NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C 11044 Research Boulevard (800) 252-9224

DECEMBER 38, 1989

ZGODFX679
BAYLOR MEDICAL CENTER AT
WAXAHACHIE
1425 JEFFERSON
WAXAHACHIE, TX 75165

DEAR PROVIDER

WE HAVE COMPLIETED THE ENROLLMENT OF BASCO, MICHAEL A. MD, PERFORMING PROVIDER NUMBER PD85G4412, AND HAVE ADDED HIM/HER TO YOUR GROUP ASSOCIATION.

PLEASE USE THIS PERFORMING NUMBER IN THE DETAIL PORTION OF THE CLAIM FORM TO IDENTIFY THE PERFORMING PROVIDER.

IF THIS PROVIDER SHOULD CHOOSE TO LEAVE YOUR GROUP, PLEASE NOTIFY THE PROVIDER ENROLLMENT DEPARTMENT IMMEDIATELY.

THANK YOU FOR YOUR PARTICIPATION IN THE TEXAS MEDICAID PROGRAM.

SINCERELY,

PROVIDER ENROLLMENT

1124135

TEXAS MEDICAID

Group Practice Enrollment Application

This form is to be used to request the enrollment of a new physician into an established group practice.

If you would like to enroll your new physician in the Texas Title XIX (Medicaid) Program, please have the physician sign in the section below and return this form to:

National Heritage Insurance Company PROVIDER ENROLLMENT DEPARTMENT 11044 Research Blvd., Bldg. C Austin, Texas 78759-5239

If you have claims for services performed by this new physician, send the claims to:

National Heritage Insurance Company CLAIMS PREPARATION P. O. Box 200555 Austin, Texas 78720-0555

All claims for services rendered to Medicaid recipients who do not have Medicare benefits are subject to a 90-day filing deadline by program requirements. This means that your claim for services must reach our offices within 90 days, plus 5 days mail time, of the date of service of that recipient. Please submit as soon as possible any claims you may have even though your physician is not yet enrolled with NHIC.

Claims without Medicare involvement will be denied until you are enrolled in the Texas Title XIX Program. However, your claims will be reconsidered for payment after you are enrolled. The denial of your claims will serve as documentation that your claim was filed within the 95-day filing deadline. Procedures for resubmitting your denied claims for payment consideration will be attached to your enrollment notification letter.

Sincerely,

	Provider Enrollment
PHYSICIAN'S INFORMATION:	GROUP NAME AND ADDRESS:
Physician's Name: Michael A. Basco, M.D.	Baylor Medical Center at Waxahachie
Group Number: FX67	1405 W. Jefferson
Physician's Specialty: ER Medicine	Waxahachie, Texas 75165
85644	
Physician's Medicare Number:	DO NOT WRITE IN THIS AREA
Physician's Medicare Number: 85644 License Number: 4515	DO NOT WRITE IN THIS AREA
License Number: #515 (If Temporary*, attach a copy)	DO NOT WRITE IN THIS AREA County Door Type Lecelty Effective Date
License Number: +5 5 (If "temporary", attach a copy) Please enroll me with the group practice listed above.	Country Spac Type Lecality Effective Date
License Number: #515 (If Temporary*, attach a copy)	. 1

POWER OF ATTORNEY

Medicare/Medicaid requires that we include a Power of Attorney authorizing EmCare to sign for the individual physician when applying for numbers on your behalf. These applications are submitted for each hospital or facility in our system for which you will be working. This Power of Attorney will be kept in your file to expedite the application process for these numbers.

POWER OF ATTORNEY

I hereby authorize _______ Of EmCare Incorporated, to apply for Medicare/Medicaid privileges on my behalf while I am working with EmCare Incorporated.

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Michael Basco, M.D.

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Print Name Please

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C 11044 Research Boulevard (800) 252-9224

DECEMBER C8, 1989

ZGUGCT119 NORTH TEXAS MEDICAL CENTER 1800 N GRAVES ST MCKINNEY, TX 75669

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BASCO, MICHAEL A. MD, PERFORMING PROVIDER NUMBER POSOF1976, AND HAVE ADDED HIM/HER TO YOUR GROUP ASSOCIATION.

PLEASE USE THIS PERFORMING NUMBER IN THE DETAIL PORTION OF THE CLAIM FORM TO IDENTIFY THE PERFORMING PROVIDER.

IF THIS PROVIDER SHOULD CHOOSE TO LEAVE YOUR GROUP, PLEASE NOTIFY THE PROVIDER ENROLLMENT DEPARTMENT IMMEDIATELY.

THANK YOU FOR YOUR PARTICIPATION IN THE TEXAS MEDICAID PROGRAM.

SINCERELY,

PROVIDER ENROLLMENT

TEXAS MEDICAID Group Practice Enrollment Application

This form is to be used to request the enrollment of a new physician into established group practice.

If you would like to enroll your new physician in the Texas Title XIX (Medicaid) Program, please have the physician sign in the section below and return this form to:

National Heritage Insurance Company PROVIDER ENROLLMENT DEPARTMENT 11044 Research Blvd., Bldg. C Austin, Texas 78759-5239

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If you have claims for services performed by this new physician, send the claims to:

National Heritage Insurance Company CLAIMS PREPARATION P. O. Box 200555 Austin, Texas 78720-0555

All claims for services rendered to Medicaid recipients who do not have Medicare benefits are subject to a 90-day filing deadline by program requirements. This means that your claim for services must reach our offices within 90 days, plus 5 days mail time, of the date of service of that recipient. Please submit as soon as possible any claims you may have even though your physician is not yet enrolled with NHIC.

Claims without Medicare involvement will be denied until you are enrolled in the Texas Title XIX Program. However, your claims will be reconsidered for payment after you are enrolled. The denial of your claims will serve as documentation that your claim was filed within the 95-day filing deadline. Procedures for resubmitting your denied claims for payment consideration will be attached to your enrollment notification letter.

Sincerely,

	Provider Enrollment
	GROUP NAME AND ADDRESS: North Texas Medical Center
Physician's Name: Michael A. Basco, M.D.	1800 North Graves Street
Group Number: 200°CT119	McKinney, Texas 75069
Physician's Specialty: ER Medicine Physician's Medicare Number: 80 F 197(
Physician's Medicare Number:	DO NOT WRITE IN THIS AREA
License Number: H 5 15 1 (If "temporary", attach a copy)	County Spec Type Locality Effective Date
Please enroll me with the group practice listed above.	Errollmant Date: 1248 Initials: 12
Physician's Signature Date - 28 - 80	Erroument debt.

POWER OF ATTORNEY

Medicare/Medicaid requires that we include a Power of Attorney authorizing EmCare to sign for the individual physician when applying for numbers on your behalf. These applications are submitted for each hospital or facility in our system for which you will be working. This Power of Attorney will be kept in your file to expedite the application process for these numbers.

POWER OF ATTORNEY

I hereby authorize She Hally of EmCare Incorporated, to apply for Medicare/Medicaid privileges on my behalf while I am working with EmCare Incorporated.

Date Date

Signature Michael Basco, M.D.

Print Name Please

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TEXAS MEDICAID

PROVIDER ENROLLMENT APPLICATION

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ALL INFORMATION MUST BE COMPLETED OR MARKED "NA"	AND CONTAIN A VAUD BIGNATURE TO BE PROCESSED.			
A PROVIDER OF SERVICE INFORMATION NORTH	TEXAS MEDICAL CENTER			
APPLICANT NAME (HIDTY., GROUP, MC., DRA-SHOW AS LICENSED)	ADDRESS HO. 1 (Presiden Lawriton)			
Basco, Michael A. M.D.	1800 N. GRAVES ST.			
Lauria Groupi a Company First Instal The Dag or	Notes -			
TELEPHONE NUMBER Aveccode (800) 962-3303 - :	McKINNEY TX 75069			
TYPE OF PROVIDER (PRIMARY SPECIALTY)	EMERCENCY HYSICIANS BILLING SERVICE, INC.			
	P.O. BOX 96118, S.E. STATION			
EMERGENCY MEDICINE	Notice Street of P.O.Box			
PHYSICIAN LICENSE 4 FISCAL YEAR END	OKLAHOMA CITY OK 73143			
· H5151	Gy State Zo			
B BILLING INFORMATION				
	1913 Employer's I.D. 4 Seeds Security 4			
SIGNATURE ON FILE	73-1230653			
What is your MEDICARE or SLUE SHIELD Provided Humber?	I you win never bill the Medicars Program. due to your speciality or practice, shack here			
00D94Z				
C GROUP PRACTICE INFORMATION: List all ph	ysician members of your group.			
LICENSE # NAME	Title Medicare "800000" series #			
:				
1				
,				
D OTHER INFORMATION				
is this location: In addition to other Located will Practice locations?	thin a hospital? If yes, is this application for the purpose of billing as an YPC			
Full Time X Part Time Yes X	He Emergency Room Physician? YES			
PALLET	DO NOT WRITE IN THIS AREA			
To the best of my knowledge, the information supplied on	DO NOT WAITE IN THIS AREA			
this document is accurate and complete and is hereby	County Spec Type Locality Effortive Date			
released to National Heritage Insurance Company and	L'arrangement de la constitución			
Texas Department of Human Services for the purpose of the purpose				
issuing a Provider Number.				
Signature of Applicant	RETURN FORM TO:			
Michael A Grandle Sur Stall	N.H.I.C.			
Milliam Masculation That	Provider Enrollment			
aigniture .	11044 Research Blvd., Bldg. "C"			
711) S[31]90	Austin, Texas 78759			
1 1111				

POWER OF ATTORNEY

Medicare/Medicaid requires that we include a Power of Attorney authorizing EmCare to sign for the individual physician when applying for numbers on, your behalf. These applications are submitted for each hospital or facility in our system for which you will be working. This Power of Attorney will be kept in your file to expedite the application process for these numbers.

POWER OF ATTORNEY

I hereby authorize _______ of EmCare Incorporated, to apply for Medicare/Medicaid privileges on my behalf while I am working with EmCare Incorporated.

Ul Apr 89

Michael Basco, M.D.

Print Name Please

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C 11044 Research Boulevard (800) 252-9224

JUNE 08, 1990

PODOD94Z2 BASCO, MICHAEL A. MD 1800 N GRAVES ST MCKINNEY, TX 75069

DEAR PROVIDER

THIS LETTER NOTIFIES YOU OF YOUR ENROLLMENT IN THE TEXAS MEDICALD PROGRAM. YOUR NINE-DIGIT PROVIDER NUMBER IS POODD9422.

NATIONAL HERITAGE INSURANCE COMPANY (NHIC) IS THE INSURER OF THE TEXAS MEDICAID PROGRAM UNDER CONTRACT WITH THE TEXAS DEPARTMENT OF HUMAN SERVICES. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE CONTACT OUR PROVIDER RELATIONS STAFF AT 1-800-252-9224 OR 512-343-4900.

A TEXAS MEDICAID PROVIDER PROCEDURES MANUAL AND PROVIDER BILLING LABELS ARE BEING SENT TO YOU UNDER SEPARATE COVER. THE BILLING LABELS ARE PRE-PRINTED WITH YOUR NAME, ADDRESS AND PROVIDER NUMBER AND SHOULD BE PLACED IN THE APPROPRIATE BLOCK OF YOUR CLAIM FORM. PLEASE VERIFY THE INFORMATION ON THE PRINTED LABELS AND ADVISE THE PROVIDER ENROLLMENT DEPARTMENT OF ANY CORRECTIONS.

THANK YOU FOR YOUR PARTICIPATION AND WELCOME TO THE TEXAS MEDICALD PROGRAM.

SINCERELY.

PROVIDER ENROLLMENT

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C 11044 Research Boulevard (800) 252-9224

DECEMBER 08, 1989

ZODO ¢T283 BAYLOR MEDICAL CTR AT ENNIS 803 WEST LAMPASAS ST ENNIS, TX 75119

DEAR PROVIDER

WE HAVE COMPLIETED THE ENROLLMENT OF FASCO, MICHAEL A. MD, PERFORMING PROVIDER NUMBER P 3793952, AND HAVE ADDED HIM/HER TO YOUR GROUP ASSOCIATION.

PLEASE USE THIS PERFORMING AUGRER IN THE DETAIL PORTION OF THE CLAIM FORM TO IDENTIFY THE PERFORMING PROVIDER.

IF THIS PROVIDER SHOULD CHOOSE TO LEAVE YOUR GROUP, PLEASE NOTIFY THE PROVIDER ENROLLMENT DEPARTMENT THREDITATELY.

THANK YOU FOR YOUR PARTICIPATION TO THE TEXAS MEDICATO PROGRAM.

SINCERELY.

PROVIDER ENGOLLMENT

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TEXAS MEDICAID Group Practice Enrollment Application

This form is to be used to request the enrollment of a new physician into an established group practice.

If you would like to enroll your new physician in the Texas Title XIX (Medicaid) Program, please have the physician sign in the section below and return this form to:

National Heritage Insurance Company PROVIDER ENROLLMENT DEPARTMENT 11044 Research Blvd., Bldg. C Austin, Texas 78759-5239

If you have claims for services performed by this new physician, send the claims to:

National Heritage Insurance Company CLAIMS PREPARATION P. O. Box 200555 Austin, Texas 78720-0555

All claims for services rendered to Medicaid recipients who do not have Medicare benefits are subject to a 90-day filting deadline by program requirements. This means that your claim for services must reach our offices within 90 days, plus 5 days mail time, of the date of service of that recipient. Please submit as soon as possible any claims you may have even though your physician is not yet enrolled with NHIC.

Claims without Medicare involvement will be denied until you are enrolled in the Texas Title XIX Program. However, your claims will be reconsidered for payment after you are enrolled. The denial of your claims will serve as documentation that your claim was filed within the 95-day filing deadline. Procedures for resubmitting your denied claims for payment consideration will be attached to your enrollment notification letter.

Sincerely. Provider Enrollment PHYSICIAN'S INFORMATION: GROUP NAME AND ADDRESS: Physician's Name: Mi Chie Baylor Medical Center at Ennis Group Number: 222CT28 P. O. Box 1420 Physician's Specialty: ER Medicine Ennis, Texas 75119 Physician's Medicare Number License Number: DO NOT WRITE IN THIS ARE (If "temporary", attach a copy) Please enroll me with the group practice listed above. Physician's Signature Date 11-21-89

9/8, 1/46

2000年10月20日本の日本の一、日本日本の

POWER OF ATTORNEY

Medicare/Medicaid requires that we include a Power of Attorney authorizing — EmCare to sign for the individual physician when applying for numbers on your behalf. These applications are submitted for each hospital or facility in our system for which you will be working. This Power of Attorney will be kept in your file to expedite the application process for these numbers.

POWER OF ATTORNEY

I hereby authorize ________ of EmCare Incorporated, to apply for Medicare/Medicaid privileges on my behalf while I am working with EmCare Incorporated.

AYDV 89

Signature Michael Basco, M.D. Print Name Please

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- 10			

TITLE

National Heritage Insurance Company 12545 Riata Vista Circle Austin, Texas 78727-6404 (512) 514-3000

An EDS Company July 14, 2000

IMPORTANT! Immediate Response Required Annual Provider File Verification Needed

In accordance with the Texas Provider Procedures Manual, providers must promptly advise the NHIC Provider Enrollment Department in writing of changes in address (physical location or accounting), telephone number, name, ownership status, tax identification, and any other information pertaining to the structure of the provider's organization. Failure to notify NHIC of changes affects accurate processing and timely claims payment. This information is collected and stored independently from any information you may have supplied NHIC through the re-enrollment process. You will receive an annual verification letter for each Medicaid and CSHCN (CIDC) number you have on file with NHIC.

The information below represents the data currently on file for your provider number printed. Please verify that all of the provider specific information printed on this letter is correct. Mark the appropriate box below and respond to NHIC via fax or mail. If the information on this form is incorrect, please correct the information directly on this form and return to NHIC. If you have any questions, please call NHIC Customer Service at (800) 925-9126,

Please mail or fax your response to:

National Heritage Insurance Company (NHIC) Attention: Provider Enrollment P.O. Box 200795 Austin, Texas 78720-0795 FAX (512) 514-4252

PROVIDER SPECIFIC INFO:	CURRENT INFO:	CORRECTIONS
PROVIDER #	P087G3952	CORRECTIONS: (Completed by Provider)
PHYSICAL NAME:	BASCO, MICHAEL A. MD	
PHYSICAL ADDRESS:	803 W Lampasas St Ennis, TX 75119-4535	
PHYSICAL PHONE #:	(000) 000-0000	
ACCOUNTING NAME:	BASCO, MICHAEL A. MD	
ACCOUNTING ADDRESS:	PO BOX 1420	1
(if name change submit W9)	ENNIS, TX 75119	
ACCOUNTING PHONE #:	(000) 000-0000	
LICENSE: (if incorrect submit license copy)	H5151	
TAX IDENTIFICATION NUMBER: (if incorrect submit W9)	Refer to Group #T.I.N.	
* If Tax ID # correction is	due to a change in ownership contact NHIC by phone or w	uny ode phis com 6
☐ Please CANCEL the provide	r number listed on this form	
☐ My provider specific informa	(Provider signature or authorize individual if a group or facility tion contained on this form is correct (response not necessary).	Date
	tion contained on this form is incorrect	
	tion contained on this form is incorrect, and I have made the ne	ecessary corrections on this form for update.
7 7.3 ° 2	(or authorized individual if a group or facility)	
Provider Name (printed):	and a good of the landy)	Date
_	(or authorized individual if a group or facility)	Date

IF YOU DO NOT RESPOND TO THIS INQUIRY NHIC WILL ASSUME THAT ALL OF THE PROVIDER SPECIFIC INFORMATION REPORTED ON THIS FORM IS TRUE AND ACCURATE.

