AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

AgendaTitle:
Provider Participation Agreement; Colorado Department of Health Care Policy and Financing; CHP+ Client Immunizations and Family Planning Services; 6/30/13 thru 8/30/13

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Gunnison County & CHP+ Managed Care Network

Term Begins: 7/1/2013 **Term Ends:** 8/31/2013 **Grant Contract #:**

Summary:
This is a 2 month contract extension with CHP+ that will only be in place until they develop a new contract. Public Health provides services to CHP+ clients for immunizations and family planning.

Fiscal Impact: fee fro service reimbursement in Public Health

Submitted by: B. Lucero for R. Morgan **Submitter's Email Address:** rmorgan@gunnisoncounty.org

Finance Review: ○ Required ● Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ○ Required ● Not Required

Comments:

Reviewed by: Discharge Date: Certificate of Insurance Required Yes ○ No ○

County Manager Review:

Comments:

Reviewed by: MBirnie Discharge Date: 6/27/2013

● Consent Agenda ○ Regular Agenda ○ Worksession Time Allotted:

Agenda Date: 7/2/2013 Follow Up Agenda Date: N/A

Revised April 2013

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

Received
County Adminstration
6/19/13

June 7, 2013

Gunnison County
DBA: Gunnison County Public Health
Attention: Channell Hap
200 E Virginia
Gunnison, CO 81230

RECEIVED
JUN 21 2013
GUNNISON COUNTY
DEPT. OF HUMAN SERVICES

Re: CHP+ State Managed Care Network Provider Agreement

Dear CHP+ State Managed Care Network Provider,

In accordance with Section 5. General Provisions, Paragraph C., Holdover Provision, of the above referenced Provider Agreement; the Department desires to continue the Contractors' services while a replacement Provider Agreement is completed for CHP+ State Managed Care Network providers. This replacement Provider Agreement will not be fully executed by the end of the current Provider Agreement performance period, June 30, 2013. The Department is hereby unilaterally extending the above referenced Provider Agreement for a period of two (2) months under the same terms and conditions as the above referenced Provider Agreement, including rates and service delivery requirements.

If you have any questions or concerns, please contact Regina Maxey at 720-744-5100 ext. 5219 or regina.maxey@coaccess.com

Sincerely,

Alan S. Kislowitz, MSHA
Health Plan Manager
Colorado Dept. of Health Care Policy and Financing
Managed Care and Contracts Division

CHP+ Child Health Plan *Plus*

May 30, 2013

Gunnison County
dba: Gunnison County Public Health
Attention: Channell Hap
200 E Virginia
Gunnison, CO 81230

Dear Provider:

Colorado Access and The Colorado Department of Health Care Policy and Financing (HCPF) would like to thank you for your continued participation in the Child Health Plan Plus (CHP+) State Managed Care Network (SMCN). We sincerely appreciate your organization for serving the medically underserved. Enclosed you will find the revised renewal agreement with HCPF.

The packet includes one (1) copy of the renewal agreement, which will extend your participation in the CHP+ State Managed Care Network. All terms of the original agreement and current reimbursements will remain the same. Please review the revised renewal agreement, sign the signature page and review the pre-populated Provider Questionnaire. Make any necessary changes on the pre-populated Provider Questionnaire. Please do **not** write on the agreement or fill in the contract date on the first page of the contract.

Please return the signed agreement, pre-populated Provider Questionnaire and current copies of all clinical staff's Medical License(s), DEA (if applicable) and liability insurance to my attention in the enclosed self addressed envelope.

After we receive the signed agreement and required documents, we will assign an effective date, counter sign and send a copy to your attention. Until you received notification of the renewal agreement effective date please continue to follow the business rules applicable to participating providers. If you have any concerns or questions, please do not hesitate to contact me at 720-744-5100 ext. 5219 or regina.maxey@coaccess.com.

Sincerely,

Regina Maxey
Colorado Access
Provider Contracting Coordinator

State Managed Care Network

CONTRACT INSTRUCTION GUIDELINES

Thank you for choosing to participate in the State Managed Care Network. If you have any questions, please call the Child Health Plan *Plus* (CHP+) administrator's Provider Contracting Department at 720.744.5219 or toll free 1.800.511.5010 ext 5219.

- **Items in the Contract Packet to keep for future use:**
  - **Contract Instruction Guidelines-** This will give you clear directions on what is included in your contract packet and how to complete and return the necessary items **to avoid delay in processing your contract**.
  - **Notice from the State of Colorado-** This memo from the Department of Health Care Policy & Financing states the CHP+ requirements for legal signatory authorization.
  - **Provider Change Form-** Please keep this document in your files in case of future need. Instructions for completion and submission are listed on the form.
    Clinical Staff Update Form- Please keep this document in your files and use when adding or terminating clinical staff from your practice. Instructions for completion and submission are listed on the form.

- **Items to be completed, signed and returned:**
  - **Provider Agreements**
    One person authorized to sign the contract for your organization or practice should sign and date the Original copy of the agreement. Please also print or type the name and title of the authorized signatory for your organization or practice on the contract signature page in the appropriate field of each copy of the agreement. Please do **not** write on the agreement or fill in the contract date on the first page of the contract.

    To avoid any delays in processing your agreement, please do not cross out, make any corrections or additions to the contract language or practice information included in the agreements. If you have any concerns regarding the contract language or practice information that is listed in the agreement please call the CHP+ administrator's Provider Contracting Department at the numbers listed above.

  - **Signature Authority**
    Please provide a copy of your organizational by-laws, board minutes, or submit a statement on company stationery affirming the authority of the signatory to execute contracts on behalf of your organization or practice. If you are the sole proprietor, please submit a statement on your practice letterhead affirming you are the owner and therefore authorized to sign contracts on behalf of your practice. If the authorized Contractor signatory and/or title differs from the authorized signatory that is listed in the agreement under section V, General Provisions, sub-section I, Representatives and Notice, do not cross out. Please send one of the above mentioned items to show authority of the signatory.

  - **Provider Questionnaire**
    Existing CHP+ Providers- Please review the pre-printed CHP+ Contract Questionnaire for accuracy and mark any changes directly on the form.
    New CHP+ Providers- Please complete the blank CHP+ New Provider Questionnaire in its entirety. In future contracting years, you will receive the pre-printed form. You will need to **provide the requested details that are listed on the questionnaire if you supply a roster listing the providers in your organization or practice.**

  - **Form W-9, Request for TIN and Certification-** Please complete the enclosed W-9 document. The Legal Name and Address information on your W-9 should match the information referenced in your contract.

  - **Credentialing Information**
    Primary Care and Specialty Care Providers (including Behavioral Health) – If you currently participate with the Council for Affordable Quality Health Care (CAQH), please ensure that your CAQH record and supporting documentation are up to date. If you are not currently participating with CAQH, please contact the Colorado Access credentialing staff at 720.744.5100. **Ancillary, Hospital, ER, and Ambulance Providers-** Please provide current copies of any applicable State licenses or certificates and proof of liability insurance for your organization or facility. If you currently participate with CAQH, please ensure that your CAQH record and supporting documentation are up to date.
    All Facility Providers – Please provide current copies of any applicable State licenses or certificates and proof of liability insurance for your organization.

Return completed contract packet to:

Child Health Plan *Plus*
State's Managed Care Network
Provider Contracting Dept
PO Box 17580

Print Form

CHPA_61

State Managed Care Network

CLINICAL STAFF UPDATE FORM

Please complete and submit this form to add or terminate a provider from your practice or organization. Return by mail to:

Child Health Plan *Plus*
State Managed Care Network
Provider Contracting Department
PO Box 17580
Denver, CO 80217-0580
or
Return by Fax: **303.755.2368**
Attention: Provider Contracting Department
CHP+ State Managed Care Network

Please contact CHP+ Provider Network Services for the State Managed Care Network at 720.744.5211 or send an email to pns@coaccess.com if you have questions regarding this form.

Step 1: Please provide the following information for your practice or organization:

Legal Name: _____
Tax Identification Number: _____
Contact Name and Phone Number: _____

Step 2: Please provide the following information for clinical staff that are joining or leaving your practice or organization:

☐Add: ☐Terminate: Effective Date: _____ National Provider Identification #:_____

Name (first, last, mi):_____ Degree Type: _____ Gender: ____

DOB: _____Languages Spoken: _____Specialty: _____

Medical License Number: _____ Expiration Date: _____

DEA License Number: _____ Expiration Date: _____

☐ Board Certified ☐Provide Pre-Natal Care ☐Provide OB Care

Malpractice Insurance: _____**Coverage Span:** _____

List all hospitals where the new provider has admitting privileges:

_____
_____

Insurance Carriers Accepted: ☐CO Access ☐Denver Health ☐Kaiser ☐Rocky Mtn HMO
Age Groups Accepted: ☐Child ☐Teen ☐Adult
Patient Choice: ☐New ☐Existing Patients

Service Locations:_____
_____
Phone Number:_____Fax Number:_____

Step 3:
If you currently participate with CAQH, please ensure that your CAQH record and supporting documentation are up to date. If you are not currently participating with the CAQH, please contact the Colorado Access credentialing staff at 720.744.5100 or toll free at 800.511.5010 and they will assist you.

