Please return entire application packet with the new information.



**Network Facility
Application Requirements**

Thank you for your interest in the HealthChoice Provider Network.

Please complete the attached Application and submit with the required attachments listed below.

Complete all sections of the application. If an area of inquiry is not applicable to the facility, please indicate. If you need additional space to provide complete answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

Retain the Contract for your records.

REQUIRED ATTACHMENTS

Please attach a copy of each of the following documents to your completed Application:

- Current state(s) license(s)**
- Face Sheet of current general and medical liability insurance policy**
Insurance Certificate/Face Sheet must have the name or the Facility listed as the insured. The insurance limits must be at the levels in the Contract and must indicate clearly that it is general and medical liability coverage.
- W-9 form for each Federal Tax Identification Number**
W-9 forms must be signed and list only the Federal Tax Identification Number listed on the Application which will be used on claim forms submitted to HealthChoice.
- Contract Signature Page**
- Electronic Funds Transfer (EFT) Form**
- Copy of voided check or bank letter for Electronic Funds Transfers**
- Copy of Medicare Certification Letter**
- Copy of Joint Commission Accreditation Certificate (if applicable)**
- Copy of AAAHC Accreditation Certificate (if applicable)**

Incomplete applications will be returned.



Network Facility Application

The completed Network Facility Application should be returned to the Office of Management and Enterprise Services Employees Group Insurance Division in its entirety, accompanied by the applicable attachments. You may mail, fax or email the completed application to:

Office of Management and Enterprise Services
Employees Group Insurance Division
ATTN: Network Management
3545 N.W. 58th St., Ste. 600
Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-844-804-2642
Fax: 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

General Information

Legal Name of Owner: _____
Trade Name/DBA: _____
Medicare Facility Classification: _____ Medicare Number: _____

License Information

State: _____
License Number: _____
Expiration Date: _____

A copy of facility license is required for each state of practice.

Accreditation

Is this Facility accredited by the Joint Commission: Yes No
Joint Commission Program ID Number: _____
Date of most current accreditation: _____ Expiration Date: _____
Is this Facility accredited by the AAAHC? Yes No
Date of most current accreditation: _____ Expiration Date: _____

Insurance Information

Copy of Insurance Certificate/face sheet is required.

Please provide the following information about the Facility's current general and medical liability insurance coverage.

Name of Carrier: _____

Limits of General and Medical Liability Per Occurrence: _____ Expiration Date: _____

Important Facility Contacts

CEO/Administrator: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

CFO: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Credentialing Contact: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Address Information

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 form for each Federal Tax ID number.

Physical Address – physical location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing Address

Mailing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.

Billing/Remit Address – for claims payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Additional Location

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 form for each Federal Tax ID number.

Physical Address – physical location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing Address- for correspondence/credentialing

Mailing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Billing/Remit Address – for claims payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

City

State

ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Please use copies of these pages to report any additional locations.

HOSPITAL AND NON-HOSPITAL BASED SERVICES; if applicable

Does the Hospital provide the following specialty services?

- | | |
|--|---|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Infusion Therapy |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Long Term Acute Care |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Psych/Substance Abuse |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Independent Diagnostic Testing Facility | <input type="checkbox"/> Sleep Study |

Does the Hospital provide the following services by a group of specialists? If yes, please list the provider group name.

- Anesthesiology Group: _____
- Emergency Physician Group: _____
- Pathology Group: _____
- Radiology Group: _____



**Network Provider Infusion Therapy Contract
Signature Page**

The Office of Management and Enterprise Services Employees Group Insurance Division (EGID), and the Facility incorporated by reference the terms and conditions of the HealthChoice Network Facility Contract (Contract) located in HCITCv2.0 at www.ok.gov/sib/Providers/Contracts_and_Applications into this Signature Page and acknowledge the Contract is an electronic record created according to 12A O.S. § 15-011 et seq. EGID and the Facility further agree that the effective date of the Contract is the effective date denoted on the copy of the executed Signature Page returned to the Facility. The original of the signed document will remain on file in the office of EGID.

FOR THE FACILITY:

FOR EGID:

Legal Name of Owner (Typed or Printed)

Diana O’Neal
Deputy Administrator
Employees Group Insurance Division

Trade Name/DBA (Typed or Printed)

Federal Tax ID Number

Address of the Facility:

Authorized Officer or Representative (Typed or Printed)

Title

Signature

Signature Date

Please return the completed Application, Signature Page, and required attachments to:

Office of Management Enterprise Services
Employees Group Insurance Division
ATTN: Network Management
3545 N.W. 58th St., Ste. 600
Oklahoma City, OK 73112
Phone: 405-717-8790 or 844-804-2642
Fax: 405-717-8977
EGID.NetworkManagement@omes.ok.gov