Date

NATIONAL HERITAGE INSURANCE Co.

Austin, Texas 78759-5239

Building C 11044 Research Boulevard (800) 252-9224

JANUARY 05. 1990

ZOOOHV333 HOOD GENERAL HOSP ER PHYS 1310 PALUXY 20 GRANBURY, TX 76048

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BASCO. MICHAEL A. MD. PERFORMING PROVIDER NUMBER PO89G3324. AND HAVE ADDED HIM/HER TO YOUR GROUP ASSOCIATION.

PLEASE USE THIS PERFORMING NUMBER IN THE DETAIL PORTION OF THE CLAIM . FORM TO IDENTIFY THE PERFORMING PROVIDER.

IF THIS PROVIDER SHOULD CHOOSE TO LEAVE YOUR GROUP, PLEASE NOTIFY THE PROVIDER ENROLLMENT DEPARTMENT IMMEDIATELY.

THANK YOU FOR YOUR PARTICIPATION IN THE TEXAS MEDICAID PROGRAM.

SINCERELY.

PROVIDER ENROLLMENT

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National Heritage Insurance Company PROVIDER ENROLLMENT DEPARTMENT 11044 Research Blvd., Bldg. C Austin, Texas 78759-5239

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National Heritage Insurance Company CLAIMS PREPARATION P. O. Box 200555 Austin, Texas 78720-0555

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Sincerely.

	Provider Enrollment
PHYSICIAN'S INFORMATION:	GROUP NAME AND ADDRESS:
Physician's Name: Basco, Michael Md	Hood General Hospital ER
Group Number: Z000HV333	1310 Paluxy Rd
Physician's Specialty: OB Gen	Granbury, TX 76048
Physician's Medicare Number: 10 89G332 4	2000.00
License Number: H5151 - (If "temporary", attach a copy)	DO NOT WRITE IN THIS AREA
Please enroll me with the group practice listed above. Michael Bosco md 12-15-8	County Spec Type Lacestry Effective Data 17-3-90 C 5-1

Section C REQUIRED INFORMATI	ON FOR:
All Licensed Providers: PS - 500 7150	, DEA-BB179-4797.
Must attach a copy of license	, DEA- BOITS 4717,
Must attach a copy of license	1
Ambulance: N/A	
Must attach a copy of the permit/license from TDH	: 41
	The state of the s
Birthing Center Providers Only: N/A Must attach a copy of the certification permit from TDH	
Certified Registered Nurse Anesthetist Providers On	ly: <i>N/A</i>
Must attach a copy of CMA certification or recertification card	
Chemical Dependency Treatment Facility Providers (Only: N/A
Must attach a copy of TCADA license	
CLIA Providers: #-45/00/708223	
Must attach a copy of CLIA license with Lipp. Jved specialty services as appropriate	
FQHC Providers Only:	
Must attach a list of contracted providers and names and addresses of your satellite	centers that have been approved by the Public Health Service and
copy of grant award	
Mammography Services Only:	
Certification Number:	DC/Long
Must attach a copy of certification of mammography systems from the Texas Departr	ment of Bureau of Radiation Control (BRC)
MHMR Providers Only: N/A	
Must attach a copy of approval letter, from the Texas Department of MHMR	minimum II H.I.P.
To the best of my knowledge, the information supplied on this	Do Man Weign to This A
document is accurate and complete and is hereby released to	Do Not Write In This Area (For Office Use Only)
National Heritage Insurance Company and Texas Department of Health for the purpose of issuing a Medicaid provider number.	,
Signature of applicant or an authorized representative fl.you are enrolling as a provider group/supplier)	#
	· · · · · · · · · · · · · · · · · · ·
Signature	Date:
organiste 12 /attai	100 m
Tal.	Initials:
Title Date	
otification of your assigned Texas Medicaid provider number will be mailed to the Ph	HYSICAL address listed on your application.
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•	Initials:
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TEXAS DEPARTMENT OF HEALTH (TDH) - TEXAS MEDICAL ASSISTANCE PROGRAM (MEDICAID) PROVIDER AGREEMENT (MEDICAID) PROVIDER AGREEMENT

Name of Provider Michael A. Basco, M.D.	*Medicaid Provider I.D. # POCOH 78VL
(Doing Business As) OB Gun	Medicare Provider I.D. # OOHT8V
Physical Address 1600 W College St. 1130	Mailing Address 1600 W College St #LL 30
Grapevine TX 74051	Grapevine

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

A copy of the current Texas Medicaid Provider Procedures Manual (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled Texas Medicaid Bulletin, and written notices are incorporated into this Agreement by reference. Provider has a duty to become familiar with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state and federal laws and amendments governing and regulating Medicaid.

1.2 State and Federal regulatory requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. §1320a-7), or Executive Order 12549.

Provider also has not been excluded or debarred from participation in any other state or federal health-care program. Provider must notify TDH or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 C.F.R. Part 76, "Governmentwide Debarment and

*Please list additional provider numbers on the Addendum Statement for this Agreement. New applicants should leave this pace blank.

Suspension (Nonprocurement); and Governmentwide Requirements for Drug-Free Workplace (Grants)." This regulation requires the Provider, in part, to: (a) execute the attached "Certification (Grants)." This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to TDH or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 C.F.R. Part 76 by participants in lower tier covered transactions.

- 1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to TDH; the Texas Health and Human Services Commission, the Texas Department of Human Services, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing TDH or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least ten (10) business days prior to making such changes. Provider also agrees to notify TDH or its agent within ten (10) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to TDH complete information related to any such suspension or restriction.
- 1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. §431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. §431.107 and copies of those records free of charge to TDH, TDH's agent, the Texas Health and Human Services Commission, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for five (5) years from the date of service [six (6) years for freestanding rural health clinics]; or until all audit or audit exceptions are resolved, whichever period is longest. Provider must cooperate with and assist TDH and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and/or their agents access to its premises.

FEB O 1 1959
Received

- 1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit. Texas Health and Human Samiles
- The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services 1.2.4 Commission's Office of Investigations and Enforcement, and internal and external auditors for the state/federal government and/or TDH may conduct interviews of Provider employees, subcontractors and their employees, witnesses, and recipients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and their employees, witnesses, and recipients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit and/or the Texas Health and Human Services Commission's Office of Investigations and Enforcement. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.
- 1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.
- 1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and TDH's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.
- Child Support. (1) The Texas Family Code §231.006 requires TDH to withhold contract 1.2.7 payments from any entity or individual who is at least thirty (30) days delinquent in child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25% ownership interest is delinquent in any child support obligation, Provider must attach a list of the names, social security numbers; and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25% ownership interest in the Provider. (2) Under Section 231.006 of the Family Code; the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not incligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than thirty (30) days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified grant, loan or payment. (3) If TDH is informed and verifies that a child support obligor who is more than thirty (30) days delinquent is a partner, shareholder, or owner with at least a 25% ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

- Cost Report, Audit, and Inspection. Provider agrees to comply with all state and federal laws 1.2.8
- 1.2.8 Cost Report, Audit, and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.3 Claims and Encounter Data

- Provider agrees to submit claims for payment in accordance with billing guidelines and 1.3.1 procedures promulgated by TDH, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true and accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.
- Provider must submit encounter data required by TDH or any managed care organization to 1.3.2 document services provided, even if the Provider is paid under a capitated fee arrangement by an HMO or IPA.
- All claims or encounters submitted by Provider must be for services actually rendered by 1.3.3 Provider. Physician providers must submit claims for services rendered by another in accordance with TDH rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by TDH for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that TDH is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a recipient for a covered service.
- Federal law prohibits Provider from charging a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20).
- As a condition for eligibility for Medicaid benefits, a recipient assigns all rights to recover from any third party or any other source of payment to TDH (42 C.F.R. §433.145 and Human Resources Code §32.033). Except as provided by TDH's third-party recovery rules (25 TAC Chapter 28), Provider agrees to accept the amounts paid under Medicaid as payment in full
- 1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by TDH of the agent and implement an effective method to track submitted claims against payments made TDH.

- 1.3.8 TexMedNet and Electronic Claims Submission. Provider may subscribe to the TDH TexMedNet
- 1.3.8 TexMedNet and Electronic Claims Submission. Provider may subscribe to the TDH TexMedNet system, which allows the provider the ability to electronically submit claims, claims appeals, verify recipient eligibility, and receive electronic claims status inquiries, remittance and status reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic remittance report. Provider agrees to comply with the provisions of the Provider Manual and the TexMedNet licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to TDH or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from TDH, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

II. ADVANCE DIRECTIVES - HOSPITAL AND HOME HEALTH PROVIDERS

- 2.1 The recipient must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:
- 2.1.1 the individual's right to self-determination in making health-care decisions;
- 2.1.2 the individual's rights under the Natural Death Act (Health and Safety Code, Chapter 672) to execute an advance written Directive to Physicians, or to make a nonwritten directive regarding their right to withhold or withdraw life sustaining procedures in the event of a terminal condition;
- 2.1.3 the individual's rights under Health and Safety Code, Chapter 674, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,
- 2.1.4 the individual's rights to execute a Durable Power of Attorney for Health Care under the Civil Practice and Remedies Code, Chapter 135, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.
- 2.2 The Provider must have a policy regarding the implementation of the individual's rights and compliance with state and federal laws.
- 2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.
- 2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the recipient has or has not executed an advance directive.
- 2.5 The Provider must provide written information to all adult recipients on the provider's policies concerning the recipient's rights.

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2.6	The Provider must provide education for staff and the community regarding advance directives.

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

3.1 Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to TDH the amount of state matching funds expended for eligible services according to established TDH procedures:

school health and related services (SHARS)

case management for high risk pregnant women and infants (PWI)

case management for blind and visually impaired children (BVIC)

case management for early childhood intervention (ECI)

case management for mental retardation (MR)

case management for mental health (MH)

mental health rehabilitation (MHR)

tuberculosis clinics

state hospital physician

3.2 Public entity SHARS providers are also required to reimburse TDH, according to established TDH procedures, the nonfederal share of expenditures made by TDH for SHARS provided by Medicaid approved nonschool providers to children enrolled in their school district.

IV. RECIPIENT RIGHTS

- 4.1 Provider must maintain the recipient's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.
- 4.2 The recipient must have the right to choose providers unless that right has been restricted by TDH or by waiver of this requirement from HCFA. The recipient's acceptance of any service must be voluntary.
- 4.3 The recipient must have the right to choose any qualified provider of family planning services.

SESO PROCESSION SESSION

SB30 Re-Enrollment FEB 0 1 1999 Received

V. TERM AND T	ERMINA'	TION		
This Agreement will be	.66			
days advance notice of in the Provider is excluded certificate, becomes ineli provisions of this Agreer risk. TDH may terminate Medicaid program for 12 Provider Signature	from the M gible for p ment, or if this Agree months.	rminate this Agreement be rminate. TDH may immed Medicare or Medicaid proparticipation in the Medica the Provider is or may be sement without notice if the Date	y providing the providing the programs for a program placing the Provider	ne date the Agreement is terminated g the other party with thirty (30) ninate the Agreement for cause if any reason, loses its licenses or m, fails to comply with the e health and safety of recipients at has not submitted a claim to the
Printed Name and Title o				
Michael A.	06560	M.D		
are fully represented by t	he inform	ation contained in the	e-signed ag n I am rep	greement, application, and provider orting that these provider numbers ments and that all provisions s. List all provider numbers:
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CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

Attachment I

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors. Contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor; "contract" refers to both contract and subcontract.

By signing and submitting this certification the potential contractor accepts the following terms:

- The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is
 later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal
 government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or
 the HHSC may pursue available remedies, including suspension and/or debarment.
- The potential contractor will provide immediate written notice to the person to which this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
- The words "covered contract", "debarred", "suspended", "ineligible", "participant", "person", "principal", "proposal", and "voluntarily excluded", as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.
- 4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract?

Indicate in the appropriate box which statement applies to the covered potential contractor:

- The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.
- 6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.
- 7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
- 8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRAC

The potential contractor certifies, by submission of this certification, that neither declared ineligible, or voluntarily excluded form participation in this contract by	r it nor its principals is presently debarred, y any federal department or agency or by th	suspended, proposition of debugment, when the State of Texas.
The potential contractor is unable to certify to one or more of the terms in this ceach of the above terms to which he is unable to make certification. Attach the explanation of the above terms to which he is unable to make certification.	ertification. In this instance, the potential cuation(s) to this certification.	contractor must attach an explanation for
Name of Potential Contractor Michael A. Basco, M.D.	Vendos ID No. Or Social Security No. 27772	HHSC Contract No. (if applicable)
Mily Jan W 12/28/98	Printed Typed Name and Title of Apporized R	0 14.0 0; "
Signature of Authorized Representative Date	-	Received 1955

CERTIFICATION

REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

Attachment I

DEFINITIONS

DEFINITIONS

Covered Contracts/Subcontract.

- (1) Any nonprocurement transaction which involves federal funds (regardless of amount and including such arrangements as subgrant and are between HHSC or its agents and another entity.
- (2) Any procurement contract for goods or services between a participant and a person, regardless of type, expected to equal or exceed the federal procurement small purchase threshold fixed at 10 U.S.C. 2304(g) and 41 U.S.C. 253(g) (currently \$25,000) under a grant or subgrant.
- (3) Any procurement contract for goods or services between a participant and a person under a covered grant, subgrant, contract or subcontract, regardless of amount, under which that person will have a critical influence on or substantive control over that covered transaction:
 - a. Principal investigators.
 - b. Providers of audit services required by the HHSC or federal funding source.
 - c. Researchers.
- Debarment. An action taken by a debarring official in accordance with 45 C.F.R. Part 76 (or comparable federal regulations) to exclude a person from participating in covered contracts. A person so excluded is "debarred".
- Grant. An award of financial assistance, including cooperative agreements, in the form of money, or property in lieu of money, by the federal government to an eligible grantee.
- Ineligible. Excluded from participation in federal nonprocurement programs pursuant to a determination of ineligibility under statutory, executive order, or regulatory authority, other than Executive Order 12549 and its agency implementing regulations; for example, excluded pursuant to the Davis-Bacon Act and its implement regulations, the equal employment opportunity acts and executive orders, or the environmental protection acts and executive orders. A person is ineligible where the determination of ineligibility affects such person's eligibility to participate in more than one covered transaction.
- Participant. Any person who submits a proposal for, enters into, or reasonably may be expected to enter into a covered contract. This term also includes any person who acts on behalf of or is authorized to commit a participant in a covered contract as an agent or representative of another participant.
- Person. Any individual, corporation, partnership, association, unit of government, or legal entity, however organized, except: foreign governments or foreign governmental entities, public international organizations, foreign government owned (in whole or in part) or controlled entities, and entities consisting wholly or partially of foreign governments or foreign governmental entities.
- Principal. Officer, director, owner, partner, key employee, or other person within a participant with primary management or supervisory responsibilities; or a person who has a critical influence on or substantive control over a covered contract whether or not the person is employed by the participant. Persons who have a critical influence on or substantive control over a covered transaction are:
 - (1) Principal investigators.
 - (2) Providers of audit services required by the HHSC or federal funding source.
 - (3) Researchers.
- Proposal. A solicited or unsolicited bid, application, request, invitation to consider or similar communication by or on behalf of a person seeking to receive a covered contract.
- Suspension. An action taken by a suspending official in accordance with 45 C.F.R. Part 76 (or comparable federal regulations) that immediately excludes a person from participating in covered contracts for a temporary period, pending completion of an investigation and such legal, debarment, or Program Fraud Civil Remedies Act proceedings as may ensue. A person so excluded is "suspended".
- Voluntary exclusion or voluntarily excluded. A status of nonparticipation or limited participation in covered transactions assumed by a person pursuant to the terms of a settlement.

