MISSISSIPPI Physicians Care NETWORK Change Networks. Not Doctors.

Dear Provider,

Thank you for your interest in joining the Mississippi Physicians Care Network (MPCN).

We proudly serve over 500,000 lives across the state, offering a fully credentialed and comprehensive network of healthcare providers to third-party administrators and to insurance companies alike.

Additionally, we work with governmental programs offering providers the option to participate in 15 different products.

Participation is OPTIONAL. If you choose not to participate in the governmental products, you will still be a member in the MPCN Commercial Network.

To enroll in the MPCN network, please complete and submit the following:

**Numbers 1-5 below are REQUIRED documents for participation**.

1. New Enrollment Checklist
2. MPCN Provider Registration Form
3. Mississippi Participating Physician Application
4. MPCN Disclosure of Ownership and Control Interest Statement
5. MPCN Agreement

**Numbers 6–13 below are optional products. You must actively OPT IN to each one, except for Shared Health, which requires an OPT OUT.**

6. Molina MississippiCAN, Molina Marketplace, Molina CHIP, and Molina Medicare Advantage D-SNP (All Molina Products are included on one attachment)
7. Magnolia MississippiCAN, Magnolia Ambetter, and Magnolia CHIP (All Magnolia Products are included on one attachment)
8. WellCare Medicare Advantage
9. Primewell (Vantage) Medicare Advantage and Primewell (Vantage) Exchange (Both Primewell/Vantage Products are included on one attachment)
10. Shared Health OPT OUT form –
    * Note: To decline participation in Shared Health, you must opt out.
11. American Health Plan form
12. Healthy Mississippi (Qualexa)
13. TrueCare MSCAN and TrueCare CHIP

MPCN providers are offered the option to opt-in or opt-out of select products outside of MPCN's commercial network as listed on the Application Checklist.

Send your completed application, optional agreements, and application fee to:

MPCN – New Enrollment
P.O. Box 1530, Ridgeland, MS 39158-1530
or email to mlafleur@mpcn-ms.com

**Incomplete applications will remain pending until all forms are received.**

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors.**

# New Enrollment Checklist (Physician)

- ☐ **$75.00 Application/Initial Credentialing Fee**
  - ***Please note there is an annual membership fee of $75.00***
- ☐ **MPCN Provider Registration Form**
- ☐ Completed MS Participating Physician Application
  - Physician Signature - Section C. Certification (pg. 10)
  - Physician Signature - Section D. Attestation Questions (pg. 11)
  - Physician Signature – Section E. Release/Acknowledgments (pg. 12)
- ☐ **Signed MPCN Physician Agreement**
- ☐ **Current State Medical License Copy**
- ☐ **Board Certification Certificate Copy**
- ☐ **Federal DEA Certificate Copy** (if applicable)
- ☐ **CLIA Certificate if applicable**
- ☐ **Malpractice Policy Document/COI** – Must include policy number, coverage amount, expiration date, carrier address. Must not expire within (3) months.
- ☐ **Curriculum Vitae** or Documentation showing past (5) year's continuous education & practice
  - Must include month/year dates of employment/training
  - (6) Month or greater gaps in training or employment must be documented
- ☐ **ECFMG** (For foreign medical graduates licensed after 1986)
- ☐ **W-9**
- ☐ **Verification of NPI** number from NPPES NPI Registry
- ☐ **Disclosure of Ownership form**

---------- **Optional Product Opt-in/Opt-out Amendments to MPCN Contract** ----------

- ☐ **Magnolia Healthcare –** Signed Product Amendment Required
  - Sign for each Magnolia product(s) you want to participate in
- ☐ **Molina Healthcare** – Signed Product Amendment Required
  - Sign for each Molina product(s) you want to participate in
- ☐ **WellCare Medicare Advantage** – Signed Product Amendment Required
- ☐ **Primewell Medicare Advantage & Primewell Exchange** – Signed Amendment Required
- ☐ **American Health Plan –** Signed Product Amendment Required
- ☐ **Shared Health Mississippi DSNP** – **Opt-Out** only - Written notice to MPCN Required.
- ☐ **Healthy MS (Qualexa) -** Medicare Advantage Signed Product Amendment Required
- ☐ **TrueCare** - MSCAN & CHIP - Signed Product Amendment Required

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors.**

# MPCN Provider Registration/Update Form

## Section 1: Current Information (Required for all updates)

*Please attach W9 for all Tax ID and Group NPI updates*

Practitioner Name:_____

Practitioner Individual NPI:_____

Individual Medicaid ID:_____ Individual Medicare ID: _____

Specialty:_____ PCP: ◯ Yes or ◯ No

Credentialing/Office Manager Name:_____

Email: _____ Phone:_____

Credentialing address:_____

Collaborating Physician: _____

Collaborating Physician Specialty: _____

Collaborating Physician NPI: _____

## Section 2: Type of Update – Check All that Apply

☐ Practitioner Name Change
☐ Practice Location Add/Update
☐ Billing Change
☐ Location Termination
☐ Tax ID/GNPI Addition (W-9 Required)
☐ Other Changes

Effective Date of Change: _____

## Section 3: Practitioner Name Change – Attach updated Medical License & supporting documents

New Name: _____
Last, First Middle Suffix

## Section 4: Location Term

Term Address: _____
City, State Zip code

Tax ID of termed Address_____

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors**.

## Section 5: Location Addition/Update

| ☐ Add New Location | ☐ Update Existing Location |
|---|---|

Provider Name (as listed on attached W-9) _____

Clinic DBA Name: _____

Tax ID_____ Group NPI_____

Office Phone_____ Office Fax_____

Physical Address_____

_____

Billing Address_____

_____

Mailing Address_____

_____

**Additional Locations: Please complete for each physical location. Make copies if necessary.**

Provider Name (as listed on W-9)_____

Clinic DBA Name: _____

Tax ID_____ Group NPI_____

Office Phone_____ Office Fax_____

Physical Address_____

_____

Mailing Address_____

_____

Billing Address_____

_____

**Mississippi Physicians Care Network**
**PO Box 1530, Ridgeland MS 39158**
**Phone: 601-605-4756 Fax: 601-605-4753**

Please check one:

☐ Original Application

☐ Reappointment

# Mississippi Participating Physician Application

This application is submitted to _____, herein, this Managed Care Entity [1].