Clinical Staff Update Form Completed by:_____ Date: _____

Please visit our website at *www.chpplusproviders.com* for the latest provider information.

State Managed Care Network

PROVIDER ADDRESS CHANGE FORM

Please complete this form if your legal name, service location or your taxpayer identification number (TIN) has changed and does not match your current contract information.

Return by mail to:
Child Health Plan *Plus*
State Managed Care Network
Provider Network Services
PO Box 17580
Denver, CO 80217-0580
or
Return by Fax: **303.755.2368**
Attention: Provider Network Services
State Managed Care Network

Please contact CHP+ Provider Network Services for the State Managed Care Network at 720.744.5219 or send an email to pns@coaccess.com if you have questions regarding this form.

Step 1: Please provide your current Taxpayer Identification Number. You must complete this field.

Existing TIN of Contract Entity

New TIN of Contracting Entity, if applicable — Effective Date

Step 2: Please provide the Legal Name of the contracted entity.

Existing Legal Name of Contracting Entity

New Legal Name of Contracting Entity, if applicable — Effective Date

Step 3: Please update the Legal Address or Service Location of the contracting entity.

Existing Legal Address of Contracting Entity

New Legal Address of Contract Entity, if applicable — Effective Date

Existing Service Location of Contracting Entity

New Service Location of Contract Entity, if applicable — Effective Date

Step 4: Please have the authorized signatory sign and date this form to affirm the updates noted are accurate and complete.

Signature — Date Signed

Name and Title of Authorized Signatory

Please visit our website at *www.chpplusproviders.com* for the latest provider information.

PROVIDER PARTCIPATION AGREEMENT

This Provider Participation Agreement ("Agreement") is made and entered into this _____ day of _____, 2013 by and between **THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,** ("Department"), and **Gunnison County d.b.a. Gunnison County Public Health,** ("Provider"). This Agreement is entered into in order to define Department expectations of providers who perform services and submit billing, transactions, and/or data to the Children's Basic Health Plan. This Agreement is also established to facilitate business transactions by electronically transmitting and receiving data in agreed formats; to ensure integrity, security and confidentiality of the aforesaid data; and to permit appropriate disclosure and use of such data as permitted by law.

RECITALS

A. The Colorado Department of Health Care Policy and Financing is the single state agency responsible for the administration of the Children's Basic Health Plan, herein after referred to as "the Program", pursuant to the provision of Article 8, Title 25.5, Colorado Revised Statutes, as amended, and Title XXI of the Social Security Act.

B. Provider is capable of providing Primary Care Service and/or Specialty Care Services, and desires to do so in accordance with the terms of this Agreement and 25.5-8-101, C.R.S.

C. Electronic transmission of any/all data shall be in strict accordance with the standards set forth in this Agreement and as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under by the U.S. Department of Health and Human Services and other applicable laws, as amended.

D. This Agreement is subject to modification, revision, or termination according to changes in federal or state laws, rules, or regulations. This Agreement will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

E. Provider is an individual practitioner, single or multi-specialty group practice, or practitioner that provides professional medical or health care services or products, or a licensed pharmacy. Provider also includes a "health care entity" which is defined as a health care facility or agency that is required to obtain a license from the Department pursuant to section 25-3-101, C.R.S.

F. Department and Provider desire to enter into this Agreement to facilitate Provider's ability to render Covered Services to Enrollees of the Children's Basic Health Plan.

G. This Agreement delineates the responsibilities of the Parties, and any agent, subcontractor, or employee of a Party, in regard to the Children's Basic Health Plan, the provider certifies and agrees to the terms and conditions that follow.

A. DEFINITIONS

Whenever used in this Agreement or its Addenda, Appendices or Exhibits, the following terms shall have the indicated meaning:

A. 1 CHP+. Child Health Plan Plus. The marketing name for the Program. The Children's Basic Health Plan will be known to the public as CHP+.

A. 2 Clean Claim. A claim with the required documentation timely submitted by a Participating Provider to Department or designee on a Uniform Claim Form with all required fields fully completed correctly, consistent with the provisions of the CHP+ Provider Manual, Colorado Revised Statutes § 10-16-106.5,and other applicable State and Federal Law.

A. 3 CLIA. The Clinical Laboratory Improvement Act of 1988, as amended.

A. 4 Colorado Department of Health Care Policy and Financing. The Colorado State governmental agency responsible for the administration of the Children's Basic Health Plan program pursuant to Title XXI of the Social Security Act.

A. 5 Coordination of Benefits. The allocation of financial responsibility between two or more Payers regarding Covered Services received by an Enrollee.

A. 6 Copayment. If required under the Program, that portion of the cost of Covered Services that an Enrollee is obligated to pay directly to a Participating Provider or the State or another Payer is contractually obligated to pay on behalf of an Enrollee, including deductibles, coinsurance, and similar cost-sharing charges. Such cost may be a fixed dollar amount, a percentage amount, or a combination of the two.

A. 7 Covered Services. The services and benefits described and limited in the Evidence of Coverage document. Services are Covered Services only if they are performed, arranged and authorized in accordance with the terms, limitations and exclusions set forth in the Evidence of Coverage and the CHP+ Provider Manual.

A. 8 Department Subsidiary. An entity or organization wholly owned, or controlled by Department.

A. 9 Drug Formulary. The list of medications eligible for coverage in conjunction with the Program as updated from time to time.

A. 10 Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 placing the health of the Enrollee (or, with respect to a Enrollee who is a pregnant woman, the health of the Enrollee and/or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.)

A. 11 Emergency Services Covered Services required by a Enrollee that are furnished by a Provider qualified to furnish or provide emergency medical services and needed to evaluate or stabilize an Emergency Medical Condition.

A. 12 Enrollee. Any individual who is entitled to the benefits of the Program, classified in the State's management information system as an active enrollee, and not as a member of a health plan provided by an insurance carrier under contract with the Department.

A. 13 Evidence of Coverage The document that governs the terms of the health care services provided to enrollees in the program. The Evidence of Coverage sets forth the benefits, limitations, exclusions and policies and procedures of the Program. Terms included in the Evidence of Coverage may be periodically modified by the Department with at least fifteen (15) days prior written notice to the Provider.

A. 14 Experimental and/or Investigational Services: A service is experimental or investigational for an Enrollee's condition if any of the following statements apply to it as of the time the service is or will be provided to the Enrollee. The service:

1. Cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted; or
2. Is the subject of a current new drug or new device application of file with the FDA; or
3. Is provided as a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the service; or
4. Is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives; or
5. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity or efficacy of services; or
6. Is provided pursuant to informed consent documents that describe the service as experimental or investigational or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy; or
7. The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of the service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:

1. The Enrollee's medical records;
2. The written protocol(s) or other document(s) pursuant to which the service has been or will be

provided;

3. Any consent document(s) the Enrollee or the Enrollee's representative has executed or will be asked to execute to receive the service;

4. The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;

5. The published authoritative medical or scientific literature regarding the service as applied to the Enrollee's illness or injury; and

6. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human services, or any state agency performing similar functions.

If two or more services are part of the same treatment plan or diagnosis, all of the services in that treatment plan or diagnosis are excluded if one of the services is experimental or investigational.

A. 15 Federal Health Program. Medicare, Medicaid, TRICARE, Veteran's Administration, Public Health Service, Indian Health Service, and children's health insurance under Title XXI of the Social Security Act, and any future health related programs developed and funded by the federal government.

A. 16 HIPAA. The federal Health Insurance Portability and Accountability Act of 1996 and associated implementing regulations and standards, as amended periodically by the federal government.

A. 17 Material Change. A change to this Agreement that decreases Provider's compensation for Covered Services, modifies Program Requirements in a way that may reasonably be expected to significantly increase Provider's administrative expenses, or adds a new category of service. A Material Change is further defined in Colorado Revised Statutes § 25-37-101.

A. 18 Medically Necessary Services Those Covered Services which are determined under the applicable Utilization Management Program to be:

(a) Appropriate, necessary, and reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and

(b) Within standards of good medical practice within the organized medical community of the treating Provider; and

(c) Not primarily for the convenience of the Enrollee or the treating Provider; and

(d) Not Experimental or Investigational; and

(e) Consistent with the medical policy, the Utilization Management Program, Quality Management Program, and Program Requirements; and

(f) The most appropriate and cost effective service or supply consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the Enrollee is receiving or the severity of the Enrollee's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.

A. 19 Enrollee. Any individual who is entitled to the benefits of the Program, classified in the State's management information system as an active enrollee, and not as a member of a health plan provided by an insurance carrier under contract with the Department.

A. 20 Participating Provider. The health care facility, professional corporation, professional limited liability company, partnership, or individual health care provider, licensed Pharmacy, or other entity, including Provider, who has in effect an agreement with the Department to provide Covered Services to Enrollees.