TEXAS MEDICAID MEDICAID

MEDICAID PROVIDER ENROLLMENT APPLICATION 2							
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	ROVIDER OF SERVICES INFO				4		É
APPLICANT NAME	(INDIV., GROUP, INC., DBA) AS IT		M.D.		ADDRESS OF PHY	SICAL LOCATIO	N (NOT A P.O. BOX)
BASCO Last Name/Group/G	MICHAEL First	Initial 1	, ב.נ. אין Title/Degree	<u></u>	Number	Street	Room/Suite
TELEPHONE NUM		DO YOU WAN		CK.			74
Area Code (81	7)- 545-4850	IN PROVIDER		(NO)	Bedford	Tx	76021
TYPE OF PROVID	ER (PRIMARY SPECIALTY): 8	B/Gyn			City	State	Zip Code
	TION FOR THE PURPOSE OF	IF AMBULANC			ACCOUNTING ADD	DRESS/MAIL CH	ECK TO: ()
	MERGENCY ROOM PHYSICIAN		ACH A COPY			port Free	
	NO)		RTIFICATION	<u> </u>	Number S	treet/P.O. Box	/ Room/Suite
IS THIS AN VE	ENTIFICATION NUMBER (TIN): EMPLOYER'S TAX ID ORSOC	7524577 IAL SECURITY N	UMBER?		Bedford	TX	76026
	E THE NAME OF THE ABOVE TIN A	S SHOWN ON I.F			City	State	Zip Code
	ICHAEL A. BASC	<u>a. M.D</u>					
LICENSE # (Attact	copy if temporary) Issue Date:	POOD H	7886	\supset	PROVIDER NUMBI		NO MEDICAID
If name of app	nlicant in Section "A" is a group	practice, plea	se complet	e sect	ion "B" below.		
B G	ROUP PRACTICE INFORMA	TION - List all	members	of yo	ur group.		
LICENSE #	NAME		TITLE	ME	DICARE 800,000 #	SPECIALT	Y OF PRACTICE
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National Herita	ge Insurance Company and	Texas Departm	nent of	١.			
Health for the p	surpose of issuing a Medicaid p	rovider numbe	er.	#	<u> </u>		
Signature of Pt	nysician/Doctor			(County Spec. T	ype Locality	Effective Date
(or an authorized r	representative if you are enrolling as a	provider group/s	upplier))	- [.			
	Day (Issaio	mD			111 111 1	11 1111	cuiu
	Signature		— I	١,	، س		الطلطاطاط
		3/2010					
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ALL INFORMATION MUST BE COMPLETED OR MARKED "N/A" AND CONTAIN A VALID SIGNATURE TO BE PROCESSED.

RETURN COMPLETED FORM TO:

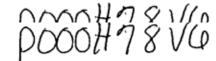
HECEIVED

NHIC'S RECEIPT OF APPLICATION;

Provider Enrollment
National Heritage Insurance Company
11044 Research Blvd., Bldg. C
Austin, Texas 78759-5239

APR 0 3 1993

PAOV. ENA.



MICHAEL A. BASCO, M.D.

Medical Plaza Professional Building 800 Eighth Avenue, Suite 616 Fort Worth, Texas 76104 0240603753000 Phone: (817) 335-5333

TO WHOM IT MAY CONCERN:

EFFECTIVE JANUARY 01, 1993 NEW TAX ID # FOR MICHAEL A. BASCO, MD IS:

75-2457772 (PREVIOUS #552350350)

ANY QUESTIONS, PLEASE CONTACT THIS OFFICE.

MICHAEL A BASCO, MD

RECEIVED

JAN 28 1993

PROV. ENR.

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Medical Plaza PRECENED Build 800 Eighth Aven RECENED Phone: (817) 33 JAN 20 1993

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TO WHOM IT MAY CONCERN:

EFFECTIVE JANUARY 01, 1993 NEW TAX ID # FOR MICHAEL A. BASCO, MD IS: POUNDER ₱ PODOH78V6

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(PREVIOUS #552350350)

ANY QUESTIONS, PLEASE CONTACT THIS OFFICE.

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MICHAEL A BASCO, MD

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INFERTILITY

Austin, Texas 78759-5239

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F00178V6 BASCO, RICHAEL A. RD 800 8TH AVE # 616 P0RT BORTH, TX 76104

DEAR PROVIDER

THIS LETTER NOTIFIES YOU OF YOUR EUROLLMENT IN THE TEXAS MEDICATO

MATIONAL HERITAGE INSURANCE COMPANY (NHIC) IS THE INSURER OF THE TEXAS DEPARTMENT OF HUMAN SERVICES. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE CONTACT OUR PROVIDER RELATIONS STAFF AT 1-800-873-6768 OR ST2-343-4900.

A TEXAS MEDICAID PROVIDER PROCEDURES MANUAL AND PROVIDER BILLING LABELS ARE BRING SENT TO YOU UNDER SEPARATE COVER. THE BILLING LABELS ARE PRE-PRINTED WITH YOUR NAME, ADDRESS AND PROVIDER NUMBER AND SHOULD BE INFORMATION ON THE PRINTED LABELS AND ADVISE THE PROVIDER ENROLLHENT INFORMATION ON THE PRINTED LABELS AND ADVISE THE PROVIDER ENROLLHENT

PROGRAM.

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PROVIDER EUROLLHENT

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TEXAS MEDICAID PROVIDER ENROLLMENT APPLICATION

NHIC'S RECEIPT OF APPLICATION RECEIVED

APR 2 0 1992

PROV. ENR.

A PROVIDER OF SER	VICE INFORMATION	
APPLICANT NAME (INDIV., GROUP, INC., DBA) A	S IT APPEARS ON LICENSE	ADDRESS OF PHYSICAL LOCATION (NOT P.O. BOX)
Basco Micha		800 8th Aveneu, Suite #616
Last Name / Group / Company Frst	Induit Tide/Degree	Number Street Room / Suite
TELEPHONE NUMBER	DO YOU WANT TO BE A LOCK-IN PROVIDER?	
Area Code (817) 335-5333	YES NO X	Fort Worth Texas 76104
TYPE OF PROVIDER (PRIMARY SPECIALTY)	OB/GYN	Coy State Zo Cook ACCOUNTING ADDRESS / MAIL CHECK TO:
IS THIS APPLICATION FOR THE PURPOSE OF BILLING AS AN EMERGENCY ROOM	IF AMBULANCE COMPANY OR CRNA	Same as above
PHYSICIAN? YES NO A	ATTACH A COPY OF YOUR CERTIFICATION	Number Steet / P.O. Bax Room / Suite
tRS EMPLOYER'S TAX ID # (for yearly tax reporting) 552350350	SCCIAL SECURITY # if no employer's tax ID # applicable) 552-35-0350	City State Zo Coor
LICENSE # (attach copy if temporary) MEDICARE PROVIDER #:		HAVE YOU EVER BEEN ASSIGNED A MEDICAID PROVIDER #?
H5151 Issue date:	00H78V	YES NO X

*** If name of applicant in section "A" is a group practice, please complete section "B" below. ***

B GROUP	PRACTICE INFORMA	ATION - List all r		
LICENSE #	NAME	TITLE	MEDICARE 800,000 #	SPECIALTY OF PRACTICE
	N/A			
1		I		

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to National Heritage Insurance Company and Texas Department of Human Services for the purpose of issuing a Medicaid provider number.

Signature of Physician/Doctor
(or an authorized representative if for an enrolling as a provider group/supplier)

Signature

M.D. 4/17/92

Tale

Date

do not write in this area
P000 H78V 6
County Spec. Type Locality Effective Date
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Encollment Date: 4-27-93 Initials:
Enrollment Date: U-27-G> Initials:

ALL INFORMATION MUST BE COMPLETED OR MARKED "N/A" AND CONTAIN A VALID SIGNATURE TO BE PROCESSED.

RETURN COMPLETED FORM TO:

Provider Enrollment
National Heritage Insurance Company
11044 Research Blvd., Bldg. C
Austin, Texas 78759-5239

PO Box 200795 Austin, TX 78720-0795 Fax: 1-512-514-421

March 14, 2011

MICHAEL BASCO 1903 DOCTORS HOSPITAL DR # 36 BRIDGEPOINT, TX 76426

ATTN: All REQUIRED PROVIDERS BE ADVISED: For the year 2011, all required group and performing provider TPI's must attest for the WHP Certification online individually prior to submitting the individually signed forms by mail.

Please review the comments section for assistance.

The Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment Department has received a request to update your file; however, we are unable to process it for the following reason(s): The name you provided does not match the National Provider Identifier (NPI), Atypical Provider Identifier (API), or Texas Provider Identifier (TPI) that you submitted. The effective date of the Tax Identification Number (TIN) or Social Security Number (SSN) is missing. The provider's signature is required. The signature of an authorized representative is required if you are a group or facility. A performing provider cannot sign as an authorized representative. You did not provide an Internal Revenue Service (IRS) W-9 Form. The W-9 Form you provided has two types of taxpayer identification. Indicate the Tax Identification Number (TIN) or Social Security Number (SSN), but not both. Your nine-digit Texas Provider Identifier (TPI) number is required. If you have more than one TPI, include all of the numbers applicable to this request. Your National Provider Identifier (NPI) or Atypical Provider Identifier (API) information is missing. Please include your NPI or API, primary taxonomy, benefit code (if applicable), and physical address. If you have more than one NPI or location, include all of the taxonomies and addresses applicable to each TPI included in this request. Other: The provider must initiate the WHP certification process in PIMS for every TPI. The original signature must be mailed to TMHP (no faxes are allowed). First the provider must have an account registered under the questioned NPI in our website @ www.tmhp.com. Once registered, go to www.tmhp.com, click my account on the blue

the Provider Information Changes screen.

Information Management System. Click on the Medicaid Waiver Programs section of

bar, and then go manage provider accounts, click on the link titled Provider

Should you have provider(s) that fit the listed provider types below in the table, they too will need to go online to attest individual NPI numbers. Each provider NPI for the listed types below enrolled with TMHP will need to go through the WHP Certification. If the performing providers do not have a provider file already setup for certification of WHP services the provider will need assistance on how to create an individual provider file online. Please contact 1-800-925-9126 and follow the prompts to the TMHP EDI line for assistance. Thank you.

Code	Description
19	PHYSICIAN (D.O.)
20	PHYSICIAN (M.D.)
21	PHYSICIAN GROUP (D.O.S ONLY)
22	PHYSICIAN GROUP (M.D.S ONLY AND MULTISPEC.)
46	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
55	MATERNITY SERVICE CLINIC
71	FAMILY PLANNING CLINIC
78	RURAL HEALTH CLINIC - FREESTANDING/INDEPENDENT
79	RURAL HEALTH CLINIC - HOSPITAL BASED

Please submit all of the required information and a copy of this letter to the following address:

Texas Medicaid & Healthcare Partnership Attn: Provider Enrollment Department PO Box 200795 Austin, TX 78720-0795

Thank you for your continued participation in Texas State Health-Care Programs. If you have any questions or need assistance, please call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

PROVIDER	INFORMA	TION CH	ANGE	FORM
	** ** ** ****			

Complete this form to update your provider file(s). Fax the completed form or mail to the appropriate entity PLEASE PRINT OR TYPE THE INFORMATION SUBMITTED ON THIS FORM. PLEASE PRINT OR TYPE THE INFORMATION SUBMITTED ON THIS FORM. P000 H78V6 Date: 12-11-00 Nine-digit Medicaid provider number:___ If you have more than one Medicaid number that will also be using this same information, list the other provider numbers: Accounting/Mailing Address Secondary Physical Address (Cannot be a P.O. Bar) (W-9 Form Required) Telephone Fax Type of Change: (please check the appropriate selection below) Change of Physical Address, phone and/or fax number Change of Billing/Mailing Address, phone and/or fax number Change/Add Secondary Address, phone and/or fax number Change of provider status (i.e., termination from plan, moved out of area, specialist, etc.), please give explanation Other (i.e., panel closing, capacity changes, age acceptance, etc.) Explanation Required: Tax Information: IRS ID Number 75 - 245 - 7172 Effective Date: 12-11-00 List the exact name reported to the IRS for the above Tax ID number: micheal A. Baso M.D. Must be signed and dated or changes cannot be completed: Date: 12-11-00 Provider Signature: Email Address: _

Send your completed change forms to:

NHIC Atm: Provider Enrollment/Melvina. 12545 Rists Vists Circle Austin, TX 78727-6404 Fax: (512) 514-4214 4224 If Managed Care, please send this form via mall or fax to NHIC c/o your respective plan.

Provider Enrollment

An EDS Company

Date: 02/22/01

IRS W9 Form is required to change accounting name and/or Tax I.D. number select only one Tax I.D. number) (excluding providers) is required if you are a group or facility. W-P-A We must have the provider's signature. The signature of an authorized representative Information provided does not match the information in our files. We are unable to locate the name you have given us in our files. unable to process it because of the following reason(s). The WHIC Provider Enrollment Department has received a request to update your file; we are GRAPEVINE, TX 76057 4100 HERITAGE AVE STE 102 MICHEAL A BRASCO MD

administered through the Bureau of Radiation Control. MAR 1 3 2001 We must have your nine digit (alpha, numeric) Texas Medicaid provider number to process your request. It you have more than one Medicaid provider number please include all of the numbers applicable to this request.

Please submit the certificate that is titled, Certification of Mammography Systems,

:radtO [

Thank you for your continued participation in the Texas Medicaid Program. You may contact NHIC's Telephone Inquiry Unit at 1-800-925-9126 if you have any questions. Please provide all the required information and return it to the Provider Enrollment Department.

Enclosures

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INS W9 Form required to change accounting name and 12X LD. number.	3
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We must have the provider's signature (or the signature of an authorized representati	
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GRAPEVINE, TX 76057	
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that you are not subject to backup withholding under 3 above (for reportable

4. You do not certify to the requester

your tax return (for reportable interest and

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2. The IRS tells the requester that you

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payments will not be subject to backup

TIN, make the proper certifications, and If you give the nequester your correct

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Note: If a requester gives you a form other Dackup withholding. certain payments from being subject to appropriate certifications will prevent GMng your correct TM and making the withholding if you are an exempt payee. or (3) to daim exemption from backup you are giving to overect (or you are waiting for a number to be issued). (2) to certify requester (the person requesting your TIN) and, when applicable, (1) to certify the TIN Form W-9 to give your contect TIN to the property, careculation of celot, or IRA. Use contributions you made to an IRA. Use Form W-9 to or in the celot of the celo transactions, montgage interest you paid, the acquisition or abandonment of secured the acquisition or abandonment of secured the secured Income paid to you, real extate

the IRS must get your correct TIN to report rithy muten notismothi as est of betapen Purpose of Formal orthy nosted A

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certain payments from fishing bost operators. Real estate transactions are not muts, raysties, nonemployee, pay, and that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, payments under centain conditions. This is called "backet withholding." Payments

withholding, if applicable, will begin and positive trails out TIN. withholding, if applicable, will begin and continue until you turnlen your TIN. requester. If the requester does not neceive your TIN within 60 days, backup requester. Generally, you will then have 60. and date the form, and give it to the For in the space for the TIN in Part I, sign beliqqA" sinw , VIT a svsrl fon ob uoy il

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for Employer Identification Number from businesses and all other entifies), from the continues of the contin Administration, or Form 55-4, Application, not principle of the principle How To Get a TIM—If you do not have 1899 in the popy for one brunediately. Getpopy, get Form SS-6! Application for a Social Security Number Card (for individuals). I foun your local office oil the Social Security form your local office oil the Social Security form your local office of the Social Security. for the Requester of Form W-9.

information reporting. See the Part II Centain payees and payments are exempl from backup withholding and

5. You do not certify your TIN. See the Part III instructions for exceptions. effer 1883 only, or .

Denego arruccoa brachido bra tzanatri

TIM (Also see Part III bretuctions on page 2.) (RA), and generally payments other than interest and dysdends, you are not required to sign the Certification, but you must provide your correct Certification Instructions.—You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup. For motification instructions, flom 2 does not apply. For motification that because of understoring interest or dividends on your transferrent.

Interest paid, the acquisition or abandonment of secured property, carcetation of debt, contributions to an individual returnment arrangement. The fact that is not always to always the contribution of the contribution of debt, can always the contribution of the contribution of debt, can always the contribution of the contribution of debt, can always and contribution of the contribution of debt. em that I am no longer subject to backup withtholding

I am not subject to bactoup withholding because: (a) I am exempt from bactoup withholding, or (b) I have not been notified by the internal or captor to internal or captor to internal or captor to bactoup withholding as a result or a failure to report all interest or dividence, or (c) the IPS has notified

1. The number shown on this form is my correct taxpayer identification number (or I am writing for a number to be issued to me), and Under penalties of perjury, I certify that III fied

number to enter. see the chart on page 2 for guidelines on whose 0194818896 Note: If the account is in more than one name, fastuctions on page 2) number, see How To Get a TIN below. on page 2. For other entities, it is your employer blocktification number (EIN). If you do not have a Il fiss eet) BribloritiiW III THE (SSN). For sole proprietors, see the instructions <u>oldelofaetalae</u> todmun (thuces bises trey is sirtl, taleubishing צסמקון בינחנות נוישופת. Enter your TIN in the appropriate box. For

For Payees Exempt From Back Taxpayer Identification Number (TIN) List account number(s) here (optional) 201420077 state, and ZIP code

Requester's name and address (optional) TARGE Check Appropriate box 4 3400 Individual/Sole proprietor Corporation drizertite . <u>202500</u> LS egad no troitsutize see mushoon sood senan associate

Marie (Il joint names, first and circle the name of the person of entity whose merber you enter in Part I below, See lastructions on page 2 il your name has changed.)