## SECTION A.

### *Practice, Educational, Licensure and Work History Information*

## I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application.**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

## II. IDENTIFYING INFORMATION

| | | |
|---|---|---|
| Last Name: | First: | Middle: |
| Is there any other name under which you have been known (AKA/Maiden Name)? Name(s): | | |
| Home Mailing Address: | City: | |
| | State: | ZIP: |
| Home Telephone Number: | E-Mail Address: | |
| Home Fax Number: | Pager Number: | |
| Birthday Date: Birth Place (City/State/Country): | Citizenship (If not a United States citizen, please include a copy of Alien Registration Card). | |
| Social Security #: | Gender [2]: ☐ Male ☐ Female | |
| Specialty: | Race/Ethnicity [2] (voluntary): | |
| Subspecialties: | | |

## III. PRACTICE INFORMATION

| | |
|---|---|
| Practice Name (if applicable): | Department Name (if Hospital based): |
| Primary Office Street Address: | Primary Office Mailing Address if different from Street Address: |
| City: State: County: Zip: | City: State: County: Zip: |
| Telephone Number: | FAX Number: |
| Office Manager/Administrator: | Telephone Number: |
| | Fax Number: |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |

[1] As used in the information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

| | |
|---|---|
| Secondary Office Street Address: | City:<br>State: ZIP: |
| Office Manager/Administrator: | Telephone Number:<br>FAX Number: |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |
| Tertiary Office Street Address: | City:<br>State: ZIP: |
| Office Manager/Administrator: | Telephone Number: ( )<br>FAX Number: ( ) |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |
| Handicap Access: ☐ Yes ☐ No | 24 Hour Coverage: ☐ Yes ☐ No |
| Will you accept new patients? ☐ Yes ☐ No | Back office Telephone Number: ( ) |

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

| **Name of Network** | **Address** | **Reason for Denial or Deselection** |
|---|---|---|
| | | |
| | | |
| | | |

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc? ☐ Yes ☐ No

If Yes, please list:

Medical Group(s) / IPA(s) Affiliation:

| | |
|---|---|
| Do you intend to serve as a primary care provider? ☐ Yes ☐ No<br>Do you intend to serve as a specialist? ☐ Yes ☐ No<br>If Yes, please list specialty(s): | Please check all that apply:<br>☐ Solo Practice ☐ Single Specialty<br>☐ Group Practice ☐ Multi Specialty |

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No
If so, please list:

| Name: | Type of Provider: | License Number: |
|---|---|---|
| | | |
| | | |
| | | |

Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) ☐ Yes ☐ No

| Name: | Mississippi Medical License Number: |
|---|---|
| | |
| | |
| | |

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you **do not** perform that are typically associated with your specialty:

Is your practice limited to certain ages? ☐ Yes ☐ NO If Yes, specify limitations:

Do you participate in EDI (electronic date interchange)? ☐ Yes ☐ No
If so, which Network**?**

Do you use a practice management system/software: ☐ Yes ☐ No
If so, which one?

What type of anesthesia do you provide in your group/office?
☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify):

Has your office received any of the following accreditation's, certifications, or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) ☐ Medicare Certification
☐ Mississippi Department of Health Licensure ☐ Other:

## IV. BILLING INFORMATION

Billing Company

Street Address:

City:

State**:**

ZIP:

Contact:

Telephone Number:

Name Affiliated with Tax ID Number:

Federal Tax ID Number:

## V. OFFICE HOURS – Please indicate the hours your office is open:

| Monday 24 HOUR COVERAGE | Tuesday 24 HOUR COVERAGE | Wednesday 24 HOUR COVERAGE | Thursday 24 HOUR COVERAGE | Friday 24 HOUR COVERAGE | Saturday 24 HOUR COVERAGE | Sunday 24 HOUR COVERAGE | Holidays 24 HOUR COVERAGE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)

Answering Service Company:

Telephone Number: ( )

Fax Number: ( )

Mailing Address:

City:

State:

ZIP:

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

## VII. FOREIGN LANGUAGES SPOKEN

| Fluently by Physician: | Fluently by Staff: |
|---|---|
| | |

## VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

| Tax ID #: | Billing Name: | Type of Service Provided: |
|---|---|---|
| | | |

| Do you have a CLIA Certificate? ☐ Yes ☐ No | Do you have a CLIA waiver? ☐ Yes ☐ No |
|---|---|
| Certificate Number: | Certificate Expiration Date: |

## IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

| Medical School: | Degree Received: | Date of Graduation (mm/yy) |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Medical/Professional School: | Degree Received: | Date of Graduation (mm/yy) |
| Mailing Address: | City: | |
| | State & Country | ZIP: |

## X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)

| Institution: | Program Director: | |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Type of Internship: | | |
| Specialty: | From: (mm/yy) | To: (mm/yy) |

## XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

| Institution: | Program Director: | |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Type of Training (e.g. residency, etc) | Specialty: | From: (mm/yy) / To: (mm/yy) |

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

| | | | |
|---|---|---|---|
| Institution: | | Program Director: | |
| Mailing Address: | | City: | |
| | | State & Country: | ZIP: |
| Type of Training (e.g. residency, etc) | Specialty: | From: (mm/yy) | To: (mm/yy) |

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

| | | | |
|---|---|---|---|
| Institution: | | Program Director: | |
| Mailing Address: | | City: | |
| | | State: | ZIP: |
| Type of Training (e.g. residency, etc) | Specialty: | From: (mm/yy) | To: (mm/yy) |

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

## XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which are duly organized and recognized by:
- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

| **Name of Issuing Board**: | **Specialty:** | **Certification Number**: | **Date Certified/ Rectified:** | **Expiration Date (if any):** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you applied for board certification other than those indicated above?
☐ Yes ☐No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? ☐ Yes ☐ No If Yes, Provide details.

## XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

| | | |
|---|---|---|
| Type: | Number: | Expiration Date: |
| Type: | Number: | Expiration Date: |

## XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)

| | | | |
|---|---|---|---|
| Mississippi State Medical License Number: | Issue Date: | Expiration Date: | Active: ☐ Yes ☐ No |
| Drug Enforcement Administration (DEA) Registration Number:<br>Unlimited? ☐ Yes ☐ No If "No", please explain on separate sheet | | Expiration Date: | |
| Controlled Dangerous Substances Certificate (CDS) (if applicable): | | Expiration Date: | |

| ECFMG Number (applicable to foreign medical graduates): | Date Issued: | Valid Through: |
|---|---|---|
| Visa Number: | Date Issued: | Valid Through: |

| Medicare UPIN/National Physician Identifier (NPI): | Mississippi Medicare Number: | Mississippi Medicaid Number: |
|---|---|---|

## XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical licenses now or Previously Held. (Attach additional sheets if necessary. Reference this section number and title.)

| State | License Number: | Expiration Date: | Active: |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| State: | License Number: | Expiration Date: | Active: |
| | | | ☐ Yes ☐ No |
| State: | License Number: | Expiration Date: | Active: |
| | | | ☐ Yes ☐ No |

## XVI. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

| ORGANIZATION NAME | Applicant | Member |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

Are you an Officer or Director of any of the professional organizations listed above?
If Yes, please list: ☐ Yes ☐ No

## XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

| Current Insurance Carrier: | Policy Number: | Original effective date: |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Telephone Number: ( ) | Fax Number: ( ) | |
| Per Claim Amount: $ | Aggregate Amount: $ | Expiration Date: |

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

**If you have had professional liability carriers in the last five years other than the one listed above, please list them below.**

| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
|---|---|---|---|
| Mailing Address: | | City: | |
| | | State and Country:: | ZIP: |
| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
| Mailing Address: | | City: | |
| | | State and Country: | ZIP: |

| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
|---|---|---|---|
| Mailing Address: | | City: | |
| | | State & Country: | ZIP: |
| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
| Mailing Address: | | City: | |
| | | State & Country: | ZIP: |

## XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

### A. CURRENT AFFILIATIONS **(Attach additional sheets if necessary. Reference this section number and title.)**

| Name and Mailing Address of Primary Admitting Hospital: | City: | |
|---|---|---|
| | State: | ZIP: |
| Department/Status (Active, provisional, courtesy, etc.): | Appointment Date: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | ZIP: |
| Department/Status (Active, provisional, courtesy, etc.): | Appointment Date: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | ZIP: |
| Department/Status (Active, provisional, courtesy, etc) | Appointment Date: | |
| If you do not have hospital privileges, please explain. | | |