A. 21 Payer. Department or any other public or private entity which provides funds, administers funds, insures, sponsors a plan, is responsible for insuring, or is responsible for paying Participating Providers for Covered Services. No entity which contracts, directly or indirectly, with Department for access to health care providers solely for its Enrollees, participants, or beneficiaries while outside of either their primary health care provider network or the service area of such network shall be deemed a Payer under this Agreement.

A. 22 Primary Care Physician ("PCP"). A physician who is a Participating Provider and who is responsible for coordinating and managing the delivery of Covered Services to Enrollees who have selected or been assigned to such physician.

A. 23 Prior Authorization. When required by the Program or associated Utilization Management Program, the unique authorization to be obtained from Department or its designee by a Enrollee's PCP, or by a Participating Provider, Provider Representative, or other health care provider prior to admitting a Enrollee to a hospital or providing certain other Covered Services to a Enrollee.

A. 24 Program Requirements. The rules, procedures, policies, protocols, legal and regulatory requirements, and other conditions to be followed by Department, Participating Providers, Provider Representatives, and Enrollees regarding the Children's Basic Health Plan.

A. 25 CHP+ Provider Manual. The manual and materials, including provider manuals, available to Participating Providers by Department for use during the term of this Agreement, as amended and supplemented by Department from time to time and made available through its website, newsletters or other means. In the event that a conflict exists between the terms of the CHP+ Provider Manual and the terms of this Agreement, the terms of this Agreement shall prevail. The process required by State and Federal Law for Material Changes to the CHP+ Provider Manual are discussed below in Section E.

A. 26 Provider Representative. A physician, allied health professional, or other health care provider who has a direct or indirect contract with Provider, or is employed by Provider, and who has been accepted by Department to provide Covered Services to Enrollees.

A. 27 Quality Management Program. The functions, including, but not limited to, credentialing and certification of providers, review and audit of medical and other records, outcome rate reviews, Department peer review, and provider appeals and grievance procedures performed or required by Department, a Payer, or any other permitted person or entity, to review and improve the quality of Covered Services rendered to Enrollees.

A. 28 Referral When required by the Program or associated Utilization Management Program, the process by which an Enrollee's PCP or Provider Representative directs an Enrollee to seek and obtain Medically Necessary Services from a Participating Provider.

A. 29 Specialty Care Provider. A licensed, certified or registered health care provider who is a Participating Provider, who practices in a specialty care area of medicine (not family medicine, pediatric, general practice or internist), and is responsible for providing health care services to an Enrollee upon referral of the Enrollee by the Enrollee's Primary Care Provider or another participating provider.

A. 30 Standard. Standard is as defined 45 C.F.R.160.103.

A. 31 State and Federal Law. The laws and regulations of the State of Colorado or of the United States of America that apply to Department, Payers, Provider, Provider Representatives, and this Agreement.

A. 32 Transaction. Transaction is as defined in 45 C.F.R. 160.103.

A. 33 Transaction and Code Set Regulations. Means those regulations governing the transmission of certain health claims transactions as promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. Parts 160 and 162.

A. 34 Uniform Claim Form. A claim form submitted on Form CMS 1500, UB-04 or Form CMS 1450, or the equivalent, and also electronic claims populated with similar information in HIPAA-compliant format, as required by State and Federal Law and as described further in the CHP+ Provider Manual.

A. 35 Utilization Management Program. The functions, including, but not limited to Prior Authorization, and prospective, concurrent, and retrospective review, performed or required by Department, a Payer, or any other person or entity, to review and determine whether medical services or supplies provided to Enrollees, or proposed to be provided to Enrollees, are covered under the Program and meet the definition of Medically Necessary Services.

B. PROVIDER REPRESENTATIONS AND RESPONSIBLITIES

B. 1 Provision of Covered Services. Provider agrees to provide or arrange for and accept full responsibility for, and to ensure that any Provider Representatives provide or arrange for and accept full responsibility for, Covered Services to Enrollees in accordance with:

(a) The terms and conditions of this Agreement;
(b) State and Federal Law;
(c) The Utilization Management Program, Quality Management Program, Program Requirements, and grievance, appeals, and other policies and procedures of the Children's Basic Health Plan;
(d) Standards requiring services to be provided in the same manner, and with the same availability,as services provided to other patients; and
(e) The clinical quality of care and performance standards that are professionally recognized and/or adopted by Department.
(f) Provider will maintain licensure and/or certification granted by the State licensing agency that regulates the services that are provided and will make disclosure of ownership and provide access to medical records and billing information to the Department, or its designees, as required by State and Federal Laws and regulations.

B. 2 Offices and Hours Provider shall maintain such offices, equipment, patient service personnel, and allied health personnel as may be necessary to provide Covered Services under this Agreement.

B. 3 Coverage. Provider shall ensure that each Provider Representative arranges for coverage by a Participating Provider in the event of his/her illness, vacation, or other absence in accordance with Department' policies and procedures.

B. 4 Representations of Provider: At all times during the term of this Agreement, Provider represents and warrants that:

(a) If a legal entity, Provider is organized, validly existing, and in good standing under State and Federal Law;
(b) Provider has the authority to execute and perform the obligations of this Agreement;
(c) Provider holds all necessary registrations, permits, licenses, and other approvals required by State or Federal Law to perform the obligations of this Agreement;
(d) Provider's organizational documents, and any separate agreement to which Provider is a party, do not conflict with this Agreement;
(e) Provider shall utilize its best efforts to ensure that all Provider Representatives comply with the applicable terms of this Agreement, including the obligations of Provider; and
(f) Provider will not act in a manner that will cause the Provider to be investigated, arrested, sanctioned, debarred or excluded by authorized State and Federal law enforcement, regulatory or licensing agency.
(g) Neither Provider nor any of its employees, Providers, subcontractors or agents are indentified on the HHS/OIG List of Excluded Individuals/Entities (www.oig.hhs.gov/FRAUD/exclusions/listofexcluded.html). In the event Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Provider shall have an obligation to immediately notify the Department of such ineligible person status and within 10 days of such notice, remove such individual from responsibility for, or involvement with the Provider's business operations related to this Agreement.

B. 5 Credentialing of Provider. Provider shall participate with Department' credentialing standards and requirements as set forth in Department' policies and procedures and shall submit to Department, or its designee, the Colorado Health Care Professional Credentials Application or the Department Organizational Provider Application and other required attachments, as modified from time to time in accordance with National Committee for Quality Assurance ("NCQA") and Department standards. This Agreement shall not become effective, and Provider and its Provider Representatives shall not begin to perform services under this Agreement, until such application has been approved by Department.

B. 6 Requirements for Provider Representatives Provider represents and warrants that, at all times during the term of this Agreement, each Provider Representative shall:

(a) Be duly licensed, certified, or otherwise authorized to provide Covered Services;
(b) Hold active staff privileges on the medical staffs of hospitals that are Participating Providers if required by Department;
(c) Hold a current Drug Enforcement Agency narcotic registration certificate, where applicable;

(d) Maintain a professional relationship with each Enrollee for whom Provider Representative provides Covered Services;
(e) Have professional liability insurance equal to, or in excess of, the minimum policy limits required by State and Federal Law;
(f) Comply with State and Federal Law in the provision of Covered Services;
(g) Comply with all credentialing standards and requirements established by Department for Participating Providers as set forth in the CHP+ Provider Manual; and
(h) Ensure that it will not act in a manner that will cause the Provider Representative to be investigated, arrested, sanctioned, debarred or excluded by authorized State and Federal Law enforcement, regulatory or licensing agencies.

B. 7 Restriction, Suspension, or Termination of Provider Representatives. Provider shall immediately restrict, suspend, or terminate any Provider Representative from providing Covered Services if:

(a) A Provider Representative fails to meet the requirements described above in Section B.6;
(b) Any of the events described in Section B.9 occur with regard to a Provider Representative;
(c) Provider or Department reasonably determines that there exists material deficiencies in the professional competence, conduct, or quality of care of the Provider Representative that adversely affects, or could adversely affect, the health or safety of a Enrollee or the reputation of Department; and
(d) Department requests that the Provider restrict, suspend, or terminate the Provider Representative from providing Covered Services.

B. 8 Prompt Notice of Material Events. Provider shall notify Department in writing immediately after Provider becomes aware of:

(a) Provider's failure to satisfy the representations described above in Section B.4;
(b) A Provider Representative's failure to meet the requirements described above in Section B.6;
(c) The commencement of any investigation, action, or proceeding against Provider or a Provider Representative by any State or Federal licensing or certifying agency or board;
(d) A Provider Representative's failure to comply with Department' or a Payer's Quality Management Program or Utilization Management Program;
(e) Provider's or a Provider Representative's failure to maintain any insurance coverage required by this Agreement;
(f) Provider's or a Provider Representative's indictment, arrest, or conviction for any criminal charge related to the provision of health care services;
(g) The exclusion or threatened exclusion of Provider or a Provider Representative from any State or Federal health care program;
(h) Provider's or a Provider Representative's voluntary opting-out of participating in programs operated under the Centers for Medicare and Medicaid Services; or
(i) Any event that would materially impair Provider's or a Provider Representative's ability to provide Covered Services under this Agreement.