Identification Number and Certification Request for Taxpayer

send to the IRS, requester. Do NO: Give form to the ENG COMM PURIT

(Page 6 of 7)

Information Note for Internal Use Only

Note Date: 2001-03-19 14:34:43.000
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TWO TIN'S LISTED

ATTO ALIT U DEULDD

NHIC

National Heritage Insurance Company National Heritage Insurance Company

12545 Riata Vista Circle Austin, Texas 78727 (512) 514-3000 An EDS Company

Date: 03/19/01

MICHAEL A BASCO MD 4100 HERTAGE AVE STE 102 GRAPEVINE, TX 76051

The NHIC Provider Enrollment Department has received a request to update yunable to process it because of the following reason(s).	your file; we are
☐ We are unable to locate the name you have given us in our files.	
☐ Information provided does not match the information in our files.	
We must have the provider's signature. The signature of an authorized (excluding providers) is required if you are a group or facility.	ed representative
IRS W9 Form is required to change accounting name and/or Tax I.I only one Tax I.D. number).	D. number select
We must have your nine digit (alpha, numeric) Texas Medicaid proprocess your request. If you have more than one Medicaid proplease include all of the numbers applicable to this request.	
Please submit the certificate that is titled, Certification of Mammo administered through the Bureau of Radiation Control.	graphy Systems,
Other:	
Please provide all the required information and return it to the Provider Enrollm You may contact NHIC's Telephone Inquiry Unit at 1-800-925-9126 if you hav Thank you for your continued participation in the Texas Medicaid Program.	
Enclosures	

Wedate CLIA FORM FOR o DR MICHAREL BASEO MD # 136435807 DR Edwind D Cluek MD # 143895403 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES

LABORATORY NAME AND ADDRESS

MICHAEL A BASCO'MD 4100 HERITAGE AVENUE SUITE 102 GRAPEVINE, TX-76051

LABORATORY DIRECTOR

EXPIRATION DATE

08/31/2004

09/01/2002

EFFECTIVE DATE

CLIA ID NUMBER 45D0708223

TABORALOM I

MICHAEL A BASCO MD

Pursuant to Section 353 of the Public Health Services A

for the purposes of performing laboratory examinations of procedures.

This certificate shall be valid until the expiration date above but is subject to revocation, suspension

For violation of the Act or the regulations promulging

CMS

Mary Party Party Party Party

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

TEXAS MEDICAID

PROVIDER ENROLLMENT

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ALL INFORMATION MUST BE COMPLETED OR MARKED "NA" AND CONTAIN A VALID SIGNATURE TO BE PROCESSED. PROVIDER OF SERVICE INFORMATION 02508002 LATE COMPO COM # 800 ma Code (214) DALLAS OF PROVIDER (PRIMARY SPECIALTY) ADDRESS NO. 2 (ACCOUNTING ADDRESS/MAIL CHECK TO) AMBULANCE COMPANY ATTACH A COPY OF YOUR CERTIFICATION FROM THE 9550 Skillman, L/B 107 DEPARTMENT OF HEALTH Street or P.O.Box OCIAL SECURITY # Dallas, Texas 75243 1990476 *** If name of applicant in "Section A" is a group practice, please fill out "Section B" below: GROUP PRACTICE INFORMATION: List all physician members of your group. M.D. or D.O. SPECIALTY OF PRACTICE LICENSE # SOLANKI, KIRIT. F 2940 MD GP MD HOWE, RUBERI GP EILIA PRICE, JOEL мD GP 65441 LARSON, ARLAN 63120 GP MD2KSTEROVA, NGRID F 5114 BUSAART, JAMES G58L9 BILLING INFORMATION What is your MEDICARE Provider Number? What is your MEDICARE Certification date? DO NOT WRITE IN THIS AREA To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to National Heritage Insurance Company and Texas Department of Human Services for the purpose of issuing a Provider Number. Signature of Applicant RETURN FORM TO: N.H.I.C. 11044 Research Blvd., Bldg. "C" Austin, Texas 78759 Title

Fags 3 DD Stringer らんぽ ROBERT L. HOWE, M. D. COIADARLAN P. LARSON, M. D. H5198 RONALD M. RAMUS, M. D. 0881836 7 Fa940 KIRIT SOLANKI, M. D. 4467 RICHARD L. SALSMAN, M. D. \$\infty 8818333 F5114 INGRID ZASTEROVA, M. D. G5 86 JAMES BUSHART, M. D. michael Besce mo.

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MARCH 24, 1990.

ZOOOLK194 EMERGENCY MEDICAL CLINIC 14902 PRESTON RD #800 DALLAS. TX 75240

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BUSHART, JAMES MD, PERFORMING PROVIDER NUMBER POSSIB309, AND HAVE ADDED HIM/HER TO YOUR GROUP ASSOCIATION.

PLEASE USE THIS PERFORMING NUMBER IN THE DETAIL PORTION OF THE CLAIM FORM TO IDENTIFY THE PERFORMING PROVIDER.

IF THIS PROVIDER SHOULD CHOOSE TO LEAVE YOUR GROUP, PLEASE NOTIFY THE PROVIDER ENROLLMENT DEPARTMENT IMMEDIATELY.

THANK YOU FOR YOUR PARTICIPATION IN THE TEXAS MEDICAID PROGRAM.

SINCERELY.

PROVIDER ENROLLMENT

NON POR 4-17-80 1-68.20- ,001 POR 817 601 1-11.89 1618 ROBERT L. HOWE, M. D. P08818391-1-11-69 10881838 3 057-08-20-001 COLADARLAN P. LARSON, M. D. Now fac 1-11-891 **6**9881836 HS 198 RONALD M. RAMUS, M. D. 057-22-20-001 1-11-85 PO8818359 Fagyo KIRIT SOLANKI, M. D. won pur 057-16-20-001 H4671 **₹**08818333 RICHARD L. SALSMAN, M. D. 1-11-8 9 D8818325 Forly INGRID ZASTEROVA, M. D. meru fac wed bas 10881830 P G5 86 JAMES BUSHART, M. D. Michael 8:500 mg 1-11-84 Non Pa P08818317 Joel Price m.D.

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MARCH 24. 1990

Z000LK194 EMERGENCY MEDICAL CLINIC 14902 PRESTON RD #800 DALLAS, TX 75240

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BOSCO, MICHAEL MD. PERFORMING PROVIDER NUMBER POSSIB317, AND HAVE ADDED HIM/HER TO YOUR GROUP ASSOCIATION.

PLEASE USE THIS PERFORMING NUMBER IN THE DETAIL PORTION OF THE CLAIM FORM TO IDENTIFY THE PERFORMING PROVIDER.

IF THIS PROVIDER SHOULD CHOOSE TO LEAVE YOUR GROUP. PLEASE NOTIFY THE PROVIDER ENROLLMENT DEPARTMENT IMMEDIATELY.

THANK YOU FOR YOUR PARTICIPATION IN THE TEXAS MEDICAID PROGRAM.

SINCERELY.

PROVIDER ENROLLMENT

02/27/2002 02:43 FAX

Heritage Women's Center
Dr. Michael A. Basco & Dr. Edward D. Clark
Gynecology*Infertility*Obstetries
4100 Heritage Avc., Stc. 102
Grapevine, Tv. 76051
Office: (817) 318-0966 Fay: (817) 318-0931

гууна, 1817) 318-0966 — Гах: (817) 318-0931

facsimile transmittal

To: Prov	uder Enn	ollment	Fax:	512-51	4-4214
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Thank you,

MICHAEL A. BASCO M.D.

Michael BASCO TPI# 136435807 Edward D Clark TPI# 143895403

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

MICHAEL A BASÇO MD

1600 WEST COLLEGE STREET SUITE LLXO MICHAEL & BASKO MID

1600 WEST COLLEGE STREET SOTTE LL30 GRAPEVINE TX 76031

MICHAEL A BASCO

1600 WEST COLLEGE STRUET SUITE LLIO GRAPEVENE TX 76031

CLIA ID#: 45D0708223

CLIA ID#: 45D0708223

Effective Deter September 01, 2000

Expiration Detail Aspek 31, 2001

CLIA LABORATORY CERTIFICATE FOR PROVIDER-PERFORMED MICROSCOPY PROCEDURES

ment to Section 353 of the Public Health Survice Act (42 U.S.C. 2634) as revised by the Clinical Laboratory tempoverget Amendment on most laboratory tempos as the sciences shows hereon (and other exproved formical) may except human specimens for the purpose information procedures that have been specified as provides-performed microscopy procedures and, if applicable, examinations or proposed as waited trate by the Department of Health and human Services.

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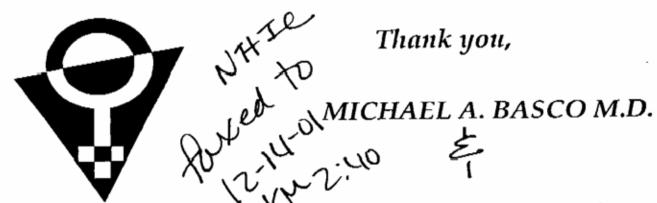
Edward D. Clark 1438 95403

facsimile transmittal

Heritage Women's Center Michael A. Basco & Dr. Edward D. Clark Gynecology*Infertility*Obstetrics 4100 Heritage Arc., Stc. 102 Grapevine, Tx 76051

136435807

To: Pru	vider En	rollment.	ax: 512-5	14 4214	
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Edward Clark HD



Health Care Financing Administration DEPARTMENT OF HEALTH & HUMAN SERVICES

Mailing Addrddress: Laboratory: y: MICHAEL A BASCO MID

1600 WEST COLLEGE STREET SUITE LL30

GRAPEVINE TX 76051

Laboratory Dy Director: MICHAEL A BASCO

1600 WEST COLLEGE STREET SUITE LL30

GRAPEVINE TX 76051

Physical Localocation:

Effective Date:

Septermber 01, 2000



CLIA ID#: 45D0708223

Expiration Date: August 31, 2002

PROVIDER-PERFORMED MICROSCOPY PROCEDURES CLIA LABORATORY CERTIFICATE FOR

been approved and as waived tests by the Department of Health and Human Services. Pursuant to Secisection 353 of the Public Health Service Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the those laboratory ory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have above named latt laboratory: located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing

This certificate lite is subject to revocation, suspension, limitation, or other sanctions for violation of the Act of the regulations promulgated thereunder

Gudies a. Yest

Survey and Certification Group Division of Laboratories and Acute Care Services Center for Medicaid and State Operations Judith A. Yost, Director

FAX	Date 12/	27/01
		es including cover sheet 3
TO: Iracy M	FROM:	NHIC/Andrea Daniel
		12545 Riata Vista Circle AUSTIN, TX 78727-6404
Phone 453-1859	Phone Fax Phone	(512)514-3000 (512)514-4214
cc:		
REMARKS: Urgent For your review	√ ☐ Reply A	SAP Please Comment
This letter came. Think it should it be reached as a	have co	me to you.

Confirmation Report-Memory Send

Time : 12-27-01 10:57am

Tel line 1 : +

Name : NHIC P#E N12D015816 Name : NHIC P#E N12D015816

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Pages sent

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*** SEND SUCCESSFUL ***

FAX Date 12/27/01 NHIC/Andrea Danielp To: Iracy M PROVIDER ENROLLMENT 12545 Riata \'Ista Circle AUSTIN, TX ;'8727-6404 (512)514-3007 (512)514-4214 Fax Phone Please Comment Reply ASAP For your review □ Urgent REM.I.RKS: This letter came to me + I really think it should have come to your the me, I cam be reached a 5143077. andrea

December 9, 2001

Texas State Board of Insurance 9860 P. O. Box 149104
Austin, Texas 74714-9104

I am writing this letter in reference to Dr. Michael A. Basco, M.D.OB/GYN. dba Heritage Women's Center, 4100 Heritage Ave, Ste. 102, Grapevine, Texas 75056.

I was the Office Manager for Heritage Women's Center for 5 months. During that time I discovered illegal activity with regards to billing of claims. Dr. Edward D. Clark occupies space in the Heritage Women's Center but is not a partner, however he shares the overhead with Dr. Basco.

During the course of the year 2000, Dr. Clark was seeing and treating Medicaid patients. As it turns out the previous Office Manager Pam Salinas had not credential Dr. Clark with Medicaid and he did not have a Medicaid number. Under Dr. Basco's direct order all the claims were re-billed under Dr. Basco. However, Dr.. Clark was the treating physician. The claims that were still within the filing deadline were paid, \$50,000.00 dollars worth of claims by Medicaid. This money did not go to Dr. Clark, it went to Dr. Basco. The checks came in made out to Dr. Basco, he claimed since Dr. Clark was in debt to Dr. Basco for six - eight months of overhead, this money-was-rightfully his to repay outstanding debt of Dr. Clark's. This method of filing claims continued on into the year 2001.

Dr. Basco fired m on August 28th, 2001 for reporting him to the Texas State Medical Board for unsafe and unprofessional medical practices. Dr. Basco has been under investigation by the Medical Board for several months now. Every hospital in Tarrant county has canceled his privileges and only one hospital remains he can deliver in. Osteopathic Hospital of Ft. Worth. Baylor Hospital filed a lawsuit against him as well and pulled his privileges. Dr. Basco has had at least 2 malpractice suites against him to my knowledge. It is my understanding that the Medicaid billing for Dr. Clark is still being billed in Dr. Basco, s name. I also know first hand that all

24 7 7

Aetna billing for Dr. Clark was re billed in Dr. Basco's name for a period of time, Dr. Clark was not credentialed with Aetna in 2000. Dr. Clark had nothing to do with this erroneous billing it was done under Dr. Basco's control.

I believe it is time for Dr. Michael Basco to step up to the plate and take responsibility for his actions and direct orders.

Please be aware that Dr. Edward Clark had nothing to do with this decision to re bill his patients under Dr. Basco. However, the Doctors do put in their own-charges-for-billing and the-original-charges were put in the system by Dr. Clark under his own name and were later changed by the front desk receptionist when the claims were mailed out.

Sincerely,

Sharon Gandy

(817) 428-7855

Heritage Women's Center
Dr. Michael A. Basco & Dr. Edward D. Clark
Gynecology*Infertility*Obstetrics
4100 Heritage Ave, Suite 102
4100 Heritage Ave, Suite 102
Grapevine, Tx 76051
Office: (817) 318-0966 Fax: (817) 318-0931

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Thank you,

MICHAEL A. BASCO MD

Dr Edward) Clark # 136435807 Dr Edward) Clark # 143895403 CENTER: FOR MEDICARE & MEDICAID SERVICES
CLINICAL LAI:ORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES

LABORATORY NAME AND ADDRESS

MICHAEL A BASCO MO 4100 HERITAGE AVENUE SUITE 102 GRAPEVINE, TX-76051

LABORATORY DIRECTOR

MICHAEL A BASSCO MD

CLIA ID NUMBER

45D0708223

EFFECTIVE DATE

09/01/2002

EXPIRATION DATE

08/31/2004

Pursuant to Section 353 of the Public Health Serv on Act (42 EESC: 2854) at revised by the Clinical Laboratory Improvement Amendments (CIIA), the above named laboratory located at the address shows thereon (and other approved locations) may accept human specimens for the purposes of performing laboratory commencions or procedure.

This certificate shall be valid until the expression date above but as subject to account on, auspention, instation, or other auctions

Tox violation of the Act or the identification properly and the remodes.

