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American HealthCare Group, Inc. PPO
Credentialing Application Instruction Form

This letter is to inform you that your appointment status is expired or will soon expire with American HealthCare Group, Inc.'s PPO network. Please complete the new application packet to update your file. We re-credential every three years.

I would like to thank you for your continuing participation in the American HealthCare Group PPO network, including the following insurance products:

<u>Carrier</u>	<u>Type</u>
USA Managed Care Organization	PPO, Work Comp
CCN	PPO
Procura	Work Comp
FOCUS	Work Comp—separate agreement
Multiplan	PPO

In addition to PPO network management and outsourced billing services, American HealthCare Group, Inc. offers employee benefit management and employer wellness programs. If you are interested in learning how you can save money or be involved with our programs, please call American HealthCare Group for more information.

Please fill out the credentialing application completely. If a question does not apply to you, draw a line or write N/A so that every question has been addressed. We request that you **print** them in **ink**.

If you have any **questions** about completing the form, please contact **American HealthCare Group's office** for assistance or further information. The following credentialing materials must be forwarded with your application:

- Current copy of **Curriculum Vitae** – If there is more than a three-month gap between activities, please explain on a separate page.
- Copy of **Professional Liability Policy and cover sheet**
- Copy of **Board Certification**
- Copy of **Pennsylvania Medical License**
- Copy of **DEA or CDS Certification**
- Signed **Provider Service Agreement & applicable Contract Participation Statements**

Mail the completed application and credentialing materials to the address listed above.

Thank you for your interest in American HealthCare Group, Inc.

GENERAL INFORMATION

Name _____ Gender **M** **F**
Social Security # _____ Date of Birth _____
Practice/Group Name _____
(If a corporation, list name as registered with the state)
Business Address: _____ Tax ID # _____
City _____ State _____ Zip Code _____
County _____ Phone _____ Fax _____
E-Mail and Practice Web Site Address _____
Practice Administrator/Office Manager's Name _____
Office Hours _____
(list additional addresses and office hours on a separate sheet)

Billing Address: _____
City, State & Zip _____
Phone _____ Fax _____ Billing Manager's Name _____

PRACTICE INFORMATION

Accepting Patients? **Y** **N** Owned by/Affiliated with _____
Accepting Workers' Comp Patients? **Y** **N**
Specialty _____ ABMS Board Certified **Y** **N** Date _____
Sub-specialty _____ ABMS Board Certified **Y** **N** Date _____
Do you want to be listed in the member directory as Primary Care? ___ Yes ___ No
What foreign languages are fluently spoken in your office? Self _____ Staff _____

RISK MANAGEMENT INFORMATION

(Please mark items which are not applicable with N/A or zero)

Prior Carriers and Policy #'s *(Last 5 Years)* _____

1. Have you had any settlements or judgments made against you in the last ten years, or do you have any malpractice cases pending? ___ Yes ___ No *If yes, attach information about each settlement or judgement, including brief description and dates for occurrences, claims paid or active claims.*

Carrier Claim Reserve Account Status/Balance _____

Has your professional liability insurance ever been cancelled denied? ___ Yes ___ No

2. Has your medical license ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license, in Pennsylvania or any other state? ___ Yes ___ No *If Yes, in what state? _____ Date _____*

Primary License State & License Number _____

3. Has your DEA number ever been revoked, restricted, limited, suspended or are any of these actions pending with respect to your DEA license? ___ Yes ___ No *If Yes, Date _____*

Primary DEA Number _____

4. Has your participation in Medicare, Medicaid or other government programs ever been denied, suspended or revoked; or to the best of your knowledge, have you ever been or are you under investigation by a regulatory agency? ___ Yes ___ No *If yes, specify _____*

5. Have your hospital privileges ever been revoked, suspended, reduced, not renewed; have disciplinary proceedings ever been instituted against you, or are any of these actions now pending with respect to your hospital privileges?

