



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 14 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 6–12 below are optional products. You must actively OPT IN to each one.**

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. American Health Plan form
11. Healthy Mississippi (Qualex)
12. 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](mailto:mlafleur@mpcn-ms.com)

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

## New Enrollment Checklist (Allied)

- ☐ **\$150.00 Application/Initial Credentialing Fee**
  - \*\*\*Please note there is an annual membership fee of \$150.00\*\*\*
- ☐ **MPCN Provider Registration Form**
- ☐ **Completed MS Participating Physician Application**
  - Provider Signature - Section C. Certification (pg. 10)
  - Provider Signature - Section D. Attestation Questions (pg. 11)
  - Provider Signature – Section E. Release/Acknowledgments (pg. 12)
- ☐ **Signed MPCN Allied Health Agreement**
- ☐ **Signed Collaborating Physician Agreement/Protocols**
- ☐ **Current State Medical License Copy**
- ☐ **Board Certification Certificate Copy**
- ☐ **Federal DEA Certificate Copy** (if applicable). If you do not have a DEA, we will need the Prescriptive Authority Letter
- ☐ **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 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
  - ☐ **Healthy MS (Qualexa)** - Medicare Advantage - Signed Product Amendment Required
  - ☐ **TrueCare** - MSCAN & CHIP - Signed Product Amendment Required



## 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

- |   |  |
|---|--|
| <input type="checkbox"/> Practitioner Name Change     | <input type="checkbox"/> Location Termination                |
| <input type="checkbox"/> Practice Location Add/Update | <input type="checkbox"/> Tax ID/GNPI Addition (W-9 Required) |
| <input type="checkbox"/> Billing Change               | <input type="checkbox"/> 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 \_\_\_\_\_



Change Networks. Not Doctors.

Section 5: Location Addition/Update

<input type="checkbox"/> Add New Location	<input type="checkbox"/> 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☐ ReappointmentThis application is submitted to: \_\_\_\_\_, herein, this Managed Care Entity<sup>1</sup>.

# Mississippi Participating Physician Application

## 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 <sup>2</sup> : <input type="checkbox"/> Male <input type="checkbox"/> Female		
Specialty:	Race/Ethnicity <sup>2</sup> (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:

<sup>1</sup> 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.

<sup>2</sup> This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	FAX Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	FAX Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Handicap Access: <input type="checkbox"/> Yes <input type="checkbox"/> No	24 Hour Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you accept new patients? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		
<b>Name of Network</b>	<b>Address</b>	<b>Reason for Denial or Deselection</b>
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please list:		
Medical Group(s) / IPA(s) Affiliation:		
Do you intend to serve as a primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please check all that apply:	
Do you intend to serve as a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Solo Practice <input type="checkbox"/> Single Specialty	
If Yes, please list specialty(s):	<input type="checkbox"/> Group Practice <input type="checkbox"/> Multi Specialty	
Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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 <b><u>do not</u></b> perform that are typically associated with your specialty:							
Is your practice limited to certain ages? <div style="text-align: center;"><input type="checkbox"/> Yes   <input type="checkbox"/> NO</div>				If Yes, specify limitations:			
Do you participate in EDI (electronic data interchange)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which Network?				Do you use a practice management system/software: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which one?			
What type of anesthesia do you provide in your group/office? <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> General <input type="checkbox"/> None <input type="checkbox"/> Other (please specify): _____							
Has your office received any of the following accreditation's, certifications, or licensures? <input type="checkbox"/> American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) <input type="checkbox"/> Medicare Certification <input type="checkbox"/> Mississippi Department of Health Licensure <input type="checkbox"/> Other:							
<b>IV. BILLING INFORMATION</b>							
Billing Company:							
Street Address:				City:			
				State:		ZIP:	
Contact:				Telephone Number:			
Name Affiliated with Tax ID Number:				Federal Tax ID Number:			
<b>V. OFFICE HOURS – Please indicate the hours your office is open:</b>							
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
<b>VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)</b>							
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 &amp; Country:

ZIP:

Medical/Professional School:

Degree Received:

Date of Graduation (mm/yy)

Mailing Address:

City:

State &amp; Country

ZIP:

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

Institution:

Program Director:

Mailing Address:

City:

State &amp; 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 &amp; 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?

If Yes, Provide details.