Justil a yet

Judith A. Yast, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations



(Page 3 of 3)

Information Note for Internal Use Only

Note Date: 2003-01-21 14:56:28.000
Parent ICN: EN1030135396000
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Note type: NOTE
User name: tmille01

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(Page 1 of 2) DCN: 200826139001206

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FROM

Provider Information Change Form

providers can complete and submit this form or fax the completed form and any additional	to update their provide	er enrollment file. Print o	r type all of the		
Check the box to indicate a PCCM Provider		Date: 9	117/20	08	
Nine-Digit Texas Provider Identifier (TPI):	36 4 35 807	Provider Name:	1: chael	A BAS	٠,
	647776	Primary Taxonomy Co			
Atypical Provider Identifier (API):	<u> </u>	Benefit Code:			
List any additional TPIs that use the same pr	rovider information:				
TPI:	TPI:		TPI:		
TPI:	TPI:		TPI:		
TPI:	TPI:		TPI:		
Physical Address—The physical address car change their ZIP Code mi		- -		aditional Medic	aid who
Street address 7/3 S. Fm 51 S	wite 201 City	Decatur County	Wise	State Tx	Zip Code 7629
Street address 713 S. Fm 51 S. Telephone: (940) 626-3746	Fax Number: (940	1627-4769	Email: mic	haelbasco	@ medscape.a
Accounting/Mailing Address—All providers along with the	_	the Accounting/Mailing			
Street Address 1713 S.FM 51 S	rite 201 City	No catur		State Tx	Zip Code 76234
Street Address 1713 S.FM 51 & Telephone: (940) 626-3746	Fax Number: (446	0) 627-4709	Email: mich		@ medsage.cc
Secondary Address					
Street Address	City			State	Zip Code
Telephone: ()	Fax Number: ()	Email:	01410	
Type of Change (check the appropriate box		<i></i>	1		
Change of physical address, telephone,					
Change of billing/mailing address, telep	ohone, and/or fax num	iber			
☐ Change/add secondary address, teleph	· · · · · · · · · · · · · · · · · · ·				
☐ Change of provider status (e.g., termina	ation from plan, moved	out of area, specialist)	Explain in the Co	mments field	
Other (e.g., panel closing, capacity char	- nges, and age accepta	nce)			
Comments:					
		· 			-
Tax Information—Tax Identification (ID) Nu		e Internal Revenue Serv	ice (IRS)	**	
Tax ID number: 552 − 35 − 03			117/2008		
Exact name reported to the IRS for this Tax	ID: Michae	el A. BASCO			
Provider Demographic Information—Note: 1			.com.		
Languages spoken other than English:	Spaulsh				
Provider office hours by location: M - I	F 9-5		_		
Accepting new clients by program (check on	e): Accepting ne	ew clients 💢 Cu	rrent clients on	ly 🗆	No □
Patient age range accepted by provider:	Additi	ional services offered (ch	eck one): HIV	⊠ High Ris	k OB ⊠
Participation in the Woman's Health Program	m? Yes Y Ø No□	Patient gender limitation	s: Female 🔀	Male □	Both □
Signature and date are regulred or the form	will/not be processed				
Provider signature:	Namo M			Date: 0 / /	7/2008
10/12/02/0	s Medicaid & Healthca	re Partnershin (TMHP)		ax: 512-514-42	
Provi PO B	s Medicald & Fleatifica ider Enrollment iox 200795 in, TX 78720-0795	io i didicionip (1911).	'	GM OIL GITT	'

Form (Rev. October 2007) Department of the Treasury

Request for Taxpayer **Identification Number and Certification**

Give form to the requester. Do not send to the IRS.

HILELI	ariai nevenue del vice	
	Name (as shown on your income tax return)	
<u>6</u>		
080	Business name, if different from above Michael A. Basco M.D	
5	U	
a g	Check appropriate box: M Individual/Sole proprietor	Exempt
or type	Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership)	▶ □ payee
o ta	Other (see instructions)	aria nama and address (antispol)
Print	Address (number, street, and apt. or suite no.) Pequest 1713 5. FM 51 Suite 201	er's name and address (optional)
, joeci	Check appropriate box: Main Individual/Sole proprietor Corporation Partnership Limited liability company. Enter the tax classification (D-disregarded entity, C-corporation, P-partnership) Other (see instructions) Address (number, street, and apt. or suite no.) 1713 5. FM 51 Su. +e 201 City, state, and ZIP code De catur Tx 76 234	
	List account number(s) here (optional)	
ď	σ	
Pa	Part I Taxpayer Identification Number (TIN)	
Ent	nter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid	Social security number
bac	ackup withholding. For individuals, this is your social security number (SSN). However, for a resident	552 35 0350
	ien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is our employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3	
-	ote. If the account is in more than one name, see the chart on page 4 for guidelines on whose amber to enter.	Employer identification number
Pa	Part II Certification	
Unc	nder penalties of perjury, I certify that:	
1.	The number shown on this form is my correct taxpayer identification number (or I am waiting for a n	umber to be issued to me), and
	I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I it	

I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶

Date >

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
 - Certify that you are not subject to backup withholding, or
- 3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section) 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

The U.S. owner of a disregarded entity and not the entity,

(Page 1 of 2) DCN: 200826239000653

(THU)SEP 18 2008 12:03/ST. 12:03/No. 7516098353 P

FROM

Provider Information Change Form

Traditional Medicaid, Children with Special He providers can complete and submit this form or fax the completed form and any additional	to update their provide	er enrollment file. Print or	type all of the in		
Check the box to indicate a PCCM Provider [- Date: 9	17/ 200	8	
Nine-Digit Texas Provider Identifier (TPI): 13	6435807	Provider Name: 1	117/200 1: chael	A. BAS	ده
· · · · · · · · · · · · · · · · · · ·	647776	Primary Taxonomy Coo	le: 207VI	00 000 X	
Atypical Provider Identifier (API):		Benefit Code:	<u>" </u>		
List any additional TPIs that use the same pro	ovider information:				
TPI;	TPI:		TPI:		
TPI:	TPI:		TPI:		
TPI:	TPI:		TPI:		
Physical Address—The physical address can change their ZIP Code mu				ditional Medic	aid who
Street address 713 S. Fm 51 Su	the Zol City	Decatur County	Wise	State Tx	Zip Code 76259
Telephone: (940) 626-3746	Fax Number: (944)	1.27.47.9			
Accounting/Mailing Address—All providers	·				
along with thi					
Street Address 1713 S.FM 51 S.	The 201 City	no cartur		State Tx	Zip Code 76234
Street Address 1713 S.FM 51 S. Telephone: (940) 626-3746	Fax Number: (940	1627-4709	Email: Micha		@ medsuge.cen
Secondary Address					
Street Address	City			State	Zip Code
Telephone: ()	Fax Number: ()	Email:		
Type of Change (check the appropriate box)					
Change of physical address, telephone,	and/or fax number				
Change of billing/mailing address, telep	hone, and/or fax numb	per			
☐ Change/add secondary address, telepho	one, and/or fax numbe	r			
☐ Change of provider status (e.g., terminate	ion from plan, moved	out of area, specialist) E	xplain in the Com	nments field	
Other (e.g., panel closing, capacity chan	ges, and age acceptar	nce)			
Comments:					
Tax Information—Tax Identification (ID) Nur		_			
Tax ID number: 552 - 35 - 039			117/2004		
Exact name reported to the IRS for this Tax II					
Provider Demographic Information—Note: To Languages spoken other than English:	Spantsh	upaatea on www.tmnp.	.com.		
Provider office hours by location: M - F	G-5				
Accepting new clients by program (check one): Accepting nev	w clients 📈 Cur	rent clients only		No 🗆
Patient age range accepted by provider:		onal services offered (che	eck one): HIV]	M High Ris	k OB 1⊠
Participation in the Woman's Health Program	?Yes 1x1 No □ F	Patient gender limitations		Male □	Both □
Signature and date are regulred or the form	will/not be processed	•	, .		
	Estero Mr)	Da	te: 9 /1	7/2006
Mail or fax the completed form to: Texas Provide PO Bo	Medicaid & Healthcaf ler Enrollment ox 200795 or, TX 78720-0795	e Partnership (TMHP)	Fax	x: 512-514-42	

(Rev. October 2007 Department of the Treasury

Request for Taxpayer **Identification Number and Certification**

Give form to the requester. Do not send to the IRS.

9 2.	Name (as shown on your income tax return)	
on page	Business name, if different from above Michael A. Basco M.D	· · · · · · · · · · · · · · · · · · ·
type	Check appropriate box: M Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partners☐ Other (see instructions) ►	hip) ▶ Exempt payee
Print or fic Instruc		uester's name and address (optional)
P Specific	1713 S. FM SI Suite 201 City, state, and ZIP code De catur TX 76234	
See	List account number(s) here (optional)	
Par	Taxpayer Identification Number (TIN)	
backu	your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to average withholding. For individuals, this is your social security number (SSN). However, for a resider	it 554 35 035 0
alien,	sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, i employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page.	ge 3. or
Note.	If the account is in more than one name, see the chart on page 4 for guidelines on whose er to enter.	Employer identification number
Par	Certification	-

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- 3. Lam a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here

Signature of U.S. person ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
 - 2. Certify that you are not subject to backup withholding, or
- 3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States.
- An estate (other than a foreign estate), or

Date ▶

 A domestic trust (as defined in Regulations section) 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

The U.S. owner of a disregarded entity and not the entity,

Instructions for Completing the Provider Information Change Form

Signatures

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group
 or facility provider numbers.

Address

- · Performing providers (physicians performing services within a group) may not change accounting information.
- For Traditional Medicaid and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Traditional Medicaid, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Tax Identification Number (TIN)

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers cannot change the TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as Medicaid clients and providers to view information about Medicaid-enrolled providers. To maintain the accuracy of your demographic information, please visit the OPL at www.tmhp.com, Please review the existing information and add or modify any specific practice limitations accordingly. This will allow clients more detailed information about your practice.

General:

- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier
 (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable)
 in order to process the change. Forms will be returned if this information is not indicated on the Provider
 Information Change Form.
- The W-9 form is required for all name and TIN changes.
- Mail or fax the completed form to:

Texas Medicald & Healthcare Partnership (TMHP) Provider Enrollment PO Box 200795 Austin, TX 78720-0795 Fax: 512-514-4214

Provider Information Change Form

providers can complete and submit this form or fax the completed form and any additional	to update their provide	er enrollment file. Print o	r type all of the in		
Check the box to indicate a PCCM Provider		Date: 2_	18/200	٠٤	
Nine-Digit Texas Provider Identifier (TPI): 13	6435807	Provider Name: M;	د (دهم (A. Ba	SCO MD PA
Block and Describe Administra (BIDA)	11047776	Primary Taxonomy Cod		(00000)	
Atypical Provider Identifler (API):	<u> </u>	Benefit Code:			<u>` </u>
List any additional TPIs that use the same pr	ovider information:				
TPI:	TPI:		TPI:		***
TPI:	TPI:		TPI:		
TPI:	TPI:		TPI:		
Physical Address—The physical address car change their ZIP Code mu	ist submit a copy of th	e Medicare letter along v		ditional Medica	ild who
10.0	_ suite Za				
Street address 713 5. FM Telephone: (940) 626-3746	S City C		Concili 1		Zip Code 76237
· · · · · · · · · · · · · · · · · · ·		027-4709			e medscape , con
Accounting/Mailing Address—All providers along with the		the Accounting/Mailing a	address must sub	omit a copy of	the W-9 Form
				••	
Street Address 1713 S. Fm 51 S	wite Zol City	Decatur		State"77	کا تے Zip Code کا عام
Telephone: (940) 626-3746	Fax Number: (4%) 627-4709	Email: M. cl	ه العدده 4	medscape con
Secondary Address					
Street Address	City			State	Zip Code
Telephone: ()	Fax Number: ()	Email:		
Type of Change (check the appropriate box	1				
☐ Change of physical address, telephone,	and/or fax number				
☐ Change of billing/mailing address, telep	hone, and/or fax numi	ber			
☐ Change/add secondary address, teleph	one, and/or fax numbe	er			
☐ Change of provider status (e.g., termina	tion from plan, moved	out of area, specialist) E	xplain in the Com	rments fleid	
☐ Other (e.g., panel closing, capacity char	ges, and age acceptar	nce)			
Comments: Add My My	<u> </u>	ulf			
Tax Information—Tax Identification (ID) Nu	mber and Name for the	1	ce (IRS)		
Tax ID number: 75 - 2912950 Exact name reported to the IRS for this Tax I	D: Michae	Effective Date:	M.D. P.	Δ	
Provider Demographic Information—Note: T		10		7	· -
Languages spoken other than English:	Spans 5	upuated on www.tmnp.	.com.		
Provider office hours by location:					
Accepting new clients by program (check one): Accepting ne	w clients 😾 Cur	rent clients only	П	No 🗆
Patient age range accepted by provider:		onal services offered (che			
Participation in the Woman's Health Program		Patient gender limitations			Both 🗆
Signature and date are required or the form			pra	-	-
Provider signature:	Color Lul	-	Da	te: 12 / 8	17-208
	Medicaid & Healthcar	re Partnershin (TMHP)		c: 512-514-42	
Provid PO Bo	der Enrollment ox 200795 n, TX 78720-0795	A - Artistanik (mun)	। ज	· · · · · · · · · · · · · · · · · · ·	·

1

FROM

Departm	W-9 October 2007) Nent of the Treasury Revenue Service	Request for Taxpayer Identification Number and Certification	Give form to the requester. Do not send to the IRS.
ı page 2.		on your income tax return) Michael A BASCO M.D. PA different from above	
nt or type structions on	Umited (lability Other (see instru	Paguacter's name and A	Exempt payee
Print or type Specific Instructions	City. state, and Zi	3 S. Fm S1 Suite 201	
g Ø		/er Identification Number (ΠΝ)	
Enter backı	your TIN in the ap	ppropriate box. The TIN provided must match the name given on Line 1 to avoid or individuals, this is your social security number (SSN). However, for a resident	urity number

Part II Certification

number to enter.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

atien, sale proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose

your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

- 2. I am not subject to backup withholding because; (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- 3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have falled to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here

Signature of U.S. person ▶ Mulay (Sages 40)

Date = 12/08/2008

75

OF

291295 O

Employer identification number

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

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- 1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
 - 2. Certify that you are not subject to backup withholding, or
- 3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States.
- · An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

The U.S. owner of a disregarded entity and not the entity,



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

June 22, 2009

BASCO, MICHAEL A 1713 S FM 51 STE 201 DECATUR, TX 76234

Dear Provider:

The Health and Human Services Commission (HHSC) has identified you or your facility as billing for services provided to Medicaid Women's Health Program clients during calendar years 2008 and 2009. To enable HHSC to ensure compliance with statutory requirements about the use of Medicaid Women's Health Program funds, you, as a billing provider, must complete the enclosed Certification within 30 days from the date of this request

Section 32.0248. Human Resources Code, prohibits payment of Medicaid Women's Health Program funds to a provider that performs elective abortions. A billing provider that has performed elective abortions (through either surgical or medical methods) for any patient is ineligible to serve Medicaid Women's Health Program clients and cannot be reimbursed for those services. This prohibition has been in effect since September 1, 2005.

If HHSC has reason to believe that you or your facility is ineligible to receive funds under the Medicaid Women's Health Program, HHSC may place a payment hold on Medicaid fee-for-service claims made by you or your facility until HHSC can make a final determination regarding you or your eligibility to participate in the Medicaid Women's Health Program. In addition, HHSC may recoup Medicaid Women's Health Program funds that it determines were paid to providers that have performed or promoted elective abortions.

You may call the TMHP Contact Center with questions at 1-800-925-9126.

Sincerely,

Chris Traylor

Texas Medicaid Director

Chilly you

Enclosures

(Page 2 of 3) DCN: 200918800004470

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

This Certification pertains	to the following Billing Provider:
Name of Billing I	Provider: BASCO, MICHAEL A
Tax ID Number_	752912950
	all TPI numbers associated with the Billing Provider)
-	
NPI Number: 14 The Provider's billing add	
Street Address_	1713 S FM 51 Sx 201
Street Address_	Decatur, To 710234
City/State/Zip	Decatur. To 76234
Phone Number	9406263746
The Billing Provider's phy	rsiculi address is.
Street Address_	Same
Street Address_	
(If the Billing Provider has	s additional physical addresses, please list them on a separate page.)
mind, capable of making	I am the Billing Provider or, if the Billing Provider the Billing Provider's (title or position) I am the Billing Provider or, if the Billing
during calendar years 20 use of Medicaid Women's	tified the Billing Provider as providing services to Medicaid Women's Health Program clients 08 and 2009. To enable HHSC to ensure compliance with statutory requirements about the s Health Program funds, each Billing Provider must complete this Certification within thirty s request and must return the completed Certification to:
	Texas Medicaid & Healthcare Partnership
	ATTN: Provider Enrollment PO Box 200795
	Austin, TX 78720-0795
a. I affirm	that the following statements are true and correct with respect to my or my organization's
participation in the Medic (1)	aid Women's Health Program during calendar years 2008 and 2009: The Billing Provider has not performed elective abortion ¹ procedures in calendar years
• •	2008 or 2009.
(2) (3)	The Billing Provider does not perform elective abortion procedures, None of the funds the Billing Provider has received under the Medicaid Women's Health
(0)	Program has been used to pay for or to provide direct support for elective abortion procedures.
(4)	None of the funds the Billing Provider receives under the Medicaid Women's Health Program will be used to pay for or provide direct support for elective abortion procedures

¹ For purposes of this Certification, the term "elective abortion" means the use of any means to terminate the pregnancy of a female whom the attending physician knows to be pregnant with the intention that the termination of the pregnancy by those means is reasonably likely to cause the death of the fetus, except that the term does not include an abortion: (1) to terminate a pregnancy that resulted from an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or ansing from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Name of Billing Provider: BASCO, MICHAEL A