Yes No If yes, date(s) _____

6. Have any complaints been filed against you with a Medical Society? Yes No

7. Are you currently under the care of a physician for a continuing health problem? Yes No

8. Do you now have or have you ever had a chemical dependency problem (legal or illegal drugs)? Yes No

9. Are you currently taking any medications that may affect either your clinical judgment or motor skills? Yes No

10. Other than traffic offenses, have you been convicted of a crime or do you have any felony or misdemeanor charges pending? Yes No

11. Do you have any condition that affects the performance of your duties, with or without accommodation? Yes No

12. Have you voluntarily relinquished hospital privileges, DEA Registration, academic appointments or any other professional status while an investigation was conducted? Yes No

13. Have you voluntarily relinquished any licensure or registration? _____

CREDENTIALING/EDUCATION INFORMATION

Medical School & Address _____

Date started _____ Date completed _____

Internship _____ **Residency** _____

Location _____ Location _____

Date started _____ Date started _____

Date completed _____ Date completed _____

REFERENCES

List three professional references (Include name, address & phone number)

1. _____

2. _____

3. _____

ACTIVE HOSPITAL AFFILIATIONS (attach proof of privileges)

Primary Hospital _____

Other Hospitals _____

I hereby certify and attest that all information provided herein is complete and accurate. By my signature hereon, I hereby authorize American HealthCare Group and its employees or representatives, to contact, for purposes of verification of any information contained on my American HealthCare Group Application, any institution or individual. I authorize such institution or individual to release either written or oral information accordingly as requested by American HealthCare Group. I release American HealthCare Group and all verification entities from any liability concerning the processing of this application. I authorize any and all payors to release all requested information concerning my standing, records, performance report, and practice review system report to American HealthCare Group.

Signature

Date

Print Name

PROVIDER SERVICE AGREEMENT

THIS AGREEMENT is made and entered into this ____ day of _____, 2006 by and between **AMERICAN HEALTHCARE GROUP, INC.**, a Pennsylvania corporation (hereinafter referred to as "AHG") and _____ (hereinafter referred to as "Provider"),

WITNESSETH

THAT WHEREAS, AHG is engaged in the business of utilizing medical networks to provide health care services to those persons who wish to avail themselves of such services, such persons being hereinafter referred to as "Patients", and

WHEREAS, AHG desires to procure the use of the facilities, equipment and services of Provider for the benefit of its Patients; and

WHEREAS, AHG has made arrangements with physicians under contract with AHG (hereinafter referred to as "Participating Physicians") to promote efficiencies and economies of patient medical treatment by avoidance of unnecessary hospitalization and unproductive costs through the use of cost monitoring; and

WHEREAS, Provider desires to make its facilities, equipment and services available for the benefit of AHG's Patients at the rates hereinafter set forth; and

WHEREAS, AHG and Provider mutually desire to preserve and enhance patient dignity;

NOW THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings hereinafter set forth, and intending to be legally bound hereby, the parties hereto agree as follows:

1. **PROVIDER SERVICES.** Provider will make available for the use and benefit of AHG's Patients the facilities, equipment and services used or provided by Provider in the provision of health care (hereinafter, "Services"). AHG and Provider may mutually agree in writing either to expand or limit Services made available hereunder.

2. **COMPENSATION.** AHG agrees to pay to Provider 100% of the current RBRVS fee schedule. Provider shall provide to AHG itemized records of Services and charges to Patients. Provider agrees to look solely to AHG or any applicable third party payor for payment of Services covered under this Agreement. Under no circumstances will Provider make any charges or claims against the Patients directly for any Services. Provider agrees that in no event (including, without limitation, non-payment by AHG or any applicable third party payor, AHG's insolvency or breach of this Agreement) shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or any recourse against Patients or persons other than AHG or any applicable third party payor for Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable co-payment in accordance with the terms of AHG's agreement with a Patient, or collection of charges for any services rendered which are not provided pursuant to this Agreement. Provider further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination, and shall be construed to be for the benefit of AHG's Patients, and (2) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Patients or persons acting on the Patients' behalf.

3. **PROVISION OF TREATMENT.** Provider shall perform its services for AHG's Patients in the same manner and in accordance with the same standards as offered to all other Provider patients.

4. **QUALITY ASSURANCE.** AHG will utilize a system of utilization quality assurance peer review based upon standards established under federal and state laws and healthcare industry practices, the purpose of which is to promote adherence to accepted medical treatment standards and to encourage Participating Physicians to keep medical costs of Patients at a minimum consistent with sound medical treatment. To this end, Provider agrees to provide to AHG upon request, and at reasonable cost, a copy of Patients' medical records and other pertinent data as may be required by AHG.

5. **COMPLAINTS.** Any complaints received by AHG with respect to Provider's Services will be forwarded to the appropriate officials at Provider's office. The matters will be submitted for resolution in accordance with Provider's regular procedures.

PROVIDER SERVICE AGREEMENT

6. INSPECTION OF RECORDS. Provider and AHG agree that all Patients' medical records shall be treated as confidential so as to comply with all state and federal laws regarding the confidentiality of patient records.