☐ Yes ☐ No

## **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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:	
Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain on separate sheet			
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: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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:	
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:
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: <input type="checkbox"/> Hospital <input type="checkbox"/> My office <input type="checkbox"/> Other doctor's office <input type="checkbox"/> Surgery Center <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 be 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)

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*

<sup>3</sup> 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: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> 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 than \$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

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  
ALLIED HEALTH PROFESSIONAL SERVICE AGREEMENT**

This SERVICE AGREEMENT (“Agreement”) is made and entered into this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by and between Mississippi Physicians Care Network (“MPCN”), located at 601 Crescent Boulevard, Suite 103, Ridgeland, MS 39157, and \_\_\_\_\_, (“Participating Provider”), 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 Qualified Health Plans and their Covered Individuals; and

WHEREAS, MPCN intends to enter into agreements with Participating Physicians, Hospitals, and other Allied Health Professionals which authorize MPCN to contract with self-insured employers, insurance companies, health and welfare trust funds and other entities (“Companies”) which maintain or sponsor health plans; and,

WHEREAS, Participating Allied Health Professional is licensed by the State, and

WHEREAS, MPCN and Participating Provider desire to enter into an agreement whereby Participating Provider agrees to provide Covered Services on behalf of MPCN to Covered Individuals of Qualified Health Plans which contract with MPCN and Participating Provider agrees to comply with certain MPCN administrative requirements and quality assurance, utilization and peer 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 1**  
**Definitions**

- 1.1 **Clean Claim.** A claim submitted by a Participating Provider in a manner and format prescribed by a Qualified Health Plan for health care services rendered to a Covered Individual which contains all information necessary to process and administer the claim.
- 1.2 **Companies.** 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 Qualified Health Plan as a participant in MPCN.
- 1.3 **Covered Individuals.** 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 Qualified Health Plan which utilizes Participating Providers.
- 1.4 **Covered Services.** The medical and other ancillary services and related benefits to which

Covered Individuals are entitled under the Evidence of Coverage and for which the Qualified Health Plan provides funding.

- 1.5 Emergency. 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 Covered Individual's life, cause serious injury or impairment of bodily functions, or cause serious injury or permanent dysfunction of any bodily organ or part.
- 1.6 Evidence of Coverage. A document which explains services and benefits covered by a Qualified Health Plan and defines the rights and responsibilities of the Covered Individual.
- 1.7 Medically Necessary. 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 Covered Individual or the Participating Provider.
- 1.8 Participating Hospital. A hospital which has entered into an agreement with MPCN to provide hospital services to Covered Individuals in accordance with the terms and conditions of the Evidence of coverage.
- 1.9 Participating Physician. A physician with an unencumbered license to practice medicine or osteopathy in the State of Mississippi who has entered into an agreement with MPCN to provide Covered Services to Covered Individuals.
- 1.10 Participating Provider. A hospital, other health care facility, pharmacy, or other allied health care professional which has entered into an agreement with MPCN to provide Covered Services to Covered Individuals of Qualified Health Plans.
- 1.11 Professional Service. Those services which a Participating Provider agrees to make available to Covered Individuals of Qualified Health Plans at rate calculations set forth in Schedule A, attached hereto, when such services are covered under the Qualified Health Plan, and such services are required by a Covered Individual's medical condition. Participating Providers agree to provide medical care and surgical care as appropriate to Covered Individuals within the parameters of their practice or specialty and within existing office schedules and physician settings which they customarily provide for patients who are not Covered Individuals under a Qualified Health Plans.
- 1.12 Policy Committee. The governing body of MPCN which has full responsibility and authority to act on behalf of MPCN.
- 1.13 Qualified Health Plan. A group policy issued through a licensed insurance company or a benefit agreement offered by a self-funded organization pursuant to which a Covered

Individual has a financial incentive to use Participating Providers of MPCN.

- 1.14 Self-Insurers. An employer or other entity which provides a self-funded Qualified Health Plan to eligible persons.
- 1.15 Utilization Review Committee. A committee or committees established by MPCN for (i) conducting clinical credentialing of MPCN Participating Physicians and individual Participating Providers; (ii) assessing and promoting the quality of health care services and related benefits rendered to subscribers or members of Qualified Health Plans; and (iii) reviewing and making determinations regarding whether health care services provided or to be provided to Covered Individuals by Participating Providers or Providers in connection with the Evidence of Coverage is medically necessary, and regarding whether such services are Covered Services.
- 1.16 Utilization Review Procedures. A utilization management program and procedures established to review the medical necessity of Covered Services furnished by Participating Hospitals, Physicians and other Providers to Covered Individuals of Qualified Health Plans on an inpatient and outpatient basis. Such program and procedures shall be established by MPCN in its sole and absolute discretion and shall include pre-admission, concurrent and retrospective review and shall be in addition to any utilization management program required by the conditions or provisions of a contracting Qualified Health Plan.