		
	(3c)	435807
NPI N	Number: 1	467647776
	(5)	None of the funds the Billing Provider has received under the Medicaid Women's Heat Program has been used to pay costs associated with referring women for elective ab procedures.
	(6)	None of the funds the Billing Provider receives under the Medicaid Women's Health Program will be used to pay costs associated with referring women for elective aborti procedures.
	(7)	The services for which the Billing Provider has billed the Medicaid Women's Health Program are authorized services under Human Resources Code section 32.0248(a).
	(8)	The services for which the Billing Provider currently bills the Medicaid Women's Heal Program are authorized services under Human Resources Code section 32.0248(a).
b.	In add (1)	ition, I understand and acknowledge that: if the Billing Provider fails to complete and submit this Certification or to update the information and representations made in this Certification as required in paragraph below within 30 days from the date of this request, the Billing Provider will be ineligible to participate in the Medicaid Women's Health Billing Program and Medicaid fee for service claims may be placed on payment hold;
	(2)	if the Billing Provider has in the past or currently does any of the activities listed in Pa of this Certification, the Billing Provider may be ineligible to receive Medicaid Women Health Program funds;
	(3)	if HHSC has reason to believe that the Billing Provider is ineligible to receive funds u the Medicaid Women's Health Program, HHSC may place a payment hold on Medica fee-for-service claims made by the Billing Provider until HHSC can make a final determination regarding the Billing Provider's eligibility;
	(4)	if HHSC determines that the Billing Provider is ineligible to receive funds under the Medicaid Women's Health Program: (A) HHSC may recoup Medicaid Women's Health Billing Program funds paid or claims incurred since the date the Billing Provider became ineligible: (B) HHSC may place a payment hold on all Medicaid fee-for-service claims submitted by the Billing Provider; and (C) the Billing Provider will not be eligible again to participate in the Medicaid
	(5)	Women's Health Program until it ceases every activity listed in Part a; the Billing Provider must notify HHSC at least 30 days prior to implementing any of it activities listed in Part a of this Certification; and if the Billing Provider fails to do so, I may place a payment hold on Medicaid fee-for-service claims made by the Billing Provider; and
	(6)	any false statement or misrepresentation that I knowingly make on this Medicaid Wo Health Program Certification may constitute fraud or tampering with a government re under the laws of Texas and the United States and may lead to my or my organization exclusion from participation in the Medicaid program.
		ments listed in Part a are true and correct. ments listed in Part a are not true and correct
ure	M	while I have my
Name		MA72
		777

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

This Certification pertains to the following Billing Provider:
Name of Billing Provider:
Tax ID Number 7.529(2950
TPI Number (list all TPI numbers associated with the Billing Provider) 13に435 86つ
NPI Number: The Provider's billing address is:
Street Address 1903 DOCHOYS HOSpitally Str 34
Street Address
City/State/Zip Bridge Pn+, To 76424
Phone Number 940 (0830/27
The Billing Provider's physical address is:
Street Address
Street Address School
City/State/Zip
Phone Number
(If the Billing Provider has additional physical addresses, please list them on a separate page.) My name is
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
a. I affirm that the following statements are true and correct with respect to my or my organization's participation in the Medicaid Women's Health Program during calendar years 2008 and 2009: (1) The Billing Provider has not performed elective abortion procedures in calendar years 2008 or 2009. (2) The Billing Provider does not perform elective abortion procedures. (3) None of the funds the Billing Provider has received under the Medicaid Women's Health Program has been used to pay for or to provide direct support for elective abortion procedures. (4) None of the funds the Billing Provider receives under the Medicaid Women's Health
Program will be used to pay for or provide direct support for elective abortion procedures

For purposes of this Certification, the larm "elective abortion" means the use of any means to terminate the programacy of a female whom the attention ghysician knows to be pregnant with the intention that the termination of the programacy by these means is reasonably fixely to cause the death of the letter, except that the term does not include an abortion: (1) to terminate a programacy that resulted from an act of rape or invest; or (2) in the case where a woman numbers from a physical disorder, physical fully, or physical illness, including a life-endangering physical condition caused by or straing from the pregnancy test, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

TPI NI	umber (lis	gal TPI numbers associated with the Billing Provider)	
AID! N	umber		
METH	(5)	None of the funds the Billing Provider has received under the Program has been used to pay costs associated with referring procedures.	e Medicaid Women's Health ing women for elective abortion
	(6)	None of the funds the Billing Provider receives under the M Program will be used to pay costs associated with referring procedures.	edicaid Women's Health women for elective abortion
	(7) (8)	The services for which the Billing Provider has billed the Me Program are authorized services under Human Resources. The services for which the Billing Provider currently bills the Program are authorized services under Human Resources.	Code section 32.0248(a). Medicald Women's Health
b.	in add (1)	ition. I understand and acknowledge that: If the Billing Provider fails to complete and submit this Certi information and representations made in this Certification a below within 30 days from the date of this request, the incident of participate in the Medicald Women's Health	fication or to update the is required in paragraph b(5) e Billing Provider will be h Billing Program and
	(2)	Medicald fee for service claims may be placed on paym if the Billing Provider has in the past or currently does any of this Certification, the Billing Provider may be ineligible to	nent hold; of the activities listed in Part a
*	(3)	Health Program funds; if HHSC has reason to believe that the Billing Provider is in the Medicald Women's Health Program, HHSC may place fee-for-service claims made by the Billing Provider until HH determination regarding the Billing Provider's eligibility;	a payment hold on Medicald
	(4)	if HHSC determines that the Billing Provider is ineligible to Medicaid Women's Health Program: (A) HHSC may recoup Medicaid Women's Health Bill claims incurred since the date the Billing Provider (B) HHSC may place a payment hold on all Medicaid submitted by the Billing Provider; and (C) the Billing Provider will not be eligible again to pa Women's Health Program until it ceases every according to the Billing Provider.	ling Program funds paid on r became ineligible: I fee-for-service claims rticipate in the Medicaid
	(5)	the Billing Provider must notify HHSC at least 30 days prio activities listed in Part a of this Certification; and if the Billin may place a payment hold on Medicaid fee-for-service clai	or to implementing any of the ng Provider fails to do 60, HMSC
	(6)	Provider; and any false statement or misrepresentation that I knowingly Health Program Certification may constitute fraud or tamp under the laws of Texas and the United States and may le exclusion from participation in the Medicaid program.	ering with a government record
ffirm tha	t the stat	ements listed in Part a are true and correct.	
lfirm tha	t the stat	monic listed in Parta are not true and correct	MR20
d Name	Mic	MARIA. BASCO, M.D., PA	

(Page 1 of 3) DCN: 201106039004260



Portal Ticket #: 10791397

Date Printed: Tuesday, March 01, 2011

NPI: 1467647776
Provider Name: BASCO , MICHAEL

www.tmhp.com



(Page 2 of 3) DCN: 201106039004260

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

To enable HHSC to ensure compliance with statutory requirements about the use of Medicaid Women's Health Program funds, each Medicaid enrolled provider that renders services to Women's Health Program clients must complete this Certification and return the completed Certification to:

Texas Medicaid & Healthcare Partnership **ATTN: Provider Enrollment** PO Box 200795 Austin, TX 78720-0795

This Certification pertains to the following provider:

Provider Name

Federal Tax ID Number

National Provider Identifier (NPI) Number

BASCO, MICHAEL

1467647776

The provider is a:

billing provider;

performing provider; or

both.

The Provider's billing address is:

Street Address

Street Address

City/State/Zip

Telephone Number

The provider's physical address is:

Street Address 1903 Doctors Hospital Dr Ste 36

Street Address

City/State/Zip Bridgeport, TX, 764262277

Telephone Number **9406830127**

(If the provider has additional physical addresses, please list them on a separate page.)

My name is **BASCO**, **MICHAEL**. I am the provider or, if the provider is not an individual or performing provider, I am the provider's. I am of sound mind, capable of making this Certification, and personally acquainted with the facts stated here. If I am representing the provider, I am authorized to make this Certification on the provider's behalf.

- a. I affirm that the following statements are true and correct with respect to my or my organization's participation in the Medicaid Women's Health Program:
 - The provider does not perform elective abortion¹ procedures.
 - (2) The provider will not perform elective abortion procedures within the span of effective dates listed below.

Provider Name BASCO , MICHAEL NPT Number 1467647776

- (3) None of the funds the provider receives under the Medicaid Women's Health Program are used to pay for or provide direct support for elective abortion procedures.
- (4) None of the funds the provider receives under the Medicaid Women's Health Program will be used to pay for or provide direct support for elective abortion procedures within the span of effective dates listed below.
- (5) None of the funds the provider receives under the Medicaid Women's Health Program are used to pay costs associated with referring women for elective abortion procedures.
- (6) None of the funds the provider receives under the Medicaid Women's Health Program will be used to pay costs associated with referring women for elective abortion procedures within the span of effective dates listed below.
- (7) The services for which the provider currently bills the Medicaid Women's Health Program are authorized services under Human Resources Code section 32.0248(a).
- (8) The services for which the provider will bill the Medicaid Women's Health Program are authorized services under Human Resources Code section 32.0248(a).
- b. In addition, I understand and acknowledge that:
 - (1) if the provider fails to complete and submit this Certification or to update the information and representations made in this Certification as required in paragraph b (5) below, the provider will be ineligible to participate in the Medicaid Women's Health Program;
 - (2) if the provider has in the past or currently does any of the activities listed in Part a of this Certification, the provider may be ineligible to receive Medicaid Women's Health Program funds;
 - (3) If HHSC has reason to believe that the provider is ineligible to receive funds under the Medicaid Women's Health Program, HHSC may place a payment hold on all Medicaid fee-for-service claims made by the Billing provider until HHSC can make a final determination regarding the provider's eligibility;
 - (4) If HHSC determines that the provider is ineligible to receive funds under the Medicaid Women's Health Program:
 - (A) HHSC may recoup Medicaid Women's Health Program funds paid on daims incurred since the date the provider became ineligible;
 - (B) HHSC may place a payment hold on all Medicaid fee-for-service claims submitted by the provider; and
 - (C) the provider will not be eligible again to participate in the Medicaid Women's Health Program until it ceases every activity listed in Part a;

(Page 3 of 3) DCN: 201106039004260

- (5) the provider must notify HHSC at least 30 days prior to implementing any of the activities list in Part a of this Certification; and if the provider fails to do so, HHSC may place a payment hold on all Medicaid fee-for-service claims made by the provider; and
- (6) any false statement or misrepresentation that I knowingly make on this Medicaid Women's Health Program Certification may constitute fraud or tampering with a government record under the laws of Texas and the United States and may lead

Please check the following statement:

Yes, I affirm that the statements listed in Part a are true and correct.

Effective Date of Certification 3/1/2011 through 12/31/2011

(The effective date of the Certification spans from the date of form completion through the end of the Certification year. Each provider must complete a new certification and mall it to TMHP by the end of each calendar year.)

Terminate WHP Certification Effective Date:		
Signature		
Printed Name	 	
Title	 	

www.tmhp.com



Portal Ticket #: 10791397

Date Printed: Tuesday, March 01, 2011

NPI: 1467647776

Provider Name: BASCO, MICHAEL

www.tmhp.com



(Page 2 of 3)

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

To enable HHSC to ensure compliance with statutory requirements about the use of Medicaid Women's Health Program funds, each Medicaid enrolled provider that renders services to Women's Health Program clients must complete this Certification and return the completed Certification to:

Texas Medicaid & Healthcare Partnership ATTN: Provider Enrollment PO Box 200795 Austin, TX 78720-0795

This Certification pertains to the following provider: **BASCO, MICHAEL** Provider Name Federal Tax ID Number 1467647776 National Provider Identifier (NPI) Number The provider is a: billing provider; performing provider; or Doth. The Provider's billing address is: Street Address Street Address City/State/Zip Telephone Number The provider's physical address is: Street Address 1903 Doctors Hospital Dr Ste 36

City/State/Zip Bridgeport, TX, 764262277

Telephone Number 9406830127

(If the provider has additional physical addresses, please list them on a separate page.)

My name is **BASCO**, **MICHAEL**. I am the provider or, if the provider is not an individual or performing provider, I am the provider's. I am of sound mind, capable of making this Certification, and personally acquainted with the facts stated here. If I am representing the provider, I am authorized to make this Certification on the provider's behalf.

- a. I affirm that the following statements are true and correct with respect to my or my organization's participation in the Medicaid Women's Health Program:
 - The provider does not perform elective abortion¹ procedures.
 - (2) The provider will not perform elective abortion procedures within the span of effective dates listed below.

Provider Name BASCO , MICHAEL

NPI Number 1467647776

- (3) None of the funds the provider receives under the Medicald Women's Health Program are used to pay for or provide direct support for elective abortion procedures.
- (4) None of the funds the provider receives under the Medicaid Women's Health Program will be used to pay for or provide direct support for elective abortion procedures within the span of effective dates listed below.
- (5) None of the funds the provider receives under the Medicaid Women's Health Program are used to pay costs associated with referring women for elective abortion procedures.
- (6) None of the funds the provider receives under the Medicaid Women's Health Program will be used to pay costs associated with referring women for elective abortion procedures within the span of effective dates listed below.
- (7) The services for which the provider currently bills the Medicaid Women's Health Program are authorized services under Human Resources Code section 32.0248(a).
- (8) The services for which the provider will bill the Medicaid Women's Health Program are authorized services under Human Resources Code section 32.0248(a).
- b. In addition, I understand and acknowledge that:
 - (1) if the provider fails to complete and submit this Certification or to update the information and representations made in this Certification as required in paragraph b (5) below, the provider will be ineligible to participate in the Medicaid Women's Health Program;
 - (2) if the provider has in the past or currently does any of the activities listed in Part a of this Certification, the provider may be ineligible to receive Medicaid Women's Health Program funds;
 - (3) if HHSC has reason to believe that the provider is ineligible to receive funds under the Medicaid Women's Health Program, HHSC may place a payment hold on all Medicaid fee-for-service claims made by the Billing provider until HHSC can make a final determination regarding the provider's eligibility;
 - (4) if HHSC determines that the provider is ineligible to receive funds under the Medicaid Women's Health Program:
 - (A) HHSC may recoup Medicaid Women's Health Program funds paid on claims incurred since the date the provider became ineligible;
 - (B) HHSC may place a payment hold on all Medicaid fee-for-service claims submitted by the provider; and
 - (C) the provider will not be eligible again to participate in the Medicald Women's Health Program until it ceases every activity listed in Part a;

Title _

- (5) the provider must notify HHSC at least 30 days prior to implementing any of the activities list in Part a of this Certification; and if the provider fails to do so, HHSC may place a payment hold on all Medicaid fee-for-service claims made by the provider; and
- (6) any false statement or misrepresentation that I knowingly make on this Medicaid Women's Health Program Certification may constitute fraud or tampering with a government record under the laws of Texas and the United States and may lead

Please check the following statement:

 $\ensuremath{\square}$ Yes, I affirm that the statements listed in Part a are true and correct.

Effective Date of Certification 3/1/2011 through 12/31/2011

(The effective date of the Certification spans from the date of form completion through the end of the Certification year. Each provider must complete a new certification and mail it to TMHP by the end of each calendar year.)

Effective Date:

Signature

Printed Name

M. Sheed A. BAS Some

MR20

www.tmhp.com



From:

Provider Enrollment PO Box 200795 Austin, TX 78720-0795

Instructions for Completing the Provider Information Change Form

Signatures

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group
 or facility provider numbers.

Address

- Performing providers (physicians performing services within a group) may not change accounting information.
- For Texas Medicaid fee-for-service and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Texas Medicaid fee-for-service, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Tax Identification Number (TIN)

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- · Performing providers cannot change the TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as Medicaid clients and providers to view information about Medicaid-enrolled providers. To maintain the accuracy of your demographic information, please visit the OPL at www.tmhp.com. Please review the existing information and add or modify any specific practice limitations accordingly. This will allow clients more detailed information about your practice.