B. 9 Timely Notice of Actions and Changes of Ownership. Provider shall forward to Department, within 2 business days of Provider's knowledge or receipt of:

(a) Any written complaint, grievance, investigation, malpractice suit, arbitration action, appeal, or any other civil or criminal action against, or involving, Provider, a Provider location or a Provider Representative that materially affects the performance of this Agreement; or
(b) Any material change in the ownership or business operations of Provider or its Provider location that materially affects the performance of this Agreement.

B. 10 Subcontracting. Every subcontract regarding the provision of health care services and supplies between Provider and a subcontractor, including an independent Provider Representative, shall comply with State and Federal Law and have terms and conditions that are consistent with this Agreement. Provider shall, upon request, furnish to Department copies of such subcontracts within 10 calendar days. If applicable, each such subcontractor shall meet Department' credentialing requirements before the provision of Covered Services. Provider shall be solely responsible for payment of any subcontractors allowed under this Agreement, and Provider agrees to indemnify, hold harmless, and defend

Department, Payers, and Enrollees from and against any and all claims that may be made by such subcontractors in connection with the provision of Covered Services to Enrollees.

B. 11 Quality Management Program. Provider and/or Provider Representatives shall be solely responsible for the quality of Covered Services provided by them to Enrollees. The quality of such services shall be monitored under the applicable Quality Management Program. For each applicable Quality Management Program, Provider agrees to: (a) participate in, and cooperate with, all aspects of such program; (b) comply with all decisions made in writing by Department or a Payer in connection with such program; (c) provide to such program the medical records and other information within 10 calendar days of receipt of a written request; and (d) review data and other information as may be required or requested under such program. If the quality of care furnished by Provider or Provider Representative is found to be unacceptable under an applicable Quality Management Program, Department shall give written notice to Provider to correct the specified deficiencies within the time period specified in the notice. Provider agrees to correct such deficiencies within the time period specified in the notice. If Provider fails to correct the specified deficiencies within the specified time period, the provider may be subject to corrective action including but not limited to termination in accordance with Section D.3 below.

B. 12 Utilization Management Program. Provider agrees to participate in, cooperate with, and comply with all decisions rendered in connection with the Program. Provider also agrees to provide to Department such records and other information reasonably requested under the applicable Utilization Management Program within the timeframe specified for the Program. If the Provider fails to respond to reasonable requests within the timeframe specified for the Program, Provider may be subject to corrective action including but not limited to termination in accordance with Section D.3 below.

B. 13 Prior Authorization. Except for Emergency Services, or unless the Program or its associated Utilization Management Program specifies otherwise, and for Covered Services that require Prior Authorization, Provider agrees not to seek payment from Department for Covered Services provided to an Enrollee without first obtaining Prior Authorization.

B. 14 Referral to Participating Providers If Provider determines that a Enrollee requires services not within Provider's scope of services, regardless whether for inpatient, outpatient, physician, ancillary, or other types of services, Provider agrees to refer, and agrees to ensure that Provider Representatives refer, the Enrollee to a Participating Provider in all circumstances except for: (a) Emergency Services; or (b) when Department has granted a Prior Authorization for non-Participating Provider services. For certain specialized procedures and services, Department may require that the most cost-effective, qualified Participating Provider is utilized for such care. Additionally, Provider shall admit Enrollees only to designated hospitals which are Participating Providers.

B. 15 Drug Formulary. Provider shall also comply, and ensure that its Provider Representatives comply, with Department' policies and procedures for obtaining coverage for non-formulary medications, restricted formulary medications and all other matters related to the provision of pharmacy services.

B. 16 Insurance Provider shall maintain insurance policies, issued by one or more insurance companies licensed to do business in Colorado, with policy limits equal to, or in excess of, the minimum amounts required by State and Federal Law or the amount specified below, whichever is greater. Provider agrees to provide to Department written evidence of such insurance coverage within 3 calendar days of request by Department. Provider also agrees to notify, or to ensure that its insurance carriers notify, Department at least 30 calendar days before any proposed termination, cancellation, or material modification of any insurance policy specified below. Provider shall maintain the following insurance policies for insurance coverage of activities performed in connection with this Agreement:

(a) Professional liability insurance that meets the requirements of the Colorado Health Care Availability Act, as amended;
(b) Comprehensive general liability insurance covering claims for damages arising out of premises liability, personal injury liability, and contractual liability, with minimum policy limits of $1,000,000 per occurrence and $3,000,000 in the aggregate of all claims per policy year; and
(c) Workers' compensation insurance covering all employees.

Provider shall ensure that Provider Representatives and Provider's subcontractors who perform services in connection with this Agreement and who are not insured under Provider's insurance policies shall maintain the same insurance coverage required of Provider under this Section unless otherwise permitted by Department in writing. All insurance required under this Agreement shall be provided by insurers who have an A.M Best's rating of A: VIII or better.

B. 17 Grievance System. Provider shall comply with the applicable Benefit Program's Enrollee grievance procedures as described in the CHP+ Provider Manual.

B. 18 Advance Directives Provider shall abide by an Enrollee's advance directives regarding life-sustaining treatment in accordance with State and Federal Law. Provider shall prominently document in each Enrollee's medical record whether or not the Enrollee has executed an advance directive.

B. 19 New Enrollees. Pursuant to Colorado Revised Statutes § 25-37-101(12), Provider may decline to provide services to New Enrollees of the Program by providing written notice to Department at least 60 calendar days before the effective date of such declination. Such notice shall state the reason(s) for Provider's decision. For purposes of this Section, "New Enrollees" mean those patients who have not received services from Provider in the immediately preceding 3 years. A patient shall not become a "New Enrollee" solely by changing coverage from one person or entity to another person or entity.

B. 20 Electronic Data Interchange Terms and Conditions. (only applies to Providers submitting/receiving data electronically)
a) The Parties agree to submit claims and exchange data electronically using only those approved transaction types and formats (versions) as selected by Provider within the Provider Enrollment Form.
b) For electronic claims, Provider will ensure that all required provider and patient signatures, including where applicable, appropriate signatures on behalf of patient, and required physician certifications are on file in Provider's office.
c) Transactions/documents will be transmitted electronically either directly or through a contracted third party service provider, such as a vendor, billing agent, or clearinghouse. Provider may modify its election to use, not use, or change a third party service provider by updating the Provider Enrollment Form. Provider will be responsible for the costs of any third party service provider for which it contracts, and will ensure that any third party service provider contracted will properly institute and adhere to those procedures reasonably calculated to provide appropriate levels of security for the authorized transmission of data, and protection from improper access. No Party accepts responsibility for technical or operational difficulties that arise out of third party service providers' business obligations and requirements that undermine the Transaction exchange between Provider and the Department or the Department's designated representative.
d) The Parties will not change any definition, data condition, or use of a data element or segment in a Standard transaction they exchange electronically, as per 45 C.F.R. §162.915.
e) The Parties will not add any data elements or segments to the maximum defined data set, as per 45 C.F.R. §162.915.
f) The Parties will not use any code or data elements that are either marked "not used" in a standard's implementation specification or are not in the standard implementation specification(s) as per 45 C.F.R. §162.915
g) The Parties will not change the meaning or intent of a Standard's implementation specification(s), as per 45 C.F.R. §162.915.
h) Transactions are considered properly received only after accessibility is established at the designated machine of the receiving Party. Once transmissions are properly received, the receiving Party will promptly transmit an electronic acknowledgement that conclusively constitutes evidence of properly received Transactions. Each Party will subject information to virus check before transmission to the other Party.

B. 21 Expenditures of Federal Assistance Provider and Provider Representatives agree to notify the Colorado Department of Health Care Policy and Financing when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. The Office of Management and Budget (OMB) Circular No. A-133, Audits of States, Local Governments, and Non-Profit Organizations, defines audit requirements under the Single Audit Act of 1996 (Public Law 104-156). All state and local governments and non-profit organizations expending $500,000 or more from all sources (direct or from pass-through entities) are required to comply with the provisions of Circular No. A-133. The Circular also requires pass-through entities to monitor the activities of subrecipients and ensure that subrecipients meet the audit requirements.

B. 22 Incorporated Documents The most current CHP+ Provider Manual and Evidence of Coverage are hereby incorporated into this Agreement. The Contractor hereby certifies that it has read, understands, and agrees to abide by all provisions of the CHP+ Provider Manual and Evidence of Coverage prepared by the Department, both of which are on the CHP+ Provider Website at http://www.chpplusproviders.com/. From time to time, the Contractor will be notified in writing by the Department of changes to the CHP+ Provider Manual and Evidence of Coverage. Contractor shall adhere to the policies, procedures and requirements set forth in the most recent version of the CHP+ Provider Manual and the Evidence of Coverage.