## ARTICLE 2

### Covered Individual Eligibility

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

## ARTICLE 3

### Contracting with Participating Providers

- 3.1 MPCN shall establish and maintain a panel of Participating Providers who will provide Covered Services to Covered Individuals 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 Providers and that Participating Providers include physicians who provide primary care services and who are readily accessible to Covered Individuals residing throughout the MPCN service area. The parties recognize that the Participating Providers may vary from time to time. MPCN will provide Companies with copies of a directory listing the names and addresses of all Participating Providers.
- 3.2 Participating Provider 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 Provider 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 Provider agrees that the terms and conditions of this Allied Health Professional Service Agreement shall continue in full force and effect. Participating Provider will be notified of any such product and may opt-out of individual products by providing MPCN with written notice.

- 3.3 Participating Provider agrees to pay the MPCN annual membership fee.
- 3.4 Participating Provider agrees to be re-credentialed by MPCN every three years, as required by NCQA guidelines.

#### ARTICLE 4 Referral to Participating Providers

- 4.1 Participating Provider agrees, whenever reasonably and medically appropriate, to admit to a Participating Hospital and to refer Covered Individuals to other Participating Providers when referrals are medically necessary.

#### ARTICLE 5 Participating Provider Billing Procedures

- 5.1 Participating Provider agrees to submit claims on all Covered Services directly to entity designated on Covered Individual's enrollment card within ninety (90) days from the date the service or services were rendered to Covered Individual in accordance with Schedule A. Claims shall be submitted on a standard HCFA Form 1500 or other paper or electronic format acceptable to payer and shall include gross charges for all services rendered identified by CPT code.
- 5.2 Participating Provider agrees to accept as payment in full for Covered Services rendered to a Covered Individual fees as set forth in Schedule A. Participating Provider may only bill the Covered Individual for any co-payment, deductible or co-insurance required by the Qualified Health Plan.
- 5.3 Participating Provider may bill a Covered Individual for services that are not Covered Services under the Covered Individual's Qualified Health Plan.
- 5.4 Participating Provider agrees that all payments shall be made subject to medical necessity provisions based on valid medical need and subject to MPCN Utilization Review and procedure. Participating Provider agrees to hold the Covered Individual, MPCN and Companies harmless for any and all fees associated with reimbursement determinations for Covered Services.
- 5.5 This provision shall survive the termination of this Agreement on services rendered while this Agreement was in effect.

ARTICLE 6  
Payment to Participating Providers

- 6.1 Companies, under an agreement with MPCN, shall cause automatic assignment of benefits and pay directly to the Participating Provider for Covered Services.
- 6.2 Companies, under an agreement with MPCN, shall remit payment for a clean claim as specified in Schedule A within forty-five (45) days from the date of receipt of the clean claim for services rendered by a Participating Provider.
- 6.3 Participating Providers will be provided with each approved payment an explanation of the payment for the Participating Provider's services rendered to Covered Individuals. 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 Provider agrees to cooperate with Companies or their agents in coordinating benefits with other payers. Participating Providers 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 Covered Individual. If, after Participating Provider has been paid a claim it is determined that another payer is primarily responsible for all or a portion of the claim, Participating Provider agrees to refund to Company or its agent the amount paid or to be paid by the primary payer.

ARTICLE 7  
Utilization Review

- 7.1 Participating Provider agrees to participate in and comply with the requirements of the utilization review, quality improvement, peer review, credentialing and recredentialing, grievance procedures and other utilization management programs established by MPCN.
- 7.2 Utilization review may include pre-admission, concurrent and retrospective review of claims and the medical records of Covered Individuals.
- 7.3 Participating Providers shall not charge for copies of medical records required by MPCN for utilization review.
- 7.4 All negative utilization review determinations will be rendered by a Participating Provider who is a member of MPCN.
- 7.5 Within thirty (30) days of receipt of notice of a negative determination, Participating Provider may request, in writing, a reconsideration of the negative determination by the MPCN Appeals Committee, which shall be comprised of other Participating Providers with the same or similar credentials and experience as the Participating Provider

requesting review. The Appeals Committee shall render a determination within thirty (30) days of receipt of the written request from the Participating Provider seeking review.

- 7.6 Participating Provider agrees that MPCN determinations are merely advisory and that final determination as to whether services shall be reimbursed under any Qualified Health Plan shall be the sole responsibility of the Companies acting with the advice of MPCN.
- 7.7 Participating Provider agrees that Companies 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.
- 7.8 If the Participating Provider has obtained pre-certification of medical necessity, the payer shall accept the determination of medical necessity for payment purposes, unless the Participating Provider has information showing no medical necessity and failed to disclose this or failed to present complete and accurate information. MPCN may review and determine at any time if further treatment is medically necessary.
- 7.9 Pre-certification or any other determination of medical necessity does not guarantee payment, which may be denied by Companies for reasons other than medical necessity.