7. PROVIDER'S INSURANCE AND INDEMNIFICATION. Provider, at its sole cost and expense, shall procure and maintain such policies of general and professional liability insurance and other insurance with coverage limits reasonably acceptable to AHG, as such be necessary to insure it and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the provision of Services by Provider, the use of any property and facilities provided by Provider, and any other acts or omissions by Provider in connection with this Agreement. Memorandum copies of such policies shall be delivered to AHG upon request. Provider further agrees to indemnify and hold harmless AHG and its officers, directors and employees against any claims, liabilities, and expense of any nature whatsoever, arising out of or related Provider's provision of Services to AHG's Patients, including without limitation claims based in whole or in part on the asserted negligence of AHG or its agents or employees.

8. ROSTER. Provider agrees that AHG may use Provider's name, address, telephone number, description of facilities and description of health care services in AHG's roster of participating providers.

9. TERM. This agreement shall become effective for one year from the date hereof, and thereafter shall continue in effect from year to year unless terminated on its anniversary date by either party by a written notice thereof mailed to the other party by certified or registered mail at least sixty (60) days prior to such date.

10. NOTICES. Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent certified or registered mail to the recipient party at its last known address.

11. ENFORCEABILITY. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions.

12. MODIFICATION. This agreement constitutes the entire understanding of the parties hereto and no changes, amendments or alterations shall be effective unless signed by both parties.

13. ASSIGNMENT. This Agreement may not be assigned or delegated by Provider without the prior written consent of AHG or any successor thereto.

14. RELATIONSHIP OF PARTIES. It is understood and agreed that each party to this agreement, together with its agents and employees, is at all times acting as an independent contractor, and that neither party has any express or implied authority to assume or create any obligation or responsibility on behalf of or in the name of the other party.

15. NON-CIRCUMVENTION. During the term of this Agreement, and for a period of two years thereafter, Provide covenants that it shall not, directly or indirectly, provide Services to persons who have been Patients of AHG at any time during the preceding two years, except pursuant to this Agreement. Provider acknowledges that any breach of this covenant would result in irreparable harm to AHG which would not be redressable by any remedy at law, and that such a breach would entitle AHG to equitable relief including specific performance and an accounting.

IN WITNESS WHEREOF, the parties hereunto have executed this Agreement.

AMERICAN HEALTHCARE GROUP, INC.

By: _____
Title: _____
Date: _____

PRINT NAME
By: _____
Title: _____
Date: _____

American HealthCare Group PPO

CONTRACT PARTICIPATION STATEMENT

The undersigned physician agrees as a participating provider of American HealthCare Group to the following:

1. The fee schedule upon which I will be reimbursed, for purposes of my participation in the panel described below, will be on average 110% of Medicare’s Resource Based Relative Value Scale (RBRVS) for Multiplan’s PPO Product, USA MCO PPO Product, CCN PPO Product.
2. To look solely to the payor for compensation for covered services rendered by the undersigned under these contracts except for co-payments, deductibles or coinsurance. Whether or not there is any unresolved dispute for payment, under no circumstances will the undersigned directly or indirectly make any charges or claims, other than co-payments, deductibles or coinsurance against any patients or their representatives for covered services under these contracts. Except for the collection of co-payments, deductibles or coinsurance, only those services that are not covered services may be billed directly to patients, subject to limitations listed above.

Provider/Practice Name

Signature

Date

Sign below to participate in the workers’ comp agreements.

Workers’ Comp Network Addendum

The undersigned agrees as a participating provider of American HealthCare Group, Inc. to the following:

1. The fee schedule upon which I will be reimbursed, for purposes of my participation in the panel described in Section 2 below, will be at a maximum an 11% discount off of the Pennsylvania state workers’ compensation fee schedule for workers’ compensation products contracted by American HealthCare Group.
2. To look solely to the payor for compensation for covered services rendered by the undersigned under any American HealthCare Group contract, except for copayments, deductibles, or coinsurance. Whether or not there is any unresolved dispute for payment, under no circumstances will the undersigned directly or indirectly make any charges or claims, other than copayments, deductibles, or coinsurance against any patients or their representatives for covered services under any American HealthCare Group contract. Except for the collection of copayments, deductibles, or coinsurance, only those services that are not covered services may be billed directly to patients, subject to limitations listed above.

ProviderPractice Name

Signature

Date