### B. PREVIOUS AFFILIATIONS **(Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)**

| Name and Mailing Address of Other Hospital/Institution: | City: | |
|---|---|---|
| | State: | ZIP: |
| From: (mm/yy) To: (mm/yy) | Reason for Leaving: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | ZIP: |
| From: (mm/yy) To: (mm/yy) | Reason for Leaving: | |
| Name and Mailing Address of other Hospital/institution: | City: | |
| | State: | ZIP: |
| From: (mm/yy) To: (mm/yy) | Reason for Leaving: | |

| Name and Mailing Address of Other Hospital/Institution: | City: | |
|---|---|---|
| | State: | ZIP: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: |

## XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

| Name of Reference: | Specialty: | Telephone Number: |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |

| Name of Reference: | Specialty: | Telephone Number: |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |

| Name of Reference: | Specialty: | Telephone Number: |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |

## XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

| Current Practice: | Contact Name: | Telephone Number: |
|---|---|---|
| | | Fax Number: |
| Mailing Address: | City: | |
| | State: | ZIP: |
| From: (mm/yy) | To: (mm/yy) | |

| Name of Practice/Employer: | Contact Name: | Telephone Number: |
|---|---|---|
| | | Fax Number: ( ) |
| Mailing Address: | City: | |
| | State: | ZIP: |
| From: (mm/yy) | To: (mm/yy) | |

| Name of Practice/Employer: | Contact Name: | Telephone Number: ( ) |
|---|---|---|
| | | Fax Number: ( ) |
| Mailing Address: | | City: |
| | | State: / ZIP: |
| From: (mm/yy) | | To: (mm/yy) |

# Section B.

## *Professional Liability Action Explanation*

Please complete this section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

## I. CASE INFORMATION

| City, County and State where lawsuit filed: | Court case number, if known: | | |
|---|---|---|---|
| Date of alleged incident serving as basis for the lawsuit/arbitration: | Date Suit Filed: | Sex of patient: | Age of patient: |

Location of Incident:

☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center

☐ Other, (please specify) _____

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consulting, etc.):

Allegation:

Is/was there any insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If Yes, please provide company name, contact person, phone number, location and claim identification number of insurance company or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney to serve as your authorization:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

## II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE ONE)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgement rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgement rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled, no judgement rendered, no payment made on my behalf.

**Summarize** the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include: (1) condition and diagnosis at time of incident. (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. **Please print.**

# SUMMARY

# SECTION C.
## *Certification*

I certify that the information in Section A and B of this application and any attached documents (including my curriculum-vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is not Acceptable)

# Section D.

## *Attestation Questions*

Please answer the following questions "Yes" or "No". If your answer to any question is "Yes" please provide full details on separate sheet.

**1.** Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending**?**

Yes ☐ No ☐

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending**?**

Yes ☐ No ☐

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?

Yes ☐ No ☐

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes ☐ No ☐

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes ☐ No ☐

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?

Yes ☐ No ☐

8. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)

Yes ☐ No ☐

10. Have any judgements or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?

Yes ☐ No ☐

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?

Yes ☐ No ☐

12. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written Notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes ☐ No ☐

13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself, or others? (**A "YES" ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.)**

Yes ☐ No ☐

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services? Yes ☐ No ☐

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

## Section E.
## *Information Release/Acknowledgements*

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Managed Care Entity" and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively. "Healthcare Organizations"), for the purpose of evaluating this applications and any recredentialing application regarding my professional training, experience, character, conduct and judgement, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there by any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including , without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11, and 12 of this application.

Print Name Here:_____

Physician Signature: _____Date_____
(Stamped Signature Is Not Acceptable)

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Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

***This Application is endorsed by:***
- ***Mississippi Association of Health Plans***
- ***Mississippi State Medical Association***
- ***Mississippi Hospital Association***

[3] The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.

**Mississippi Physicians Care Network**

**Disclosure of Ownership and Control Interest Statement**

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of *5%* or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

**Practice Information**

| Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity |
|---|
| Name of Individual, Group Practice, or Disclosing Entity |
| Entity: DBA Name: |
| Address: |
| Federal Tax Identification Number: |

**Section I**

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

| Name of individual or entity | DOB | Address | SSN (if listing an individual) TIN (if listing an entity) |
|---|---|---|---|
| | | | |
| | | | |

**Section II**

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

| Names | Type of relation |
|---|---|
| | |
| | |
| | |

**Section III**

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

| Name of individual or entity | DOB | Address | SSN (if listing an individual) TIN (if listing an entity) |
|---|---|---|---|
| | | | |
| | | | |

**Section IV**

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

| Name/Title | DOB | Address | SSN |
|---|---|---|---|
| | | | |
| | | | |

**Section V**

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

| Name Supplier/Subcontractor | Address | Transaction Amount |
|---|---|---|
| | | |
| | | |

**Section VI**

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

| Name/Title | DOB | Address | SSN | % Interest |
|---|---|---|---|---|
| | | | | |
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I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

**Signature** **Title (or indicate if authorized Agent)**

**Name (please print)** **Date**

# Disclosure of Ownership and Control Interest Statement Form Instructions

## Practice/Entity Information Section

**Type of Entity Check Box** – Check the box that most closely describes the type of entity you are contracting as. See the Definitions Page to assist in determine if the practice/entity is an Individual, Group Practice or Disclosing Entity.

**Name of Individual, Group Practice or Disclosing Entity** – Provide the name of the entity you are contracting as. If you are an individual practitioner who is participating through a Group Practice, enter your individual name here.

**DBA name (if applicable)** – If you are completing the form as a Disclosing Entity or Group Practice, enter any DBA name that your entity may utilize here. If you are an individual practitioner who is participating through a Group Practice, enter the Group Practice name here.

**Address** – Provide the main physical address of practice/Entity you are contracting as.

**Federal Tax ID Number** – Enter the Federal Tax ID Number for your Disclosing Entity or Group Practice. If you are an individual who is also participating through a Group Practice, enter your individual Federal Tax ID number here.

**Provider CAQH #** - If completing this form as an Individual, enter the CAQH number here if applicable.

**Section I –** Provide the all information requested for any individual or entity with an ownership or controlling interest in the Practice/Entity completing the form. See the "Determination of ownership or control interest guidelines" on page 3. Attach a separate sheet as necessary to provide complete information. Write "None" if you are an individual practitioner or if this does not apply.

**Section II** – Indicate whether or not any individuals listed in Section I are related to each other by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, list any owners that are related to each other and the type of relationship in the rows provided, attach a separate sheet if necessary to provide all information.

**Section III** – Indicate whether or not the Disclosing Entity has a 5% or more direct or indirect ownership in a subcontractor by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each subcontracted entity of which the Disclosing Entity has a 5% or more direct or indirect ownership.

**Section IV** – Indicate whether or not there are any individuals who have an ownership or control interest in the Disclosing Entity, or is an agent or managing employee of the Disclosing Entity who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Social Security Title XX services program since the inception of those programs by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each individual.