General

- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- · The W-9 form is required for all name and TIN changes.
- Mail or fax the completed form to:

Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment PO Box 200795 Austin, TX 78720-0795

Fax: 512-514-4214

From:

Form W-9

Request for Taxnaver

Departn	October 2007) nent of the Treasury Revenue Service	Identification Number and Certific	ation	requester. Do not send to the IRS.
on page 2.		on your income tax return) Michael A. BASCO M.D. PA different from above		
nt or type structions	Limited liabilit		nership) ►	Exempt payee
Print or type See Specific Instructions	Address (245) City state, and Zi List account number	S. FM. 51. St. 3/10	Requester's name and ac	ldress (optional)
Par	Taxpay	er Identification Number (TIN)		
alien,	sole proprietor, or	propriate box. The TIN provided must match the name given on Line 1 to individuals, this is your social security number (SSN). However, for a resi disregarded entity, see the Part I instructions on page 3. For other entitie tion number (EIN). If you do not have a number, see <i>How to get a TIN</i> on	dent	ity number
Note.	If the account is i	n more than one name, see the chart on page 4 for guidelines on whose	Employer ide	2-91295 0
Part	Certific	ation	1,2; 4	-112730

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- 3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here

Signature of U.S. person ▶

Date >

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- 1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued)
 - 2. Certify that you are not subject to backup withholding, or
- 3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States.
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the

The U.S. owner of a disregarded entity and not the entity,

02/23/2012 16:14

#016 P.003/003

From:

02/23/2012 17:47 FAX

2002/002

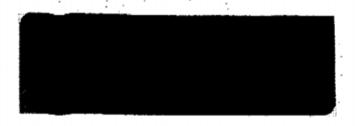
From:

02/23/2012 15:15 #014 P.002/002

Provider Information Change Form

Texas Medicaid fee-foreavine Call	TO VIGET INTOLI	auon Change	Form	
Texas Medicald fae-for-service, Chili (PCCM) providers can complete and form. Mall or fax the completed for Check the box to indicate a PCCM P	submit this form to update the	eeds (CSHCN) Services Prog ir provider enrollment file. Pr	ram, and Primary Care C	ase Management
Check the box to indicate - Door to	and deciments	tion to the address at the bo	of the page	metion on this
Nins-Oleit Taxon Provident Linear	rovider 🗅	Date : 2/2	3,2012	
Nine-Digit Texas Provider Identifier ((36435 KE)	Provider Nome		
The state of the s	67647776	Primary Taylor	school Bosc	<u> </u>
Atypical Provider Identifier (API):		Benefit Code:	90 JAMMOX	
List any additional TPIs that use the	same provider information;			
1711 13 6U 35 KU 7	TPI:			
TPI:	TPI;	TP		
	TPI:			
Physical Address—The physical add change their ZIP	ress cannot be a PO Box. Ambu	latory Surgical Centurs enrol	ed with Tradition - 1 ha	
Grange their Zip	Code must submit a copy of the	Medicare letter along with t	his form.	caid who
Street address 20515 Fa	C1 81.35			
Telephone: (Q40) (Q74)	Fax Number (deta	lety County LU	State (Zip Code 1627
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Accounting/Mailing Address—All pr along	with this form.	ne Accounting/Mailing addre	sa must submit a copy o	f the W-9 Form
			- 1-7	
treet Address 24518 F	451 84.300 CIW	Ecotus		
elephone: (440) 627421 (Fax Number: (Cua)	(2 2 (Ca) C	K State 1/2	√Zip Code
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treet Address	Ala.			
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Change of billing/mailing addres	e telephone and to s			
Change/add secondary address	s, telephone, and/or tax humbs	<u> </u>		
3-7-3-3	telephone, and/or fax number			
Change of provider status (e.g., 1	ermination from plan, moved ou	rt of erea, apacialists Fraisia	la sha Camaran a di	
Other (e.g., panel closing, capaci	ty changes, and age acceptance	a)	in the Comments field	
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x ID number: 75291295	A series and Manua for the I	nternal Revenue Service (IR		
sect name reported to the IRS for the	Tay IO: No Al	Effective Date: 12 - 1	1011	
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ovider Demographic Information—A nguages spoken other than English:	iote: Inia inio/mation can be u	edated on www.tmhp.com.		
ovider office hours by location:				
cepting new clients by program (che	24.004);			
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rticipation in the Woman's Health Pr			Hearing Services	or Children
enature and date are required on the	MON AND PRO	ent gender limitations: Fer	wale (**)	oth 🗆
ovider signature:	Print Nati Lot be blooksed.			
	N 774 ~ 1. 1 1			
all or fax the completed form to:	Texas Medicaid & Healthcare P		Deta: 02/23	112

DCN: 200911239000704



Michael A. Basco M.D.

1713'S. FM 51 Suite 201 1713 S. FM 51 Suite 201 Decatur, Texas 76234 Phone: (940) 626-3746 Fax: (940) 627-47(jg E-Mail: michaelbasco@medscape.com

For Your Information

Date: d. 22-09

Send To:

Attention:

Office Location:

Office Location:

Phone Number: 5125141214

Reply ASAP

Total Pages Including Cover:

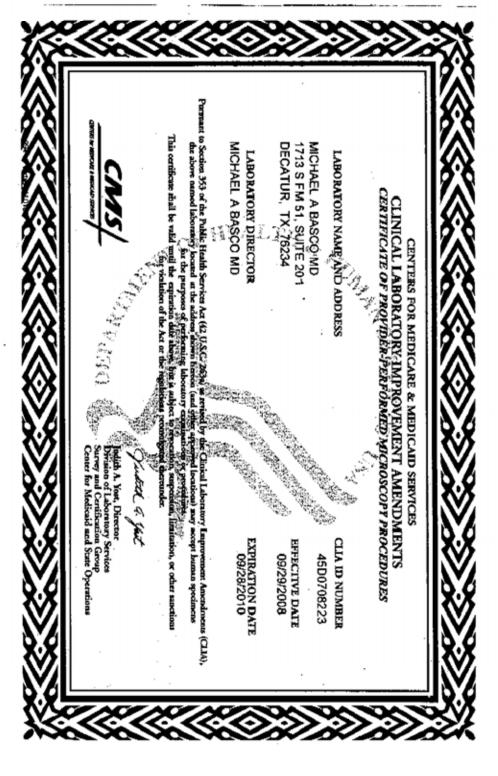
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Comments:		· · · · · · · · · · · · · · · · · · ·
	Due 1914/14/14/1979	· ·
	for your cords	

Please Comment

FROM

DCN: 200911239000704



(WED) JAN 7 2009 10:37/ST. 10:36/No. 7516098175 P 1

FROM

MICHAEL A. BASCO 1713 S FM 51 STE 201 DECATUR, TX 76234 PH: 940-626-3746 FAX 940-627-4709

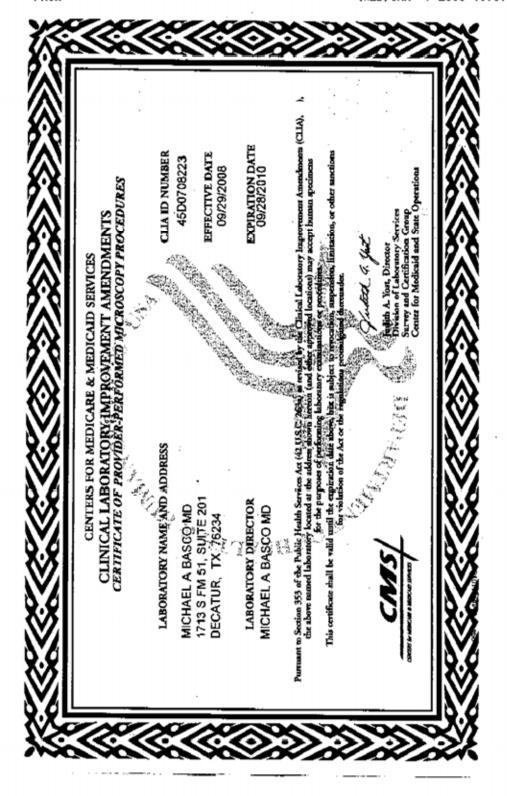
FAX COVER SHEET

TO: Prudir Fordenest	DATE: 1 - 7 - 09
FROM: Lim	FAX: 5125144214
PAGES:	RE:
Please put bhis cha	n file Kn np71
1467647776	0 000

The PHI contained in this fax/email is Highly Confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law and will be reported as such.

DCN: 200900739000892

FROM



DOCUMENT VERIFICATION SHEET

Provider #:
Initials:
Date:
Checklist for Texas Health Steps-Medical Case Management
Enrollment Application
Provider Agreement for TH Stens Case Management services

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C 11044 Research Boulevard (800) 873-6768

OCTOBER 04, 1996

EPS D31655 BASCO, MICHAEL A. MD 1305 AIRPORT FRWY STE 220 BEDFORD, TX 76021

DEAR PROVIDER

THIS LETTER NOTIFIES YOU OF YOUR ENROLLMENT IN THE TEXAS MEDICALD PROGRAM. YOUR NINE-DIGIT PROVIDER NUMBER IS EPSD31655.

NATIONAL HERITAGE INSURANCE COMPANY (NHIC) IS THE INSURER OF THE TEXAS MEDICAID PROGRAM UNDER CONTRACT WITH THE TEXAS DEPARTMENT OF HUMAN SERVICES. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE CONTACT OUR PROVIDER RELATIONS STAFF AT 1-800-873-6768 OR 512-343-4900.

A TEXAS MEDICAID PROVIDER PROCEDURES MANUAL AND PROVIDER BILLING LABELS ARE BEING SENT TO YOU UNDER SEPARATE COVER. THE BILLING LABELS ARE PRE-PRINTED WITH YOUR NAME, ADDRESS AND PROVIDER NUMBER AND SHOULD BE PLACED IN THE APPROPRIATE BLOCK OF YOUR CLAIM FORM. PLEASE VERIFY THE INFORMATION ON THE PRINTED LABELS AND ADVISE THE PROVIDER ENROLLMENT DEPARTMENT OF ANY CORRECTIONS.

THANK YOU FOR YOUR PARTICIPATION AND WELCOME TO THE TEXAS MEDICALD PROGRAM.

SINCERELY,
PROVIDER ENROLLMENT

TEXAS MEDICAID PROVIDER ENROLLMENT APPLICATION

NHIC'S RECEIPT OF APPLICATION

EPSDT MEDICAL

			Number:
A PROVIDER OF SERVICE	INFORMATION		FET.
APTICANI NAME (INDIV. AGENCY, CLINIC) A		ADDRESS OF PHYSICAL	LOCATION (NOT P.O. BOX)
BASCO MICHA		1305 Aiu	Post Freeway Suite Zza
TELEPHONE NUMBER	WILL YOU ACCEPT REFERRALS FOR EPSOT	Number Son	Poom / Sume
Area Cooks (817 , 545-4850	SCREENS (LE. PATIENTS WHO ARE NOT CURRENTLY UNDER YOUR CARE!) YES	Bedford	TX 76021 €
TYPE OF DOOR OFFE WAR AND	0.44	ACCOUNTING ADDRESS	20 Coos .
TYPE OF PROVIDER (PRIMARY SPECIALTY) NAME AND LICENSE HUMBER OF THE SUPERVISING PHYSICIAN (FAPPLICABLE) MICHAEL A. SASCO M.D. TX H5151 I I I I I I I I I I I I I I I I I I		1305 A.i	Suite C
M-CHARAIDH SHEET." 12/14	ION COMPLETE THE ATTACHED TOCATION	Bedford	TK 76021
EMPLOYERS TAX TO NUMBER (FOR YEARLY TAX REPORTING):	NOT APPLICABLE:	Cay San	20000
75245 7772	552 35 0 350	YES V	(focold 78V6)
DOENSE & (ATTACH COPY, IF TEMPORARY)	MEDICALE PROVIDER & (F APPLICABLE)		DOK-IN PROVIDER?
Tx 115151	00 H 78V	YES NO	
B			
B SCREENING PROVIDER I	NFORMATION		

В	SCREENING PROVIDER INFORMATION Please list all professionals who will be performing EPSDT screenings.						
	LICENSE	I ISSUE DATE	INAME	TITLE			
	ATX H SISI	2/24/89	Michael A. Bases M.O	Physica-			

To the best of my knowledge, the Information supplied on this document is accurate and complete and is hereby released to National Heritage Insurance Company and Taxas Department of Health for the purpose of issuing a Medical provider number. Signature of Physician/Doctor for an autorized representative if you are enrolling as a provider a provider at the purpose of Stream.		do not write in this area				
National Hemane Insurance Company and Toyac Company of		County	Spec.	Туре	Localty	Effective Date
riedun for the purpose of issuing a Medical A provider number.		ш	ш	ш	ш	шш
(or an authorized representative if you are enrolling as a provider of the principle of		Enrotment Desp				tribic
owner/physican 9/27/96		R/STURN F		N.H	LLC. Enrollment	
Office Contact: Michael A.BASCO MD Phone: (817) 545-4850			11064 5	esearch	Blvd., Bk	dg. °C°
	- 1					

ALL INFORMATION MUST BE COMPLETED OR MARKED "N/A" AND CONTAIN A VALID SIGNATURE TO BE PROCESSED.

SEP 3 0 1995

Judit Evill



P O Box 200795 Austin, TX 78720-0795 Fax 1-512-514-4214

July 8, 2011

MICHAEL A BASCO 1903 DOCTORS HOSPITAL DR STE 36 BRIDGEPORT, TX 76426-2277

NPI: 1467647776

Dear MICHAEL A BASCO

The Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment Department has reviewed your provider profile and our records indicate that your professional license number will expire on 08-31-2011.

To keep your record up to date and your transcations from being denied, you must provide your new license information to TMHP within 60 days from the date of this letter. The Texas Health and Human Services Commission (HHSC) has directed TMHP to place a payment denial code on providers who do not have a current professional license on file with TMHP. When a payment denial code is placed on your provider identifier, it results in the denial of your claims until the payment denial code is removed.

To have the payment denial code removed, please provide TMHP with a legible copy of your new license, along with your Texas Provider Identifier. Send this information to the following address or fax to 1-512-514-4214:

Texas Medicaid & Healthcare Partnership Attn: Provider Enrollment Department PO Box 200795 Austin, TX 78720-0795

Thank you for your continued participation in Texas State Health-Care Programs. If you have any questions or need assistance, please call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

PHYSICIAN FULL PERMIT

MICHAEL ANGELO BASCO, MD 1903 DOCTOR S'HOSPITAL DRIVE STE. 36 BRIDGEPORT TX 78428-2277 EXPIRATION DATE 08-31-2013

THIS CERTIFIES THAT THE LICENSEE/PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD.

THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR REGISTRATION FOR THE PERIOD INDICATED ABOVE.

PLEASE KEEP, THIS BOARD NOTIFIED OF CHANGE OF ADDRESS.

National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6404

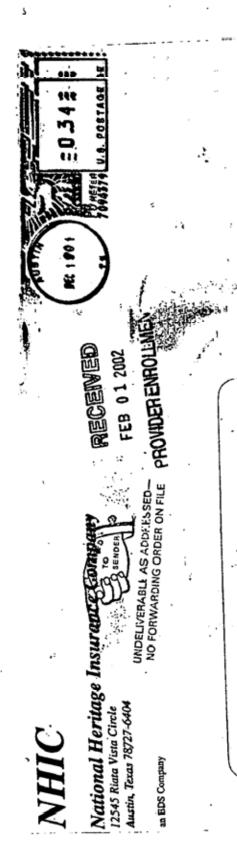
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BECENTED

PROVIDER ENROLLMEN

FEB 01 2002



NHIC nat Haritaga Inguranga Campany National Heritage Insurance Company 12545 Riata Vista Circle Austin, Texas 78727 (512) 514-3000 An EDS Company Date: 12/19/2001 MICHAEL A BASCO MD 1600 W COLLEGE STREET STE LL30 GRAPEVINE TX 76051 Thank you for your participation in the Texas Medicaid program. Your documentation regarding CLIA is being returned to you for the additional information listed below. Please return the requested information to the Provider Enrollment Department at the address listed above or fax your response to (512) 514-4214. Please submit: Nine digit TPI number(s) CLIA certificates are processed through the Medicaid group provider number Copy of current CLIA certificate Legible copy of CLIA certificate Submit the CLIA certificate from HCFA (Health Care Financing Administration) CLIA certificate or HCFA verification must have name, address, type of CLIA, effective date and expiration date. Address on CLIA certificate does not match NHIC provider files. Please submit a copy of the notification letter from HCFA regarding address change or correct the address with NHIC. Other: If you have any questions please call Customer Service at (800)-925-9126. Enclosures The day of the control of the

RESERVED
FEB 01 2002
PROVIDER ENROLLMEN

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12/11/2001

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

Laboratory:

MICHAEL A BASCO MD

1600 WEST COLLEGE STREET SUITE LL30 GRAPHYINE TX 76051

Mailing Address: Mailing Address:

1600 WEST COLLEGE STREET SUITE LL30

GRAPEVINE TX 76051

Laboratory Directors Physical Location:

MICHAEL A BASCO

1600 WEST COLLEGE STREET SUITS LL30

GRAPEVINE TX 76051

CLIA ID#: 45D0708223

CDIA IDT. TODOTOG

Effective Date: September 01, 2000 Expiration Date: August 31, 2002



Pursuant to Section 333 of the Public Health Service Act (42 U.S.C. 263a) as revised by the Clinical Lajoratory improvement Amendments (CLLA), the above named laboratory located at the address shown beroon (and other approved locations) may accept human specimens for the purposes of performing those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

PROVIDER-PERFORMED MICROSCOPY PROCEDURES

This certificate is subject to revocation, suspension, limitation, or other sanctions for violation of the Act of the regulations promutgand thereunder.

queta a. yest

ervey and Certification Group enter for Medicald and State Operations

RECEIVED FEB 01 2002 **PROVIDER ENROLLMEN**

Heritage Women's Center

Dr. Michael A. Basco & Dr. Edward D. Clark Gynecology*Infertility*Obstetrics

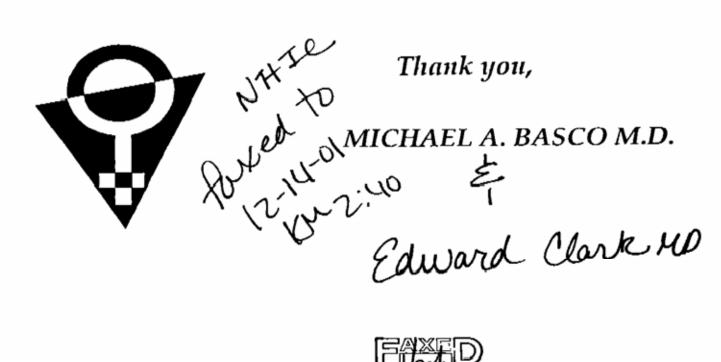
4100 Heritage Ave., Stc. 102 Grapevine, Tv 76051

Grapevine, Tv 76051

Office: (817) 318-0966 Fax: (817) 318-0931

facsimile transmittal

To: Pru	<u>widerEr</u>	rollment,	612-5	14 4214	
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Health Care Financing Administration DEPARTMENT OF HEALTH & HUMAN SERVICES

Laboratory: y:

MICHAEL A BASCO MD

Mailing Addrddress:

1600 WEST COLLEGE STREET SUITE LL30

GRAPEVINE TX 76051

Physical Locatocation:

MICHAEL A BASCO

Laboratory Dy Director:

1600 WEST COLLEGE STREET SUITE LL30

GRAPEVINE TX 76051

CLIA ID#: 45D0708223

Effective Date: September 01, 2000

Expiration Date: August 31, 2002

PROVIDER-PERFORMED MICROSCOPY PROCEDURES CLIA LABORATORY CERTIFICATE FOR

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Judith A. Yost, Director Gussel a. Yest

Survey and Certification Group Center for Medicaid and State Operations Division of Laboratories and Acute Care Services

(Page 3 of 4)

Information Note for Internal Use Only

Note Date: 2002-01-28 12:13:24.000
Parent ICN: EN1020284028000
Note ICN: EN1020284028000121313.doc
Note type: DOC

User name: monyem01

TPI NUMBER NEEDED

NHIC

National Heritage Insurance Company National Heritage Insurance Company

12545 Riata Vista Circle Austin, Texas 78727 (512) 514-3000 An EDS Company

Please submit:

Date:01/25/2002

MICHAEL A BASCO MD 1600 W COLLEGE STREET STE LL30 GRAPEVINE TX 76051

Thank you for your participation in the Texas Medicaid program. Your documentation regarding CLIA is being returned to you for the additional information listed below. Please return the requested information to the Provider Enrollment Department at the address listed above or fax your response to (512) 514-4214.