C. COMPENSATION

C. 1 Compensation Rates. Provider and its Provider Representatives shall accept as payment in full for Covered Services, and all other services rendered to Enrollees under this Agreement, the amounts payable by Department or, on behalf of the Department, the CHP+ Program Administrative Services Organization (ASO) Provider, on a fee for service basis in accordance with the CHP+ Fee Schedule established by the State and specified in the CHP+ Provider Manual and on the Department's CHP+ website. Provider may require its Provider Representatives to bill and accept compensation directly from Department or ASO. In lieu of such arrangement, Provider shall bill and accept payment for Covered Services rendered by its Provider Representatives, and be responsible for administering such funds and compensating its Provider Representatives. Provider will only request payment for Covered Services which are Medically Necessary Services and rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision. Claims will be submitted only for those benefits provided by health care personnel who meet the professional qualifications established by the Department. Provider understands that any misrepresentation or falsification by another may result in fine and/or imprisonment under state or federal law.

C. 2 Billing and Payment. .

(a) Billing. Provider will accept full legal responsibility for all claims submitted and will comply with all federal and state civil and criminal statutes, regulations and rules relating to the delivery of benefits to eligible Enrollees. Provider understands that non-compliance will result in no payment for services rendered. Provider shall submit to Department, on a Uniform Claim Form, by electronic claims submission or hard copy, Clean Claims in a format approved by Department for Covered Services provided to an Enrollee within 180 calendar days after such services are rendered. Where Department is the secondary payer under Coordination of Benefits, a claim must be received by Department within 180 calendar days of the date that the primary Payer issues its remittance advice. Neither Department nor any Payer shall be under any obligation to pay Provider for any claim not timely submitted. Provider shall not seek payment from any Enrollee in the event Department or a Payer fails to pay Provider for a claim not timely submitted.

(b) Payment. Unless the Program allows otherwise, Department shall make payment on, deny, or settle each of Provider's Clean Claims timely submitted for Covered Services within 30 calendar days for claims received by Department electronically, within 45 calendar days for claims received by Department by any other means, or within the time required by State and Federal Law, whichever is earlier. Penalties for noncompliance shall be as set forth in State and Federal Law.

(1) Payment shall also be the lesser of the billed charges or payment amount allowed under this Section, minus the Copayment, when applicable.

(2) The CHP+ Fee Schedule is based on the Centers for Medicare and Medicaid Service's (CMS) Resource Based Relative Value Scale (RBRVS) as adjusted for Colorado. CHP+ uses two separate conversion factors to calculate reimbursement: a) Medical/Surgical/Laboratory and b) Anesthesia. Most labs, durable medical equipment, and injectable drugs are paid on a flat fee basis. The Department may modify these rates during the term of this Agreement in accordance with changes in RBRVS by Medicare. In instances where the RBRVS method does not set unit values, CHP+ uses a modified Medicare fee schedule.

(3) Inpatient Hospital Services: The Department or its designees(s) shall reimburse a percentage calculation to the Provider for all inpatient hospital Covered Services based on the Colorado Medicaid DRG reimbursement schedule as defined in 10 CCR 2505-10 8.300.5.A-D, unless otherwise specified in this Agreement.

(II) The reimbursement percentage calculation shall be set at the percentage indicated on the CHP+ Provider Website at:

www.chpplusprovider.com/providers and staff/fee schedule and reimbursements

(4) Outpatient Hospital Services: The Department or its designee(s) shall reimburse a percentage calculation to the Provider for all outpatient Covered Services based on the Colorado Medicaid outpatient reimbursement methodology as defined in 10 CCR 2505-10 8.300.6.A.1 that is in effect on July 1st each year, without additional revision, unless otherwise specified in this Agreement.

(II) The reimbursement percentage calculation shall be set at the percentage indicated on the CHP+

Provider Website at:
www.chpplusprovider.com/providers and staff/fee schedule and reimbursements

(III) Reimbursement for outpatient Covered Services as described above shall constitute full and final payment for all outpatient services and benefits rendered during the billing period.

(IV) The Department's fee schedule methodology shall not be used for calculating outpatient Covered Services reimbursement.

(5) The reimbursement percentage calculation shall be updated on the CHP+ Provider Website annually on or about July 1st. The Department shall provide the Provider with at least ninety (90) days prior notice of any change to the reimbursement amount specified on the CHP+ Provider Website by updating the CHP+ Provider Website.

(6) Primary and Specialty Care: All claims for Professional Services shall be paid on a fee-for-service basis in accordance with the CHP+ Fee Schedule established by the State and specified in the CHP+ Provider Manual, regardless of whether the services are provided on an inpatient or outpatient basis.

(7) Whenever reimbursement equals the Maximum Service Reimbursement minus applicable Copayments, Provider shall make a Reimbursement Adjustment. The amount of the Reimbursement Adjustment shall not be the responsibility of the Enrollee or the Department.

(8) Reimbursement will not be increased for additional costs resulting from Serious Reportable Events during an inpatient hospital stay as identified in the CHP+ Provider Manual. Members cannot be billed or balance-billed for services related to Serious Reportable Events. No payment will be made for hospitalizations for Serious Reportable Events.

(c) Department payment by electronic funds transfer ("EFT") and advisement by deposit notice or remittance statement represents Provider's confirmation that funds were accepted for services rendered and billed.

(d) Provider, and person signing the claim or submitting electronic claims on Provider's behalf, understands that failure to comply with the provisions of this Agreement in a true and accurate manner will result in any available administrative or criminal action available to the Department, the State Attorney General's Medicaid Fraud Control Unit, or other government agencies. The knowing submission of false claims or causing another to submit false claims may subject the persons responsible to criminal charges, civil penalties, and/or forfeitures.

C. 3 Eligibility. Except for Emergency Services, Provider shall verify the eligibility of Enrollees before providing Covered Services.

C. 4 Collection of Copayments. Provider shall collect all applicable Copayments due from Enrollees, and shall not waive or fail to collect Copayments from Enrollees without first making reasonable attempts to collect. Department shall not impose Copayments that exceed the cost-share amounts permitted under Title XXI if the individual were not enrolled with Department. Provider agrees to accept the Department payment in full, or bill the appropriate State source.

C. 5 No Surcharges. Provider shall not charge an Enrollee any fees or surcharges for Covered Services except for authorized Copayments. In addition, Provider shall not collect sales, use, or other applicable taxes from Enrollees for the sale or delivery of medical services. If Department or any Payer receives notice of any additional charge, Provider shall fully cooperate with Department or such Payer to investigate such allegations, and shall promptly refund any payment deemed improper by Department or a Payer to the party who made the payment.

C. 6 Enrollee Hold Harmless. Provider agrees that, in no event, including nonpayment by Department, the insolvency of Department, or breach of this Agreement by any party, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Enrollees or persons other than Department. This provision shall not prohibit collection of Copayments on Department' or a Payer's behalf in accordance with the terms of the Program. Provider further agrees that this provision: (a) shall survive the termination of this Agreement regardless of the cause giving rise to termination; (b) shall be construed for the benefit of Enrollees; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Enrollees or persons acting on their behalf.

C. 7 Conditions for Compensation of Non-Covered Services Provider may bill an Enrollee for non-Covered Services

rendered by Provider to such Enrollee only if the Enrollee is specifically notified in advance that the specific services to be provided are not covered under the Enrollee's Benefit Program, and the Enrollee nonetheless requests in writing that Provider render the specific non-Covered Services, prior to Provider's rendition of such services. This notification must be signed by each applicable Enrollee for each applicable service. For purposes of this provision, a general waiver under which an Enrollee acknowledges he/she may be responsible for payment in the case of non-payment by a carrier is not sufficient. The Enrollee, Department, and any Payer shall not be liable to pay Provider for any Covered Service rendered by Provider to an Enrollee which is determined under a Utilization Management Program not to be Medically Necessary Services.

C. 8 Patients Who Are Not Enrollees. This Agreement does not apply to services rendered to patients who are not Enrollees at the time the services are rendered, except as provided in Section D.6 below.

C. 9 Coordination of Benefits. Provider agrees to abide by the Coordination of Benefits policies and procedures established by Department or a Payer for the Program. Provider shall not bill Enrollees for any portion of Covered Services not paid by the primary carrier when Department or Payer is the secondary carrier, but shall instead look to Department or Payer for such payment. When a Enrollee has coverage which is primary through another carrier, Department' or a Payer's compensation to Provider shall be the difference between the amount paid by the primary payer and total billed charges, limited to Department' or Payer's negotiated rates contained in the applicable Addendum to this Agreement.

C. 10 Third Party Recoveries. When Department or a Payer has compensated Provider for Covered Services, then Department or a Payer retains the right to recover from applicable third party carriers covering an Enrollee, including self-insured plans and other third party sources, and to retain all such recoveries. Provider agrees to provide Department with such information as Department may require to pursue recoveries from such third party sources and to promptly remit to Department any monies Provider may receive from, or on behalf of, such sources of recovery.