**Section V** – Indicate by checking either the Yes or No box whether or not the practice/entity has had any financial transaction with a subcontractor totaling more than $25,000 in the 12 months prior to the completion date of this form or any significant business transaction (see definitions) between the practice/entity and a wholly owned supplier or between the practice/entity and any subcontractor in the 5 years prior to the completion date of this form. If Yes, provider the Name, address

**Section VI –** If the practice/entity is completing this form as a Disclosing Entity, as indicated in the Practice/Entity Information section, check yes and list each member of the Board of Directors or Governing Board including the name, date of birth, address, social security number (SSN) and percent of interest (if known at the time of completion). If your practice/entity is not a Disclosing Entity,

**Signature/Title/Date** – Provide the printed name, signature and title of the individual completing the form either for themselves if an individual practitioner on behalf of a disclosing entity. In the date field, enter the date the form was completed.

# Disclosure of Ownership and Control Interest Statement Form Instructions

## Definitions

***Agent*** means any person who has been delegated the authority to obligate or act on behalf of a provider.

***Disclosing entity*** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

***Group of practitioners*** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

***Indirect ownership interest*** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

***Managing employee*** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

***Ownership interest*** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

***Person with an ownership or control interest*** means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

***Significant business transaction*** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

***Subcontractor*** means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

***Supplier*** means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

***Wholly owned supplier*** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

# Disclosure of Ownership and Control Interest Statement Form Instructions

## Determination of ownership or control percentages

***Indirect ownership interest.*** The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

***Person with an ownership or control interest.*** In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

## Disclosure of Ownership and Control Interest Statement Form

## Provider Type Scenarios

**Sole Practitioner** – Sole Practitioners would identify themselves as Individuals, indicate “None” in Section I, indicate “Yes” or “No” in the remaining check boxes as appropriate then sign and date the form.

**Group of Practitioners** – the Group Practice being contracted with the Health Plan would fill out one Disclosure and Control Interest form for the Group Practice. The individual practitioners participating in the Group Practice, either as employees or co-owners, would each fill out a Disclosure and Control interest form for themselves as an Individual and list the Group Practice name in the “DBA Name” section, use the Group Practice address and use their own individual Federal Tax ID number.

**Hospital or Hospital System** – The Hospital would fill out one Disclosure and Control Interest form as a Disclosing Entity. We do not need a separate Disclosure and Control interest form for each practitioner who contracts and bills through the Hospital entity.

**Independent Clinical Lab** – The entity would fill out one Disclosure and Control Interest form as a Disclosing Entity. If the Independent Clinical Lab employs a group of practitioners that will be enrolled with the Health Plan, each practitioner would fill out a Disclosure and Control Interest form for themselves as an Individual and list the Independent Clinic Lab name in the “DBA Name” section, use the Independent Clinic Lab address and use their own individual Federal Tax ID number.

**MISSISSIPPI PHYSICIANS CARE NETWORK**
**PHYSICIAN SERVICE AGREEMENT**

This PHYSICIAN SERVICE AGREEMENT ("Agreement") is made and entered into this__day of_____,_____by and between Mississippi Physicians Care Network, Inc. ("MPCN"), a Mississippi corporation, located at 601 Crescent Boulevard, Suite 103, Ridgeland, MS 39157, and _____,("Participating Physician"), having his or her principal place of business at_____.

WHEREAS, MPCN's primary objective is to arrange for the provision of high quality, cost effective health care services to Health Plans and their Beneficiaries; and

WHEREAS, MPCN intends to enter into agreements with Participating Physicians which authorize MPCN to contract with self-insured employers, insurance companies, health and welfare trust funds and other entities ("Payors") which maintain or sponsor health plans; and,

WHEREAS, Participating Physician is licensed to practice medicine, and

WHEREAS, MPCN and Participating Physician desire to enter into an agreement whereby Participating Physician agrees to provide Covered Services to Beneficiaries of Health Plans which contract with MPCN and Participating Physician agrees to comply with certain MPCN administrative requirements and quality assurance/utilization review procedures, in providing such covered services, and

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties agree as follows:

## ARTICLE I
## Definitions

1.1 "Beneficiaries" means subscribers, enrollees or members and dependents of the subscriber, enrollee or member to a health plan who are eligible to receive covered services under a Health Plan which utilizes Participating Physicians.

1.2 "Complete Claim" means a written or electronic request for payment submitted on the most current editions of the CMS-approved Form 1500 and/or CMS Form UB92, or their successor forms, as identified by the Department of Insurance, Regulation 48, "Health Insurance Standardized Claim Forms" and which is accurate and complete and as to which request for payment there is no material issue regarding Payor's obligation to pay under the terms of a Health Plan.

1.3 "Covered Services" means the medical and other ancillary services and related benefits to which Covered Individuals are entitled under the Evidence of Coverage and for which the Health Plan provides funding.

1.4 "Emergency" means the sudden and unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected as determined by a prudent layperson to

jeopardize the Beneficiary's life, cause serious injury or impairment of bodily functions, or cause serious injury or permanent dysfunction of any bodily organ or part.

1.5 "Evidence of Coverage" means a document which explains services and benefits covered by a Health Plan and defines the rights and responsibilities of the Beneficiary.

1.6 "Health Plan" means a group policy issued through a licensed insurance company or a benefit agreement offered by a self-funded organization pursuant to which a Beneficiary has a financial incentive to use Participating Providers of MPCN.

1.7 "Medically Necessary" means services or supplies determined in good faith and in accordance with the utilization review functions of the companies to be necessary for the diagnosis or treatment of a medical condition, provided in accordance with generally accepted professional standards of medical care, requested and authorized in accordance with the Evidence of Coverage requirements, and not provided primarily for the convenience of the Beneficiary or the Participating Physician.

1.8 "Participating Hospital" means a hospital which has entered into an agreement with MPCN to provide hospital services to Beneficiaries in accordance with the terms and conditions of the Evidence of coverage.

1.9 "Participating Physician" means a physician with an unencumbered license to practice medicine or osteopathy who has entered into an agreement with MPCN to provide Covered Services to Beneficiaries.

1.10 "Participating Provider" means a hospital, other health care facility, pharmacy, or other individual health care professional which has entered into an agreement with MPCN to provide Covered Services to Beneficiaries of Health Plans.

1.11 "Payors" means any entity which self-insures group health benefits offered to their employees or an insurance company or other entity that has signed an agreement with MPCN for subscriber and eligible dependent coverage under a Health Plan as a participant in MPCN.

1.12 "Physician Service" means those services which a Participating Physician agrees to make available to Beneficiaries of Qualified Health Plans, when such services are covered under the Health Plan, and such services are required by a Beneficiary's medical condition. Participating Physicians agree to provide medical care and surgical care as appropriate to Beneficiaries within the parameters of their practice or specialty and within existing office schedules and physician settings which they customarily provide for all patients.

## ARTICLE II
## Covered Individual Eligibility

2.1 Eligibility and/or scope of Covered Services offered by Payors in Health Plans and performed by Participating Physicians and Providers, as determined by Payors, should be confirmed according to procedures designated on the Beneficiary's enrollment card.

## ARTICLE III
## Contracting with Participating Physicians

3.1 MPCN shall establish and maintain a panel of Participating Physicians who will provide Covered Services to Beneficiaries upon the terms and conditions set forth herein. MPCN shall use its best efforts to assure that all major medical specialties are included among the Participating Physicians and that Participating Physicians include physicians who provide primary care services and who are readily accessible to Beneficiaries residing throughout the MPCN service area. The parties recognize that the Participating Physicians may vary from time to time. MPCN will provide Companies with copies of a directory listing the names and addresses of all Participating Physicians and Providers.