#### ARTICLE 8 Confidentiality

- 8.1 The Participating Providers, MPCN and the Companies shall maintain the confidentiality of the records of Covered Individuals and related information to the maximum extent required by applicable federal, state and local laws.
- 8.2 MPCN and the Companies 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 Covered Individual or Participating Provider.

#### ARTICLE 9 Patient Relationship

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

#### ARTICLE 10 Use of Names, Trademarks and Logos

- 10.1 The Companies and MPCN may identify in advertising and publications and information distributed to Covered Individuals, the names and addresses of all Participating Providers

at which Covered Services are available under a Qualified Health Plan.

- 10.2 The Participating Provider, by executing this Agreement, provides his or her consent for the Companies to use his or her name and address in all such advertising, publications and information distributed to Covered Individuals and Companies agree to cease the distribution of all materials and the use of any advertising which includes the name and address of the Participating Provider upon the termination of this agreement.
- 10.3 Under an agreement with MPCN, the Companies agree to permit MPCN and the Participating Providers to identify each employer who agrees to offer a Qualified Health Plan to their eligible employees in any advertising and publications.
- 10.4 The Companies 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 Providers without the Companies 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 Companies cease to offer its employees a Qualified Health Plan or when the agreement with MPCN is terminated.

#### ARTICLE 11

##### 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 Provider will be liable for any claims, actions, damages or litigation arising solely from any negligent, fraudulent or dishonest acts of the Participating Provider.
- 11.3 The Companies, under an agreement with MPCN, acknowledge their liability for payment of all legitimate health care claims from Participating Providers for Covered Services rendered to Covered Individuals which are medically necessary in addition to any claims, actions, damages or litigation arising solely from any negligent, fraudulent, or dishonest act of the Companies.

#### ARTICLE 12

##### Insurance

- 12.1 Each Participating Provider, 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.
- 12.2 Each Participating Provider 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 this Agreement.

ARTICLE 13  
General Provisions

- 13.1 **Notices.** 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 Provider 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 **Severability.** 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.** 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 **Amendment.** This Agreement may be amended only by the written mutual consent of both parties.
- 13.5 **Assignment.** 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.** Headings are solely for convenience and shall not be used in interpreting the text of this Agreement.
- 13.7 **Attorney's Fees.** 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 **Independent Contractor.** MPCN, the Companies and Participating Providers, their agents and employees respectively, are at all times acting and performing as independent contracts in the performance of their obligations under this Agreement.
- 13.9 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of Mississippi.
- 13.10 **Healthcare Insurance Portability & Accountability Act** 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 (HIPPA) 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 Entire Agreement. This Agreement, including Schedule A, 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 14 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 Provider 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 Provider 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 Companies, under a separate agreement with MPCN, agree to continue to make payments to a Participating Provider in accordance with the terms and conditions of this Agreement until the Covered Services being rendered are completed consistent with existing medical ethical and legal requirements for providing continuity of care to a patient unless MPCN or the Companies make reasonable and medically necessary provision for the assumption of such Covered Services by another Participating Provider.

- 14.6 Unless otherwise required by law, Participating Provider agrees that any MPCN decision to terminate this Agreement pursuant to any Utilization Review decision shall be subject to those appeal rights that are developed by MPCN and are in compliance with State and federal law.

EXECUTED on the date and year first above written.

**Mississippi Physicians Care Network**

By: \_\_\_\_\_  
Scott Dennis

Title: \_\_\_\_\_  
Chief Executive Officer

Date Signed \_\_\_\_\_

**Participating Provider**

By: \_\_\_\_\_  
Signature

Name: \_\_\_\_\_  
Please Print

Tax ID #: \_\_\_\_\_

Date Signed: \_\_\_\_\_

## **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.

\* Please note the following:

- REIMBURSEMENT FOR Licensed Social Workers (LSW) and Licensed Professional Counselors (LPC) - Reduce the MPCN Fee Schedule allowance by 20%.

- REIMBURSEMENT FOR Nurse Practitioners & Physician Assistants - Reduce allowance by 20% for E&M Codes (99202-99439) ONLY. All other services allow 100% of Codes fee.



# 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](mailto: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](mailto: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](mailto: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](mailto:dfoote@mpcn-ms.com)**

P.O. BOX 1530 RIDGELAND, MISSISSIPPI 39158-1530  
TEL: 601.605.4756 FAX: 601.605.4753 [www.mpcn-ms.com](http://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](mailto: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](mailto:dfoote@mpcn-ms.com)**

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

## **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](mailto: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

If yes, you must provide Individual Medicare Number \_\_\_\_\_

**Opt-In notices may be sent to: Don Foote at [dfoote@mpcn-ms.com](mailto: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  
NESHOBIA 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.**

**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](http://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](mailto: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](mailto: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](mailto:dfoote@mpcn-ms.com)**

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