C. 11 Overpayments. Unless required by State or Federal Law, Department shall have the right to periodically audit Provider's records to assure appropriate reimbursement. Department shall recoup amounts paid to the Provider in error for a period of up to twelve (12) months following the payment error. Unless required by State or Federal Law, error may be a process error on the part of Department, the Provider, or otherwise. Error includes, but is not limited to, inappropriate charges, lack of eligibility, or computer error. Recoupments shall be due within 30 calendar days of the finding and shall be recouped by reduction of future payments by Department to the Provider or direct payment by the Provider, whichever Department deems appropriate. Any and all incorrect payments discovered as a result of an audit will be adjusted or fully recovered according to the applicable provisions of the Social Security Act, as amended, federal or state laws, regulations, and guidelines.

C. 12 Disputed Claims. Upon the initiation of any action by the Department or its designee(s) regarding the payment of claims for Covered Services provided by the Provider hereunder, the Department or its designee shall issue written notice to the Provider as specified in the CHP+ Provider Manual. If Provider disagrees with the action taken or the amount paid by the Department or its designees(s) on any claim submitted under this Agreement, Provider must notify the Department or its designee(s) in writing of such dispute within 90 days after the claim is paid or denied.

The Provider hereby waives any right to dispute the amount of payment or any other action taken by the Department or its designee(s) on a claim for Covered Services provided by the Provider hereunder unless notification is received within the time frame specified in the preceding paragraph above. In such event, Provider shall be prohibited from collecting any payment from the Enrollee.

C. 13 Limitation of State Financial Liability/Suspension of Enrollment and Services. Payment pursuant to this Agreement shall be made as earned, in whole or part, from available State and federal funds, in an amount not to exceed the amount of funds available for each fiscal year this contract is in effect for the purchase of all medical services for the Program. The funds that are available for each fiscal year may be used to pay multiple Providers for services that are described in this Agreement. The eligibility of the State, at any time, for such payments shall be limited to the unexpended amount remaining of such funds.

Pursuant to section 25.5-8-108 C.R.S., if the State determines that eligibility guidelines must be adjusted or additional enrollment in the Program must be suspended and/or terminated due to insufficient funds, eligibility guidelines may be adjusted or additional enrollment terminated for the entire Program. If the State determines that the delivery of Covered Services to Enrollees in the Program must be adjusted, suspended or terminated due to insufficient funds, the delivery of Covered Services may be suspended or terminated for the entire Program.

The State shall provide at least 60 days prior written notice to the Provider before eligibility guidelines are adjusted or

enrollment in the Program and/or the delivery of Covered Services to Enrollees in the Program is suspended or terminated. Additional enrollment in the Program and/or the delivery of Covered Services by the Provider to Enrollees in the Program shall cease or be limited or adjusted consistent with the directions in such written notice by the State.

C. 14 Laboratory Testing. Provider agrees to comply with Section 353 of the Public Health Service Act (42 U.S.C. § 263a) as revised by the Clinical Laboratory Improvement Amendments ("CLIA") of 1988 or, in the alternative, shall provide Department with a Certificate of Waiver as issued by the Department of Health and Human Services with regard to Provider location as applicable

D. TERM AND TERMINATION

D. 1 Term. The term of this Agreement shall commence on the date set forth on the first page of this Agreement and it shall continue in effect for successive annual periods, unless one party notifies the other in writing of its intent not to renew this Agreement at least 120 calendar days before the next scheduled renewal date.

D. 2 Immediate Termination. Department may terminate this Agreement or any individual Provider Representative's participation under this Agreement immediately upon notice to Provider in the event of:

(a) Provider's violation of any applicable State or Federal Law;
(b) Provider's failure to maintain the professional liability insurance coverage specified hereunder;
(c) Provider's exclusion or voluntary exclusion from State or Federal programs;
(d) Provider's loss or suspension of licensure, certification(s) and/or registration(s) to provide Covered Services in the State of Colorado.
(e) Department' determination that the health, safety, or welfare of any Enrollee may be in jeopardy if this Agreement is not terminated, or
(f) Provider's notice or failure to provide notice under Section B.8 or Section B.9 above.

D. 3 Termination Due to Material Breach. In the event that either Provider or Department fails to cure a material breach of this Agreement within 30 calendar days of receipt of written notice to cure, the non-defaulting party may terminate this Agreement effective as of the expiration of said 30-day period. If the breach is cured within such 30-day period, or if the breach is one which cannot reasonably be cured within 30 calendar days, and the non-defaulting party determines that the defaulting party is making substantial and diligent progress toward correction during such 30-day period, this Agreement shall remain in full force and effect. Examples of material breach include but are not limited to (1) Provider's failure to maintain the credentialing standards specified hereunder, and (2) Provider's failure to comply with the terms, conditions or determinations of any Utilization Management Program, Quality Management Program, or other Program Requirements.

D. 4 Termination without Cause .Either party may terminate this Agreement without cause upon written notice to the other party at least 90 calendar days before the termination effective date.

D. 5 Right of Partial Termination . Either party may terminate this Agreement in accordance with D.4 above with respect to the Program as may be indicated in the notice of termination. Department reserves the right to immediate partial termination if the State or Federal government terminates the Program or Department' participation in the Program. In the case of partial termination, this Agreement shall remain in full force and effect for all other Enrollees.

D. 6 Continuity of Care. In the event that a Enrollee is receiving Covered Services at the time this Agreement terminates, Provider shall continue to provide Covered Services to the Enrollee until:

(a) The Enrollee is assigned to another Participating Provider (with which Provider shall cooperate);
(b) The Enrollee is discharged from an inpatient facility, if an inpatient on the date of termination;
(c) Conclusion of an active treatment regimen, or up to 60 calendar days, unless otherwise specified in the Program Requirements, if the Enrollee is receiving active treatment from Provider for a chronic or acute medical condition;
(d) The postpartum period for Enrollees in their second or third trimester of pregnancy; or
(e) The Enrollee is no longer an Enrollee.

Compensation for such Covered Services shall be according to the provisions agreed to in Section C of this Agreement.

D. 7 If at any time the Department determines that Provider has failed to maintain compliance with any state or federal laws, rules or regulations, Provider may be suspended from participation in the Children's Basic Health Plan and other State administered Medical Assistance Programs, and may be subjected to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

E. AMENDMENTS AND CHANGES

E. 1 Material Changes. Department may make a Material Change to this Agreement by giving to Provider 90 days advance written notice of the Material Change. Such notice shall be conspicuously entitled "Notice of Material Change." If Provider objects in writing to the Material Change within 15 calendar days of the notice, and there is no resolution of the objection by mutual agreement between Department and Provider, either party may terminate this Agreement upon written notice of termination provided to the other party. Such notice of termination shall not be effective unless given at least 60 calendar days before the effective date of the Material Change. If Provider does not so object to the Material Change, the Material Change shall be effective as specified in the "Notice of Material Change." If a Material Change is the addition of a new category of coverage and Provider so objects, the addition shall not be effective as to Provider, and the objection shall not be a basis upon which Provider may terminate this Agreement.

E. 2 Non-Material Changes. Pursuant to Colorado Revised Statutes § 25-37-101(2)(e)(i-ii), Department may make a non-Material Change to this Agreement by giving to Provider a written notice of the non-Material Change. Such non-Material Change shall be effective 15 calendar days after Department' issuance of such notice unless another later effective date is set forth in such notice. Examples of non-Material Changes include but are not limited to (1) changes to an existing prior authorization, notification, or referral program that do not substantially increase the Provider's administrative expense, and (2) changes to an edit program or to specific edits.

E. 3 Changes Required by State and Federal Law. Amendments mandated because of legislative or regulatory changes made by State and Federal government agencies may not require the consent of Provider and /or Department. Such amendments will be effective on the effective date established by such government agencies. Any amendment to this Agreement requiring prior approval of, or notice to, any State or Federal agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired.

F. ACCESS TO CONFIDENTIALITY OF RECORDS

F. 1 Medical and Other Records. Provider warrants that it prepares and maintains, and will continue to prepare and maintain, all medical and other records required by State and Federal Law in accordance with the general standards, including, but not limited to, accuracy and privacy standards, applicable to such records. Provider and any subcontractor shall maintain such financial, administrative, and other records as may be necessary for compliance by Department and Payers with State and Federal Law.

F. 2 Access to Records: Audits. The records referred to in Section F.1 shall be and remain the property of Provider and/or any subcontractor(s), and shall not be removed or transferred from Provider or any subcontractor(s) except in accordance with HIPAA and other State and Federal Law. Subject to such laws, Department and Payers, or their designated representatives, and designated representatives of any government agency having jurisdiction over Department or any Payer, shall have reasonable access to Provider's records, the applicable records of any subcontractors at Provider's or subcontractor's place of business during normal business hours, to review and make copies of such records or any information submitted by Provider. Such governmental agencies shall include the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy & Financing, the Colorado Division of Insurance, the United States Department of Health and Human Services, the State Attorney General's Medicaid Fraud Control Unit, and their designees. Additionally, Provider agrees to permit Department, its designated representatives, and designated representatives of such government agencies to conduct site evaluations and inspections of Provider's and/or any of its subcontractor's offices and service locations. Provider shall keep all records related to performance under this Agreement for 6 years unless an additional retention period is under state or federal regulations, such as an audit started before the 6 year period ended or based on a specific contract between the Provider and the Department.