3.2 Participating Physician acknowledges and agrees that MPCN may at times, in its sole discretion, cooperate with and assist in the network development of certain corporations with which it is affiliated. As a result, Participating Physician may be listed on the provider panels of affiliated corporations when such will further the efficient provision of health care services to beneficiaries; in such an event, Participating Physician agrees that the terms and conditions of this Physician Service Agreement shall continue in full force and effect. Participating Physician will be notified of any such product and may opt-out of individual products by providing MPCN with written notice.

3.3 Participating Physician agrees to pay the MPCN annual membership fee.

3.4 Participating Physician agrees to be re-credentialed by MPCN every three years, as required by NCQA guidelines.

## ARTICLE IV
## Referral to Participating Providers

4.1 Participating Physician agrees, whenever reasonably and medically appropriate, to admit to a Participating Hospital and to refer Beneficiaries to other Participating Physicians when referrals are medically necessary.

## ARTICLE V
## Participating Physician Billing Procedures

5.1 Participating Physician agrees to submit claims on all Covered Services directly to entity designated on Beneficiary's enrollment card within the time specified by the Beneficiary's Health Plan from the date the service or services were rendered to Beneficiary. Claims shall be submitted on a standard HCFA Form 1500 or other paper or electronic format acceptable to Payor and shall include gross charges for all services rendered identified by CPT code.

5.2 Participating Physician agrees to accept as payment in full for Covered Services rendered to a Beneficiary the MPCN allowable or billed charges, whichever is less. Participating

Physician may only bill the Beneficiary for any co-payment, deductible or co-insurance required by the Health Plan.

5.3 Participating Physician may bill a Beneficiary for services that are not Covered Services under the Beneficiary's Health Plan.

5.4 Participating Physician agrees that all payments shall be made subject to medical necessity provisions based on valid medical need and subject to any Payor utilization review and procedure. Participating Physician agrees to hold the Beneficiary, MPCN and Payors harmless for any and all fees associated with reimbursement determinations for Covered Services.

5.5 Participating Physician shall submit, within ninety (90) days of date of service to Payor, his/her claim for Covered Services rendered to Beneficiaries consistent with Article V of this Agreement according to each Payor's contract year. Claims submitted after ninety (90) days from contract year will be denied. Such services shall show gross charges for all Covered Services rendered identified by code as it appears in the current Physician's Current Procedural Terminology (CPT). Claims shall be submitted on standard HCFA 1500 Universal Claims Forms or on other forms or using electronic media acceptable to MPCN.

5.6 This provision shall survive the termination of this Agreement on services rendered while this Agreement was in effect.

## ARTICLE VI
## Payment to Participating Physicians

6.1 Payors, under an agreement with MPCN, shall cause automatic assignment of benefits and pay directly to the Participating Physician for Covered Services.

6.2 Payors, under an agreement with MPCN, shall remit payment for a complete claim within forty-five (45) days from the date of receipt of a non-electronic complete claim and within twenty-five (25) days from the date of receipt of an electronic complete claim for services rendered by a Participating Physician, unless one of the following has occurred:

1. The claim form is incomplete or incorrect;

2. Billing of services rendered is not consistent with current CPT;

3. Services rendered are subject to Coordination of Benefits (COB) and/or Utilization Review; or

4. Beneficiary's eligibility is under review.

6.3 Participating Physicians will be provided with each approved payment an explanation of the payment for the Participating Physician's services rendered to Beneficiaries. The explanation of payment shall identify any portion of the bill or claim which has been disallowed as non-covered or covered but deemed medically inappropriate or unnecessary, any amounts of applicable co-payments and any amounts paid by others through Coordination of Benefits.

6.4 Participating Physician agrees to cooperate with Payors or their agents in coordinating benefits with other payers. Participating Physicians will make a reasonable effort to determine whether any other payer has primary responsibility for the payment of a claim for Covered Services that was rendered to a Beneficiary. If, after Participating Physician has been paid a claim it is determined that another payer is primarily responsible for all or a portion of the claim, Participating Physician agrees to refund to Payor or its agent the amount paid or to be paid by the primary payer.

6.5 Payors shall pay to Participating Physician the lesser of his/her usual and customary fee or the MPCN fee maximum for the Covered Service rendered for all services that are payable in accordance with the Agreement.

6.6 Payment on all claims shall be subject to medical necessity provisions in the Beneficiary's certificate of coverage and payments for Covered Services rendered to Beneficiaries are to be provided only when the services are based on valid medical needs. The Participating Physician agrees to hold the Beneficiary harmless for fees associated with such Covered Services which have been determined to be medical unnecessary.

6.7 Fee maximums are established for each eligible CPT procedure code submitted. These maximums will be representative of the general experience accumulated for medical services rendered by the network of Participating Providers.

## ARTICLE VII
## Utilization Review

7.1 Participating Physician agrees to participate in and comply with the requirements of the utilization review, quality improvement, credentialing and re-credentialing, grievance procedures and other utilization management programs established by Payors.

7.2 Utilization review may include pre-admission, concurrent and retrospective review of claims and the medical records of Beneficiaries.

7.3 Participating Physicians shall not charge for copies of medical records required by Payors for utilization review.

7.4 Participating Physician agrees that Payors shall have the authority to reduce or omit payment to the extent that review has identified Covered Services that were not medically necessary or appropriate or were not otherwise Covered Services.

7.5 If the Participating Physician has obtained pre-certification of medical necessity, the Payor shall accept the determination of medical necessity for payment purposes, unless the Participating Physician has information showing no medical necessity and failed to disclose this or failed to present complete and accurate information.

7.6 Pre-certification or any other determination of medical necessity does not guarantee payment, which may be denied by Payors for reasons other than medical necessity.

## ARTICLE VIII
## Confidentiality

8.1 The Participating Physicians, MPCN and the Payors shall maintain the confidentiality of the records of Beneficiaries and related information to the maximum extent required by applicable federal, state, and local laws.

8.2 MPCN and the Payors agree to maintain the confidentiality of any information provided them under the Utilization Review programs and to use such information only for

appropriate insurance and/or plan review purposes, unless specifically authorized otherwise by a Beneficiary or Participating Physician.

## ARTICLE IX
## Patient Relationship

9.1 It is understood and agreed to by the parties that each Participating Physician shall maintain an independent physician/patient relationship with each Beneficiary and shall be solely responsible to such Beneficiary for his or her treatment. Nothing herein shall be construed to require any Participating Physician to take any action or refuse to take any action inconsistent with professional judgment.

## ARTICLE X
## Use of Names, Trademarks and Logos

10.1 The Payors and MPCN may identify in advertising and publications and information distributed to Beneficiaries, the names and addresses of all Participating Physicians and all Participating Providers at which Covered Services are available under a Health Plan.

10.2 The Participating Physician, by executing this Agreement, provides his or her consent for the Payors to use his or her name and address in all such advertising, publications and information distributed to Beneficiaries and Payors agree to cease the distribution of all materials and the use of any advertising which includes the name and address of the Participating Physician upon the termination of this agreement.

10.3 Under an agreement with MPCN, the Payors agree to permit MPCN and the Participating Physicians to identify each employer who agrees to offer a Health Plan to their eligible employees in any advertising and publications.

10.4 The Payors stipulate in that agreement the use of any symbols, trademarks, or protected service marks may not be used in any form by MPCN or the Participating Physicians without the Payors' respective and individual written permission.

10.5 The use of the employer's name or any trademark, symbol or service mark shall automatically cease at the time the Payors cease to offer its employees a Health Plan or when the agreement with MPCN is terminated.

## ARTICLE XI
## Liability

11.1 MPCN will be liable for any claims, actions, damages, or litigation arising solely from any negligent, fraudulent or dishonest acts of MPCN.

11.2 The Participating Physician will be liable for any claims, actions, damages or litigation arising solely from any negligent, fraudulent or dishonest acts of the Participating Physician.

11.3 The Payors, under an agreement with MPCN acknowledge their liability for payment of all legitimate health care claims from Participating Physicians and Providers for Covered Services rendered to Beneficiaries which are medically necessary in addition to any claims, actions, damages or litigation arising solely from any negligent, fraudulent, or dishonest act of the Payors.

## ARTICLE XII
## Insurance

12.1 Each Participating Physician, at their sole and individual expense, shall maintain professional liability insurance with limits of no less than one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate professional liability coverage with an approved carrier. Individual consideration is given to physicians with Federal Tort Claims Act coverage or in accordance with Mississippi Code Section 11-46-15. Documentation supporting the physician's coverage through these means must be provided. Other individual consideration may be given at the discretion of MPCN.

12.2 Each Participating Physician and MPCN shall maintain such other insurance as shall be necessary to insure each other, their respective agents and employees against damages arising from their respective duties and obligations under this Agreement or that which would impair their individual ability to carry out the terms of the this Agreement.

## ARTICLE XIII
## General Provisions

13.1 Any notice required by this Agreement shall be given only in written form, sent by United States mail, return receipt requested, with postage prepaid and addressed to MPCN at Post Office Box 1530, Ridgeland, MS 39158-1530 and to Participating Physician at his or her last known address. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt.

13.2 The invalidity of any term or provision of this Agreement shall not affect the validity of any other term or provision of this Agreement.

13.3 Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

13.4 This Agreement may be amended only by the written mutual consent of both parties.

13.5 This Agreement shall be binding upon, and shall inure to the benefit of the parties to it, their respective heirs, legal representative, successors and assigns. Notwithstanding the foregoing, neither party may assign any of their respective rights or delegate any of their respective duties hereunder without receiving the prior written consent of the other party.

13.6 Headings are solely for convenience and shall not be used in interpreting the text of this Agreement.

13.7 In the event either party initiates legal action with respect to the interpretation or performance of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees and costs as the court may award.

13.8 MPCN, the Payors and Participating Physicians, their agents and employees respectively, are at all times acting and performing as independent contractors in the performance of their obligations under this Agreement.

13.9 This Agreement shall be governed by and construed in accordance with the laws of the State of Mississippi.

13.10 Both parties agree, solely to the extent applicable to the terms of this agreement to comply with the Healthcare Insurance Portability and Accountability Act of 1996 regulations and rules regarding access to personal information for the transmission of healthcare data including but not limited to the Standards for Electronic Transactions and Code Sets, Privacy and Individually Identifiable Health Information, Security and Electronic Signatures, National Standard Health Care Identifier, and National Standard Employer Identifier. Both parties agree to be in compliance with Standards published as the "Final Rule" in the Federal Register not later than the compliance implementation date furnished by the Department of Health & Human Services.

13.11 This Agreement constitutes the entire agreement between the parties and as of the effective date hereof supersedes all other agreements and understandings between the parties with respect to the subject matter hereof.

## ARTICLE XIV
## Term and Termination

14.1 This Agreement shall become effective on the date first written above and shall be effective for a period of twelve (12) months thereafter. This Agreement shall automatically be renewed for successive periods of twelve (12) months each on the same terms and conditions contained herein, unless sooner terminated pursuant to the terms of this Agreement.

14.2 Either party may notify the other party in writing of its intention to terminate this Agreement. Such written notice shall be provided at least thirty (30) days prior to the date of termination.

14.3 Notwithstanding any other provision of this Agreement, MPCN shall have the right to cancel this Agreement immediately in the event the Participating Physician shall be determined by MPCN in its sole and absolute discretion to be in violation of or failing to

comply with any of the requirements of this Agreement after thirty (30) days written notice and failure to comply.

14.4 This Agreement will automatically terminate on the earlier of:

(1) The date legislation is effective, or any court interprets a law so as to prohibit the continuation of this Agreement; or

(2) The date on which MPCN or the Participating Physician ceases doing business, or files for protection in the U. S. Bankruptcy Court.

14.5 In the event this Agreement is terminated for any reason, the Payors, under a separate agreement with MPCN, agree to continue to make payments to a Participating Physician in accordance with the terms and conditions of this Agreement for Covered Services rendered.

**Mississippi Physicians Care Network**

By: _____
Scott Dennis

Title: Chief Executive Officer

Date: _____

**Participating Physician**

By: _____
Signature

Name: _____
(Please print)

Tax ID #: _____

Date: _____

## SCHEDULE A

### 1. REIMBURSEMENT SCHEDULE

Participating Provider shall submit, within ninety (90) days of date of service to COMPANY, his/her claim for Covered Services rendered to Covered Individuals consistent with Article 2 of this AGREEMENT according to each COMPANY'S contract year. Claims submitted after ninety (90) days from contract year will be denied. Such services shall show gross charges for all Covered Services rendered identified by code as it appears in the current Provider's Current Procedural Terminology (CPT). Claims shall be submitted on standard HCFA 1500 Universal Claims Forms or on other forms or using electronic media acceptable to MPCN.

Participating Provider claims for Covered Services shall be paid within 45 calendar days upon receipt unless one of the following has occurred:

1. The claim form is incomplete or incorrect;

2. Billing of services rendered is not consistent with current CPT;

3. Services rendered are subject to Coordination of Benefits (COB) and/or Utilization Review; or

4. Covered Individual's eligibility is under review.

Companies shall pay to Participating Provider the lesser of his/her usual and customary fee or the MPCN fee maximum for the Covered Service rendered for all services that are payable in accordance with the AGREEMENT.

Payment on all claims shall be subject to medical necessity provisions in the Covered Individual's certificate of coverage and payments for Covered Services rendered to Covered Individuals are to be provided only when the services are based on valid medical needs. The Participating Provider agrees to hold the Covered Individual harmless for fees associated with such Covered Services which have been determined to be medical unnecessary.

### 2. FEE MAXIMUMS (UCR)

Fee maximums are established for each eligible CPT procedure code submitted. These maximums will be representative of the general experience accumulated for medical services rendered by the network of Participating Providers.

# MOLINA HEALTHCARE OF MISSISSIPPI, INC

## MISSISSIPPICAN/ CHIP/ MARKETPLACE/ MEDICARE ADVANTAGE D-SNP

MPCN offers a streamlined approach for providers to participate in Molina Healthcare's product offerings. Through our existing agreement with Molina, providers contracted with MPCN have the *option* to participate in Molina Healthcare plans without the need to establish a separate contract or undergo additional credentialing with Molina. MPCN fulfills those requirements on your behalf, offering a more efficient and convenient path to participation.