F. 3 Confidentiality. In accordance with the requirements set forth in HIPAA, Provider and Department during and after the

term of this Agreement shall keep confidential any information regarding the diagnosis, treatment, or health of any Enrollee. Confidential data and information means any information in a form identifiable with the Enrollee, including but not limited to, Enrollee medical records, quality improvement information, utilization review information, statistical data, and reports, whether oral, written, or electronic. Department and Provider agree that nothing in this Section shall be construed as a limitation of the Provider's right or obligation to discuss with the Enrollees matters pertaining to their health. Provider acknowledges that access to the Department on-line services system and the information it contains is confidential. Provider also warrants that access to the Department on-line services system is restricted to the authorized users or the system. Any breach of this section may result in the loss of access to the system.

Provider agrees that in the event the Department determines, or has a reasonable belief that Provider has made or may have made disclosure of Colorado Children's Basic Health Plan client protected health information that is not authorized by this Agreement, the Provider Enrollment Form, or other written Department authorization, the Department, in its sole discretion, may require Maximus and/or Provider to: (a) promptly investigate and report to the Department determinations regarding any alleged or actual unauthorized disclosure; (b) promptly resolve any problems identified by the investigation; (c) submit a formal written response to an allegation of unauthorized disclosure; (d) submit a corrective action plan with steps designed to prevent any future unauthorized disclosures; and/or (e) return data to the Department.

F. 4 Copy charges. When requested by Department or representatives of local, state or federal regulatory agencies, Provider, Provider's Representatives and/or any subcontractor(s) shall produce copies of any Medical or Other Records as outlined in Section F.1 at the State prevailing rate as set forth in 6 CCR 1011-1, Chapter II 5.2.3.4. In no event shall Department be responsible for other costs or fees associated with any audit. Additionally, Department shall not reimburse Provider for copies of Medical or Other Records related to the payment of claims, credentialing, procedures related to pre-service determination, medical coverage determinations, medical necessity determinations and/or care management. Department agrees to reimburse Provider for Medical or Other Records related to quality management reviews.

G. MISCELLANEOUS

G. 1 **INDEPENDENT PROVIDER STATUS**. Provider shall perform its duties hereunder as an independent Provider and not as an employee of Department. Neither Provider nor any agent or employee of Provider shall be, or shall be deemed to be, an agent or employee of Department. Provider shall pay, when due, all required employment taxes, income taxes, and local taxes on any money paid pursuant to this Agreement. Provider acknowledges that Provider and its employees are not entitled to unemployment insurance benefits unless Provider or a third party provides such coverage, and that Department does not pay for or otherwise provide such coverage. Provider shall have no authorization, express or implied, to bind Department to any agreements, liabilities, or understandings except as expressly set forth in this Agreement.

G. 2 This Agreement is subject to and contingent upon the continuing availability of federal funds for the purpose hereof.

G. 3 Payment of Applicable Taxes. Provider shall be solely responsible for the collection and payment of any sales, use or other applicable taxes on the sale or delivery of medical services.

G. 4 G. 4 Right to Disagree Concerning Medical Decisions, Policies, or Practices. In accordance with Colorado Division of Insurance Regulation § 4-2-17:

(a) No Provider or Provider Representative shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Department or an entity representing or working for Department.

(b) Department, or an entity representing or working for Department, shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of a Provider or Provider Representative.

(c) Department shall not terminate this Agreement because a Provider or Provider Representative expresses disagreement with a decision by Department, or an entity representing or working for Department, to deny or limit benefits to a Enrollee or because the Provider or Provider Representative assists the Enrollee to seek reconsideration of Department' decision, or because a Provider or Provider Representative discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether a Covered Service or not, or policy provisions of Department, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.

G. 5 Non-solicitation for Discontinuance of Participation Provider and its employees, agents, and subcontractors shall not solicit, or attempt to convince, any Enrollee not to participate or to discontinue participation in the Program for which Provider renders Covered Services under this Agreement.

G. 6 Nondiscrimination. Provider agrees that, in providing services, Provider shall comply with the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and all related implementing regulations. Provider shall not discriminate against any Enrollee on the basis of race, color, religion, sex, national origin, age, health status, participation in any government program (including Medicaid and Medicare), source of payment, participation in a health plan, marital status, or physical or mental disability. Nor shall Provider knowingly contract with any person or entity which discriminates against any Enrollee on such basis.

G. 7 Listing of Information Both parties agree that Department and Provider may list the name, address, telephone number and other factual information of Department, Provider, Provider location, Provider Representatives, and Provider's subcontractors in its marketing and informational materials. Either party shall supply all printed materials and other information relating to its operations within 7 calendar days of request by the other party.

G. 8 Marketing. All marketing materials including, but not limited to, brochures, pamphlets, or benefit plan and enrollment information with either parties name on it, must be approved by the other party.

G. 9 Assignment. Pursuant to Colorado Revised Statutes § 25-37-101(10), Department and Provider agree that this Agreement applies to network rental arrangements and it is for the purpose of assigning, allowing access to, selling, renting, or giving Department' rights to the Provider's services. Any third party accessing the Provider's services through this Agreement is obligated to comply with all applicable terms and conditions of this Agreement, except that a self-funded plan receiving administrative services from Department or its affiliates shall be solely responsible for payment to the Provider. Provider may not assign this Agreement, or its respective rights and obligations under this Agreement, without the prior written consent of Department. Such consent shall not be unreasonably withheld by Department.

G. 10 Confidentiality of Proprietary Information Department and Provider agree to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated in this Agreement, and not for any other purpose. Specifically, Department and Provider shall keep strictly confidential all compensation rates set forth in this Agreement and its Addenda, except that this provision does not preclude disclosure of the method of compensation (*e.g.*, fee-for-service, capitation, shared risk pool, DRG, per diem, etc.), unless otherwise required by State or Federal Laws.

G. 11 Dispute Resolution. Provider and Department agree to meet and confer in good faith to resolve any problems or disputes that may arise under or relate to this Agreement. Negotiation shall be a condition precedent to the filing of any arbitration demand by either party, and no arbitration demand may be filed until the exhaustion of Department' internal appeal procedures by Provider, as set forth in the CHP+ Provider Manual. If the parties are unable to resolve any significant dispute within 60 calendar days following the date one party sent written notice of the dispute to the other party, and if either party then decides to pursue the dispute, the dispute shall thereafter be submitted to binding arbitration through the American Arbitration Association under its Commercial Arbitration Rules, with the arbitration to be held in Denver, Colorado or another location by mutual agreement. Judgment on the award rendered by the arbitrator may be entered in any court of competent jurisdiction. Arbitration shall be initiated by either party by making a written demand for arbitration on the other party. Disputes regarding claims payments or denials and/or overpayments or underpayments shall be submitted to arbitration no more frequently than once a calendar quarter. The arbitrator shall have the power to resolve all disputed issues, including questions concerning the enforceability of this Agreement and whether the dispute is subject to arbitration. The arbitrator shall also have the power to make interim awards (*e.g.*,

temporary restraining orders, preliminary injunctions, etc.). No party shall be able to recover any exemplary or punitive damages. Unless otherwise agreed by the parties in writing, the party wishing to pursue the dispute must initiate the arbitration within one year after the date on which notice of the dispute was given or that party shall be deemed to have waived its right to pursue the dispute in any forum. Except for termination pursuant to Sections D.2 of this agreement, during the arbitration proceedings, Provider shall continue to provide Covered Services to Enrollees and Department shall continue to make any undisputed payments to Provider in accordance with this Agreement.

G. 12 Entire Agreement. This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

G. 13 Survival. The following Sections of this Agreement shall survive any termination of this Agreement: Section A, Section C, Section D.6, Section F, Sections G.2 through G.7, Sections G.9 through G.12, and Sections G.15, G.16, G.18, G.19, G.20, and G.22.

G. 14 Non-Exclusive Agreement. This Agreement is non-exclusive and shall not prohibit Provider or Department from entering into other agreements with other health care providers or purchasers of health care services.

G. 15 No Third Party Rights . Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or or remedies in any third party, including Enrollees and Provider Representatives. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Enrollees or the duties or responsibilities of Provider or Department as to such Enrollees.

G. 16 Notices. Any notice required or desired to be given under this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or overnight courier, or fax, addressed as follows. The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section.