To participate in the Molina Medicaid products, **you must be a MS Medicaid provider and you must OPT-IN** by completing the information below. Enrollment is optional and does not affect your participation with MPCN**.**

**The Molina Healthcare Agreement is available upon request.** If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

Please check all that apply:

- ☐ Molina MississippiCAN
- ☐ Molina Children's Health Insurance Program "CHIP"
- ☐ Molina Marketplace
- ☐ Molina Medicare Advantage D-SNP (must have Medicare ID)

**Provider Signature and Information:**

| | | |
|---|---|---|
| Practitioner's Legal Name ("Provider"): | | |
| Authorized Representative's Signature: | | Authorized Representative's Name – Printed: |
| Authorized Representative's Title: | | Authorized Representative's Signature Date: |
| Telephone Number: | | Fax Number – Official Correspondence: |
| Mailing Address – Official Correspondence: | | Payment Address – If different than Mailing Address: |
| Individual Medicaid ID: | Individual Medicare ID: | Tax ID Number – As listed on W9: |
| Individual Practitioner NPI: | | Email Address – Official Correspondence: |

# MAGNOLIA HEALTHCARE OF MISSISSIPPI, INC

## MISSISSIPPICAN/ CHIP/ AMBETTER

MPCN offers a streamlined approach for providers to participate in Magnolia Healthcare's product offerings. Through our existing agreement with Magnolia, providers contracted with MPCN have the *option* to participate in Magnolia Healthcare plans without the need to establish a separate contract or undergo additional credentialing with Magnolia. MPCN fulfills those requirements on your behalf, offering a more efficient and convenient path to participation.

To participate in the Magnolia Medicaid products, **you must be a MS Medicaid provider and you must OPT-IN** by completing the information below. Enrollment is optional and does not affect your participation with MPCN.

**The Magnolia Healthcare Agreement is available upon request**. If you need additional information please email Don Foote at dfoote@mpcn-ms.com

Please check all that apply:

- ☐ Magnolia MississippiCAN
- ☐ Magnolia Children's Health Insurance Program "CHIP"
- ☐ Magnolia Ambetter

**Provider Signature and Information:**

| | |
|---|---|
| Practitioner's Legal Name ("Provider"): | |
| Authorized Representative's Signature: | Authorized Representative's Name – Printed: |
| Authorized Representative's Title: | Authorized Representative's Signature Date: |
| Telephone Number: | Fax Number – Official Correspondence: |
| Mailing Address – Official Correspondence: | Payment Address – If different than Mailing Address: |
| Individual Medicaid ID: | Tax ID Number – As listed on W9: |
| Individual Practitioner NPI: | Email Address – Official Correspondence: |

# WELLCARE MEDICARE ADVANTAGE PRODUCT

As a benefit to Mississippi Physicians Care Network (MPCN) participating providers, MPCN serves as a delegated credentialing entity for the WellCare Medicare Advantage market in Mississippi. This partnership has proven beneficial to MPCN providers who wish to service WellCare members, given additional credentialing is not required.

**To participate in the WellCare Medicare Advantage product, you must be a MS Medicare provider and OPT-IN by completing the information below.**

**Enrollment is optional and does not affect your participation with MPCN.**

If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

☐ **Yes, I would like to participate in WellCare Medicare Advantage Plan.**

**Individual Mississippi Medicare provider ID:** _____

**Office Hours for practice locations:** _____

**Nurse Practitioners, please list certification:** _____

_____ _____
**(Practitioner Signature)** **(Print Name/NPI)**

_____ _____
**(Date)** **(Tax ID)**

_____ _____
**(Clinic/Group Name)** **(Group NPI)**

_____ _____ ___ _____
**(Street Address)** **(City)** **(State)** **(Zip)**

**To submit enrollment, return to:**
**MPCN Network Services/Wellcare Medicare Advantage**
**Fax: 601-605-4753 or Email: dfoote@mpcn-ms.com**

P.O. BOX 1530 RIDGELAND, MISSISSIPPI 39158-1530
TEL: 601.605.4756 FAX: 601.605.4753 www.mpcn-ms.com

# PRIMEWELL MA AND EXCHANGE PRODUCTS

MPCN has expanded our relationship with Primewell Health (Formerly Vantage Health Plan) to include their Exchange Product.

By joining through your MPCN agreement, you do not have to contract with, nor be credentialed by Primewell, as you are already contracted and credentialed with MPCN.

Enrollment is optional and does not affect your current participation with MPCN.

**If you would like to participate in the Primewell MA Product and/or the Primewell Exchange Product, you may do so by simply OPTING IN and completing the information below.**

If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

☐ **Yes, I would like to participate in Primewell Medicare Advantage Plan.**

☐ **Yes, I would like to participate in Primewell Exchange Plan.**

**Individual Mississippi Medicare provider ID:** _____

**Office Hours for practice locations:** _____

**Nurse Practitioners, please list certification:** _____

_____ _____
**(Practitioner Signature)** **(Print Name/NPI)**

_____ _____
**(Date)** **(Tax ID)**

_____ _____
**(Clinic/Group Name)** **(Group NPI)**

_____ _____ ___ _____
**(Street Address)** **(City)** **(State)** **(Zip)**

## Please submit enrollment to Don Foote at:

## Email: dfoote@mpcn-ms.com

## OR FAX to Don Foote's attention: 601-605-4753.

P.O. BOX 1530 RIDGELAND, MISSISSIPPI 39158-1530
TEL: 601.605.4756 FAX: 601.605.4753 www.mpcn-ms.com

# SHARED HEALTH PRODUCT

MPCN has entered into a Professional Provider Network Agreement with SHMS that sets forth the key terms, as summarized below, relating to MPCN's planned participation in the D-SNP Medicare Advantage product.

1. Plan Sponsor: Shared Health Mississippi, Inc.
2. Line of business: D-SNP Medicare Advantage
3. Effective Date: January 1, 2021
4. Rates: 100% of Original Medicare. Provider also may be eligible to participate in incentive programs to earn additional payments.

The Professional Provider Network Agreement is available upon request.

**Provider Participation in Product**

Unless a written objection is received from Provider within thirty (30) days of receiving this Product Notice, Provider shall be deemed to have acknowledged that this Product Notice meets the requirements of the Agreement for MPCN to include Provider as a participant in a new product.

**Should you choose to not participate, please check the box below and provide requested information.**

_☐_ **I choose to OPT OUT of the Shared Health program**

**Provider's Name** _____

**Provider's Tax ID Number** _____

# American Health Advantage of Mississippi

American Health Advantage of Mississippi is a Provider Owned Health Plan that offers a Medicare Advantage Institutional Special Needs Plan (I-SNP) developed and managed by American Health Plans.

**Important facts about our plans:**

- Currently offered in 25 counties across Mississippi with anticipated growth into additional counties in 2023
- Only available to residents in skilled nursing facilities
- Uniquely designed to ensure that quality care is provided to fragile and underserved populations
- Includes a Model of Care that focuses on medical monitoring, skill-in-place care when appropriate, and the coordination of care with our members' medical providers.
- Pays 100% of the current Medicare Allowable Rate

Mississippi Physicians Care Network (MPCN) has signed an agreement with American Health Plans of Mississippi, Inc. and are requesting your participation in accordance with MPCN policy. **In order to participate in this product, you must OPT IN by signing and completing the information below.**

**If you do not participate in the American Health Advantage product, you will still remain a member in the MPCN network. MPCN appreciates your participation in our network as well as all the support so many of you provide each year. If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.**

(continued on next page)

**Yes, I will participate in the American Health Advantage of Mississippi product.**

☐

_____

**(*Signature* and Tax ID)**

_____

**(*Print Name*/NPI)**

_____

**(*Group Name/Group NPI*) (DATE)**

_____

**(*Address*)**

_____

**(*Telephone Number*)**

**Electronic signature honored.**

**Are you a Mississippi Medicare provider? Yes No** Yes

**If yes, you must provide Individual Medicare Number _____**

## Opt-In notices may be sent to: Don Foote at dfoote@mpcn-ms.com

See next page for a list of current hospitals participating in this product.

We appreciate your participation with American Health Advantage of Mississippi, Inc.

## CURRENT LIST OF PARTICIPATING HOSPITALS:

**ALLIANCE HEALTHCARE SYSTEM**
**ANDERSON REGIONAL MEDICAL CENTER**
**ANDERSON REGIONAL MEDICAL CENTER SOUTH CAMPUS**
**BAPTIST MEDICAL CENTER – LEAKE, ATTALA, AND YAZOO**
**BAPTIST MEMORIAL HOSPITAL-BOONEVILLE INC**
**BAPTIST MEMORIAL HOSPITAL-CALHOUN INC**
**BAPTIST MEMORIAL HOSPITAL-DESOTO**
**BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE**
**BAPTIST MEMORIAL HOSPITAL-NORTH MISSISSIPPI INC**
**BAPTIST MEMORIAL HOSPITAL-UNION COUNTY**
**BEACHAM MEMORIAL HOSPITAL**
**BOLIVAR MEDICAL CENTER**
**CLAIBORNE COUNTY MEDICAL CENTER**
**FORREST GENERAL HOSPITAL**
**GEORGE REGIONAL HOSPITAL**
**GREENWOOD LEFLORE HOSPITAL**
**JASPER GENERAL HOSPITAL**
**LAWRENCE COUNTY HOSPITAL**
**MAGEE GENERAL HOSPITAL**
**MAGNOLIA REGIONAL HEALTH CENTER**
**MARION GENERAL HOSPITAL**
**MERIT HEALTH BILOXI**
**MERIT HEALTH CENTRAL**
**MERIT HEALTH MADISON**
**MERIT HEALTH NATCHEZ**
**MERIT HEALTH RANKIN**
**MERIT HEALTH RIVER OAKS**
**MERIT HEALTH RIVER REGION**
**MERIT HEALTH WESLEY**
**MERIT HEALTH WOMAN'S HOSPITAL**
**MISSISSIPPI BAPTIST MEDICAL CENTER**
**NESHOBA COUNTY GENERAL HOSPITAL**
**NORTH SUNFLOWER MEDICAL CENTER**
**REGENCY HOSPITAL OF MERIDIAN**
**SE LACKEY MEMORIAL HOSPITAL**
**SELECT SPECIALTY HOSPITAL GULFPORT**
**SELECT SPECIALTY HOSPITAL JACKSON**
**SELECT SPECIALTY HOSPITAL- BELHAVEN**
**SINGING RIVER HEALTH SYSTEM**
**SOUTH CENTRAL REGIONAL MEDICAL CENTER**
**SOUTH SUNFLOWER COUNTY HOSPITAL**

**SOUTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER**
**WAYNE GENERAL HOSPITAL**
**WINSTON MEDICAL CENTER**

# Healthy Mississippi (Qualexa)

- MPCN has agreed to help Healthy Mississippi and affiliates to continue to build and expand their Medicare Network for their current 2025 Medicare Advantage product. Reimbursement is 100% of the Medicare fee schedule. They will also be expanding with additional plans in 2026.
- **MPCN in no way represents nor endorses this product**. In order to participate, YOU MUST **OPT IN** by filling out the information included. As with other products, by participating through your MPCN Agreement, you will not have to be credentialed, nor will you have to be contracted directly with Network.

## A note from Healthy Mississippi/Qualexa:

WHY Healthy Mississippi?

1. State-wide Medicare Advantage Plan
2. Pays 100% of Medicare fee schedule
3. Pays timely consistent with CMS guidelines
4. Pays value-based care incentives to participating Providers
5. Opportunity for risk-sharing contracts for interested Providers
6. Streamlined Prior Authorization procedures
7. Low-cost mail order pharmacy located in the state of MS.

**Should you choose NOT to OPT- IN, YOU WILL STILL REMAIN A PARTICIPATING PROVIDER IN THE MPCN NETWORK.**

(continued on next page)

**Provider agrees to Participate in Network and contract with Network with same terms and conditions as the MPCN Physician Service Agreement, and compliant with Medicare contract language (www.healthy-ms.com/mcrterms). The contracted reimbursement for Medicare Advantage members shall be 100% of the Medicare ("CMS") outpatient fee schedule.**

## In order to participate, you must be a MS Medicare provider and Opt-In by providing the following information:

☐ **I choose to Opt In this product**

**Provider name:** _____

**Provider Medicare#:** _____

**Provider Tax ID number:** _____

**Provider NPI Number:** _____

**Provider Signature:** _____

***For a group practice**, please attach the above information for each MPCN Contracted Practitioner in your clinic who wants to participate in this product.

**Fax number – (601) 605-4753**

For a summary of provider responsibilities, a provider manual, or more information, please email or call Don Foote. 601-605-4756 ext. 337 or dfoote@mpcn-ms.com.

****Healthy Mississippi is in the process of recruiting hospitals. Please provide us with your preferred hospitals, and where you have hospital privileges.**

# TRUECARE MSCAN AND TRUECARE CHIP PRODUCTS

MPCN is pleased to partner with TrueCare, which includes both the MSCAN and CHIP programs. The TrueCare contract is available upon request.

By joining through your MPCN agreement, you do not have to contract with, nor be credentialed by TrueCare, as you are already contracted and credentialed through MPCN.

Enrollment is optional and does not affect your current participation with MPCN.

**If you would like to participate in the TrueCare MSCAN Product and/or the TrueCare CHIP Product, you must be a MS Medicaid provider and OPT-IN by completing the information below.**

If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

☐ **Yes, I would like to participate in TrueCare MSCAN.**

☐ **Yes, I would like to participate in TrueCare CHIP.**

**Individual Mississippi Medicaid provider ID:** _____

**Office Hours for practice locations:** _____

**Nurse Practitioners, please list certification:** _____

_____ _____
**(Practitioner Signature)** **(Print Name/NPI)**

_____ _____
**(Date)** **(Tax ID)**

_____ _____
**(Clinic/Group Name)** **(Group NPI)**

_____ _____ ___ _____
**(Street Address)** **(City)** **(State)** **(Zip)**

## Please submit enrollment to Don Foote at:

## Email: dfoote@mpcn-ms.com

## OR FAX to Don Foote's attention: 601-605-4753.

P.O. BOX 1530 RIDGELAND, MISSISSIPPI 39158-1530
TEL: 601.605.4756 FAX: 601.605.4753 www.mpcn-ms.com