Department: Department
ATTN: Provider Contracting
PO Box 17580
Denver, Colorado 80217-0580
Fax number: (303) 755-2368

Provider: Gunnison County
ATTN: Hap Channell
225 N Pine Street
Gunnison, CO 81230

G. 17 Severability. If any provision of this Agreement is rendered invalid or unenforceable by any local, state, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

G. 18 Addenda. Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement.

G. 19 Governing Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Colorado without regard to conflicts of laws principles, except to the extent such laws conflict with, or are preempted by, federal law, in which case such federal law shall govern.

G. 20 Liability of Own Acts. Each party shall be solely responsible for all direct, compensatory, special, indirect, incidental, consequential, punitive, and other damages of every type, which are assessed against and/or incurred by such party, whether by verdict, settlement, or otherwise, and which arise out of or result from: (a) the acts or omissions of such party or its employees or subcontractors; (b) any breach by such party of any duty or obligation arising under this Agreement; and/or (c) any violation by such party of State and Federal Law or any judicial or administrative order.

G. 21 Federal Fund Disclosure.

(a) No federal appropriated funds have been paid or will be paid by, or on behalf of, Provider to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any contract. This includes the extension, continuation, renewal, amendment, or modification of any contract, grant, loan or cooperative agreement that utilizes federal funds.

(b) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress in connection with this federal contract, grant, loan, or cooperative agreement, Provider shall complete and submit Standard Form - LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(c) The Provider agrees that it shall include the language of this Section G. 21 in all subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements. Provider shall require that all subrecipients certify and disclose accordingly. Furthermore, this certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31 U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

G. 22 Fraud and Compliance Hotline. Provider should report issues of suspected or potential fraud to the Department Compliance Hotline (877-363-3065) or the Department Compliance Officer. Such reports may be made anonymously and/or the reporting individual or party may request confidentiality. Provider must make reasonable efforts to assist in detecting, reporting, and preventing false claims and other fraudulent or abusive practices.

G. 23 Compliance with Laws. Department and Provider shall comply with all relevant State and Federal Laws, local laws, statutes, ordinances, orders and regulations applicable to the terms and conditions of this Agreement and all requirements set forth under the Medicare, Medicaid and the Children's Basic Health Plan programs and any rules and regulations promulgated thereunder, as such standards, requirements, rules and regulations may be amended from time to time. Additionally, Provider warrants that it will comply with the National Labor Department Regulations regarding employee notification requirements for federal Providers and subcontractors as set forth in 29 CFR Part 471, Appendix A to Subpart A.

G. 24 Compliance with Federal and State False Claims Acts and Regulations . Provider acknowledges that, with regard to certain State and Federal health care programs, the federal False Claims Act and similar state laws (collectively, the "FCA") prohibit billing for services or goods not provided, billing for undocumented services, billing for services that are medically unnecessary, participating in unlawful kickbacks and rebates, and other inappropriate or wasteful conduct. Provider understands that a violation of the FCA may result in financial penalties, exclusion from the Children's Basic Health Plan and Medicaid program, and imprisonment. If Provider has not implemented its own policies and procedures regarding FCA compliance pursuant to the Deficit Reduction Act of 2005 (the "DRA"), Provider agrees to make a copy of Department' Deficit Reduction Act fact sheet at www.coaccess.com available to Provider's officers, employees, and agents who will assist with Provider's rendering of health items or services, or billing or coding functions.

G. 25 Physician Self-Referral and Anti-Kickback Compliance Provider represents that Provider and its Provider Representatives have not entered into, and during the term of this Agreement agree not to enter into, any financial relationships prohibited under the Federal Physician Self-Referral law (42 U.S.C. § 1395nn), associated implementing regulations, and similar State statutes and regulations. Provider further represents that Provider and its Provider Representatives have not engaged in, and during the term of this Agreement, will not to engage in any activities prohibited under the federal Anti-Kickback statutes (42 U.S.C. §§ 1320a-7, 1320a-7a, and 1320a-7b), associated implementing regulations, and similar State statutes and regulations.

[Signature Page Follows]

This Agreement shall become effective as of the date indicated in the first sentence of this Agreement and shall not be considered executed until both parties have affixed their signatures below.

Gunnison County

_____
Signature

_____
Printed Name

_____
Title

_____
Date

Child Health Plan *Plus*
Administrative Service Organization

_____
Signature

_____
Printed Name

_____
Title

_____
Date

Child Health Plan Plus Contract Questionnaire

The purpose of this questionnaire is to have the most accurate and up-to-date information to ensure you receive reimbursement in a timely manner and that CHP+ members are appropriately assigned or referred as applicable. This form represents the most recent contracting and supplemental information received by your office as it appears in our database. Please verify and update the information provided and return this questionnaire with your signed contracts. Changes may be made directly on this form. Please send any additional information on a separate page if there is insufficient space for this information. We appreciate your assistance in completing this information and your participation in the Child Health Plan Plus program! THANK YOU!

Demographic Information

Legal Name (as it appears on your W-9) : Gunnison County
Common Name or "d.b.a" : Gunnison County Public Health
Federal Tax I.D. Number :(if your TIN has changed, you will need to submit a new W9 with your contract.) 84-6000770
Contract Type : Specialty
Billing Address : 200 E Virginia Gunnison, CO 81230
Mailing Address : 225 N Pine Street Gunnison, CO 81230
Primary Phone Number : 970-641-0209
Secondary Phone Number(If Any) :
Fax Number : N/A
Email Address :

Administrative Information

Please list the contacts most appropriate for your practice to ensure clear communication about claims, policies, and procedures.

Administrator: Carol Worrall, RN Phone: 970 641-0209
Office/Business Manager: Randy Morgan Phone: 970 641-0209
Billing/Claims: Randy Morgan Phone: 970-641-0209
Referal Coordinator: Carol Worrall, RN Phone: 970-641-0209
Executive Director: Renee Brown Phone: 970-641-3244
Other: Phone:
Authorized Signatory: Phone:

Practice or Office Locations

Location 1 : Gunnison County Public Health, 225 N Pine Street Suite E Gunnison CO 81230
County : Gunnison **Phone** : 9706410209

☐ Available 24-7 ☐ Prenatal PCP ☐ OB Care ☐ Community Health Center

Location 2 : Gunnison County Public Health, 507 Maroon Street Crested Butte CO 81224
County : Gunnison **Phone** : 9706410209

☐ Available 24-7 ☐ Prenatal PCP ☐ OB Care ☐ Community Health Center

Clinical Staff Information (for Primary and Specialty Providers Only)

Please verify and update the following information for all health care providers (including MDs, DOs, Pas, CHAs, NPs who could have CHP+ members assigned to them as their Primary Care Provider). For additional clinical staff, attach additional copies of this form.

Name	Degree	License #	Dea #	Board Certified	Gender	Language	Ethnicity
Nicol C Talbert	PA	2297	N/A	NO	Female	English	N/A
Hospital Admitting Privileges (Where?) N/A							

Location Information	Specialty	Prenatal PCP?	24 hr/7 day coverage	New Patients?	Age Group Served	HMO Affiliation
Gunnison County Public Health 225 N Pine Street Suite E	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+
Gunnison County Public Health 507 Maroon Street	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+

Name	Degree	License #	Dea #	Board Certified	Gender	Language	Ethnicity
Brenda Ryan	RN	192117	N/A	NO	Female	English	N/A
Hospital Admitting Privileges (Where?) N/A							

Location Information	Specialty	Prenatal PCP?	24 hr/7 day coverage	New Patients?	Age Group Served	HMO Affiliation
Gunnison County Public Health 225 N Pine Street Suite E	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+
Gunnison County Public Health 507 Maroon Street	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+

Name	Degree	License #	Dea #	Board Certified	Gender	Language	Ethnicity
Carol Worrall	RN	122880	N/A	NO	Female	English	N/A

Hospital Admitting Privileges (Where?)
N/A

Location Information	Specialty	Prenatal PCP?	24 hr/7 day coverage	New Patients?	Age Group Served	HMO Affiliation
Gunnison County Public Health 225 N Pine Street Suite E	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+
Gunnison County Public Health 507 Maroon Street	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+

Name	Degree	License #	Dea #	Board Certified	Gender	Language	Ethnicity
Jean Kelley	RN	166397	N/A	NO	Female	N/A	N/A

Hospital Admitting Privileges (Where?)
N/A

Location Information	Specialty	Prenatal PCP?	24 hr/7 day coverage	New Patients?	Age Group Served	HMO Affiliation
Gunnison County Public Health 225 N Pine Street Suite E	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+
Gunnison County Public Health 507 Maroon Street	Public Health & General Preventative Medicine	No	No	New	Adult,Child,Teen	CHP+

Credentialing Documentation Required of Primary and Specialty Care Providers

Primary and Specialty Care Providers must provide copies of the following:

- ☐ **Current State of Colorado Medical License(s)**
- ☐ **DEA Number(s)**
- ☐ **Proof of Malpractice Insurance**
- ☐ **W-9/ Taxpayer Identification Form (The W-9 must match the name of the contract holder and corresponding Taxpayer Identification Number (TIN)**

Provider Questionnaire Completed by: _____

Date: _____