☑ Nine digit TPI number(s)
 ☐ CLIA certificates are processed through the Medicaid group provider number
 ☐ Copy of current CLIA certificate
 ☐ Legible copy of CLIA certificate
 ☐ Submit the CLIA certificate from HCFA (Health Care Financing Administration)
 ☐ CLIA certificate or HCFA verification must have name, address, type of CLIA, effective date and expiration date.
 ☐ Address on CLIA certificate does not match NHIC provider files. Please submit a copy of the notification letter from HCFA regarding address change or correct the address with NHIC.
 ☐ Other:
 If you have any questions please call Customer Service at (800)-925-9126.

Heritage Women's Center Dr. Michael A. Basco & Dr. Edward D. Clark Gynecology*Infertility*Obstetrics 4100 Heritage Ave., Stc. 102 Grapevine, Tv 76051 Grapevine, Tx 76051

Office: (817) 318-0966 Fax: (817) 318-0931

facsimile transmittal

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v	□ Please Reply	□ Please Recycle
2	ertificate.	Mollment Fax: 512-5 Date: 12-14- Date: 2-14- Date: 12-14- Date: 12-1



Thank you,

MICHAEL A. BASCO M.D. Edward Clark HD

Health Care Financing Administration DEPARTMENT OF HEALTH & HUMAN SERVICES

Laboratory: y: Mailing Addrddress: MICHAEL A BASCO MD

1600 WEST COLLEGE STREET SUITE LL30

GRAPEVINE TX 76051

Laboratory Dy Director:

MICHAEL A BASCO

Physical Localocation: 1600 WEST COLLEGE STREET SUITE LL30

GRAPEVINE TX 76051

CLIA ID#: 45D0708223

Expiration Date: August 31, 2002





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Gustes a. Yest

Division of Laboratories and Acute Care Services Center for Medicaid and State Operations Survey and Certification Group Judith A. Yost, Director

(Page 3 of 4)

Information Note for Internal Use Only

Note Date: 2001-12-14 15:22:14.000 Parent ICN: EN1013485273000

Note ICN: EN101348527300015223.rtf

Note type: NOTE User name: csteno01

FOR P.E.?

Note Date: 2001-12-18 16:48:23.000

Parent ICN: EN1013485273000

Note ICN: EN1013485273000164755.rtf

Note type: NOTE User name: pendin01

MAINTENANCE ISSUE CLIA

Note Date: 2001-12-19 07:26:04.000

Parent ICN: EN1013485273000

Note ICN: EN10134852730007260.doc Note type: DOC

User name: monyem01

TPI NUMBER NEEDED

NHIC

National Heritage Insurance Company National Heritage Insurance Company

12545 Riata Vista Circle Austin, Texas 78727 (512) 514-3000 An EDS Company

Please submit:

Date:12/19/2001 MICHAEL A BASCO MD 1600 W COLLEGE STREET STE LL30 GRAPEVINE TX 76051

Thank you for your participation in the Texas Medicaid program. Your documentation regarding CLIA is being returned to you for the additional information listed below. Please return the requested information to the Provider Enrollment Department at the address listed above or fax your response to (512) 514-4214.

Nine digit TPI number(s)
 □ CLIA certificates are processed through the Medicaid group provider number
 □ Copy of current CLIA certificate
 □ Legible copy of CLIA certificate
 □ Submit the CLIA certificate from HCFA (Health Care Financing Administration)
 □ CLIA certificate or HCFA verification must have name, address, type of CLIA, effective date and expiration date.
 □ Address on CLIA certificate does not match NHIC provider files. Please submit a copy of the notification letter from HCFA regarding address change or correct the address with NHIC.
 □ Other:
 If you have any questions please call Customer Service at (800)-925-9126.
 Enclosures

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	National Heritage Insurance Company	f	
	12545 Riata Vista Circle Austin, Texas 78727 (512) 514-3000 An EDS Company		
	An abo company	Date: 03/19/01	
	MICHAEL A BASCO MD 4100 HERTAGE AVE STE 102 GRAPEVINE, TX 76051	2. Date: 03/19/01	
	The NHIC Provider Enrollment Department has received a request to unable to process it because of the following reason(s).	o update your file; we are	
	We are unable to locate the name you have given us in our	files.	
	Information provided does not match the information in ou	r files.	
	We must have the provider's signature. The signature of a (excluding providers) is required if you are a group or facil	lity.	
	IRS W9 Form is required to change accounting name and only one Tax I.D. number).		
	We must have your nine digit (alpha, numeric) Texas Me process your request. If you have more than one Me please include all of the numbers applicable to this requ	dicaid provider number,	
	Please submit the certificate that is titled, Certification of administered through the Bureau of Radiation Control.	of Mammography Systems,	
	Other:		
	Please provide all the required information and return it to the Provide You may contact NHIC's Telephone Inquiry Unit at 1-800-925-9126 Thank you for your continued participation in the Texas Medicaid Provided	if you have any questions.	MAR 3 0 2001
	9-10-0-10-0-10-0-10-0-10-0-10-0-10-0-10	Recolved	MAR 3 0 2001
	Enclosures	8	3 (

Request for Taxpayer Give form to the requester. Do NOT (Rev. March 1994) Identification Number and Certification send to the IRS. Department of the Treasury send to the IRS. Department of the Treasury Name (If joint names, list first and circle the name of the person or entity whose number you enter in Part I below. See instructions on page 2 If your name has changed.) Business name (Sole proprietors see instructions on page 2J ö 500 둕 Corporation Other ► 0 state, and ZIP code 76057 opevine Taxpayer Identification Number (TIN) List account number(s) here (optional) Enter your TIN in the appropriate box. For individuals, this is your social security number Social security number (SSN). For sole proprietors, see the instructions 51512431570131570 on page 2. For other entities, it is your employer Part II For Payees Exempt From Backup identification number (EIN). If you do not have a OR Withholding (See Part II number, see How To Get a TIN below. Employer Identification n instructions on page 2) Note: If the account is in more than one name, 2912950 see the chart on page 2 for guidelines on whose number to enter. Certification Part III

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification instructions.—You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also see Part III instructions on page 2.)

Sign
Here Signature My Land Boston

Date > 1/1/2001

Section references are to the Internal Revenue Code.

Purpose of Form.—A person who is required to file an information return with the IRS must get your correct TIN to report income paid to you, real estate transactions, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. Use Form W-9 to give your correct TIN to the requester (the person requesting your TIN) and, when applicable, (1) to certify the TIN you are giving is correct (or you are waiting for a number to be issued), (2) to certify you are not subject to backup withholding, or (3) to claim exemption from backup withholding if you are an exempt payee. Giving your correct TIN and making the appropriate certifications will prevent certain payments from being subject to backup withholding.

Note: If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What Is Backup Withholding?—Persons making certain payments to you must withhold and pay to the IRS 31% of such

payments under certain conditions. This is called "backup withholding." Payments that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

- You do not furnish your TIN to the requester, or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
- 4. You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable

interest and dividend accounts opened after 1983 only), or

You do not certify your TIN. See the Part III Instructions for exceptions.

Certain payees and payments are exempt from backup withholding and information reporting. See the Part II instructions and the separate Instructions for the Requester of Form W-9.

How To Get a TIN.—If you do not have a TIN, apply for one immediately. To apply, get Form SS-5, Application for a Social Security Number Card (for Individuals), from your local office of the Social Security Administration, or Form SS-4; Application for Employer Identification Number (for Obusinesses and all other entities), from your local IRS office.

If you do not have a TIN, write "Applied For" in the space for the TIN in Part I, sign and date the form, and give it to the requester. Generally, you will then have 60 days to get a TIN and give it to the requester. If the requester does not receive your TIN within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN.

(Page 3 of 3)

Information Note for Internal Use Only

Note Date: 2001-04-04 16:19:50.000
Parent ICN: 200109405002022
Note ICN: 200109405002022161931.rtf
Note type: NOTE

User name: mokeefe01

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NHIC

National Haritage Insurance Company

May 1, 2001

National Heritage Insurance Company

12545 Riata Vista Circle Austin, Texas 78727

An EDS Company

BASCO, MICHAEL A. MD 803 W LAMPASAS ENNIS, TX 75119

IMPORTANT NOTICE NEW MEDICAID NUMBERS ENCLOSED

Listed below are all of your current Medicaid provider numbers that exist in the Medicaid system today. *Column 1* lists the inactive and active numbers in the system for claims payment and history. *Column 2* is the new 7-character Texas Provider Identifier (TPI) base that has been assigned to you as your unique provider identifier. *Column 3* is the 2-character TPI suffix that has been assigned to your base.

The 9-character TPI (7-character base + 2-character suffix) replaces your current 9-character Medicaid provider number. TPIs were issued from the provider verification of groupings mailed to your accounting address on file in May 1999.

Please contact Customer Service with anyquestions at 800-925-9126, Option 1#.

Please note that you should continue to use the current Medicaid numbers in *Column 1* for claims submission until **August 3, 2001.** On August 6, 2001 you should begin to use your new TPI for claims submission. You should use the 9-character TPI (7-character base + 2-character suffix) to bill claims filed on and after August 6, 2001 and replaces your current numbers.

The state will allow a 6-month transition period for you to bill with your old provider numbers, however, as of August 6, 2001 all outgoing correspondence including Remittance & Status reports will be using the TPI number only.

Therefore, you are encouraged to convert your systems prior to August 6, 2001.

	9-characters		
Column 1			
Column 1 Provider #, valid until 08/03/01	New 7-character base provider #, valid on	Column 3 New 2-character	
	08/06/01	suffix provider #, valid on 08/06/01	
EPSD31655 P085G4412 PCCE20049 P000H78V6 P08818317	1364358 1364358 1364358 1364358	08 01 09 07 06	
P087G3952 P000D94Z2 P080F1976 P089G3324	1364358 1364358 1364358 1364358	04 03 02 05	
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If you have any questions regarding your TPI numbers, or billing questions, please call Customer Service at 800-925-9126, Option 1#.

NHIC

National Haritage Incurance Company

National Heritage Insurance Company

12545 Riata Vista Circle Austin, Texas 78727

An EDS Company

BASCO/MICHAEL A. MD 1405 WIEFFERSON WAXAHASHIE, TX 75165 May 1 2001

May 1, 2001

Baylor Medical Center - Ellis Count

20012130500115

IMPORTANT NOTICE
NEW MEDICAID NUMBERS
ENCLOSED

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		Texas Provider Ide 9-charact	entifier (TPI) ers
-	Column 1	C-1 Acnaract	ers C · · ·
	Column 1	Column 2	Column 3
	Provider #, valid until 08/03/01	New 7-character base provider #, valid on 08/06/01	New 2-character suffix provider #, valid on 08/06/01
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If you have any questions regarding your TPI numbers, or billing questions, please call Customer Service at 800-925-9126, Option 1#.

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NHIC

National Haritago Incurance Company

May 1 2001

National Heritage Insurance Company

May 1, 2001

12545 Riata Vista Circle Austin, Texas 78727

An EDS Company

BASCO, MICHAEL A. MD 800 8TH AVE #616 FORT WORTH, TX 76104

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Column 2	Column 3
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	9-characte Column 2 New 7-character base provider #, valid on 08/06/01 1364358 1364358 1364358 1364358 1364358 1364358 1364358 1364358 1364358

If you have any questions regarding your TPI numbers, or billing questions, please call Customer Service at 800-925-9126, Option 1#.

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NHIC

National Heritage Insurance Company

National Heritage Insurance Company

May 1, 2001

12545 Riata Vista Circle Austin, Texas 78727

An EDS Company

BASCO, MICHAEL A. MD 1305 AIRPORT FRWY STE 220 BEDFORD, TX 76021

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Column 1	Texas Provider Ide 9-charact	ers		
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Column 1 Provider #, valid until 08/03/01	New 7-character base provider #, valid on 08/06/01	Column 3 New 2-character suffix provider #, valid on 08/06/01		
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2 20012130500115

NHIC

National Haritage Insurance Company

May 1 2001

National Heritage Insurance Company

May 1, 2001

12545 Riata Vista Circle Austin, Texas 78727

An EDS Company

BASCO, MICHAEL A. MD 1800 N GRAVES ST MCKINNEY, TX 75069

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Please contact Customer Service with anyquestions at 800-925-9126, Option 1#.

Please note that you should continue to use the current Medicaid numbers in Column 1 for claims submission until August 3, 2001. On August 6, 2001 you should begin to use your new TPI for claims submission. You should use the 9-character TPI (7-character base + 2-character suffix) to bill claims filed on and after August 6, 2001 and replaces your current numbers.

The state will allow a 6-month transition period for you to bill with your old provider numbers, however, as of August 6, 2001 all outgoing correspondence including Remittance & Status reports will be using the TPI number only. Therefore, you are encouraged to convert your systems prior to August 6, 2001.

Column 1	Texas Provider Identifier (TPI) 9-characters						
Column 1 Provider #, valid until 08/03/01	New 7-character base provider #, valid on 08/06/01	Column 3 New 2-character suffix provider #, valid on 08/06/01					
EPSD31655 P085G4412 PCCE20049 P000H78V6 P08818317 P087G3952 P000D94Z2 P080F1976 P089G3324	1364358 1364358 1364358 1364358 1364358 1364358 1364358 1364358	08 01 09 07 06 04 03 02					
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If you have any questions regarding your TPI numbers, or billing questions, please call Customer Service at 800-925-9126, Option 1#.

NHIC

National Heritage Insurance Company

May 1 2001

National Heritage Insurance Company

May 1, 2001

12545 Riata Vista Circle Austin, Texas 78727

An EDS Company

BASCO, MICHAEL A. MD 1800 N GRAVES ST MCKINNEY, TX 75069

IMPORTANT NOTICE NEW MEDICAID NUMBERS ENCLOSED

Listed below are all of your current Medicaid provider numbers that exist in the Medicaid system today. *Column 1* lists the inactive and active numbers in the system for claims payment and history. *Column 2* is the new 7-character Texas Provider Identifier (TPI) base that has been assigned to you as your unique provider identifier. *Column 3* is the 2-character TPI suffix that has been assigned to your base.

The 9-character TPI (7-character base + 2-character suffix) replaces your current 9-character Medicaid provider number. TPIs were issued from the provider verification of groupings mailed to your accounting address on file in May 1999.

Please contact Customer Service with anyquestions at 800-925-9126, Option 1#.

Please note that you should continue to use the current Medicaid numbers in *Column 1* for claims submission until **August 3**, **2001**. On August 6, 2001 you should begin to use your new TPI for claims submission. You should use the 9-character TPI (7-character base + 2-character suffix) to bill claims filed on and after August 6, 2001 and replaces your current numbers.

The state will allow a 6-month transition period for you to bill with your old provider numbers, however, as of August 6, 2001 all outgoing correspondence including Remittance & Status reports will be using the TPI number only. Therefore, you are encouraged to convert your systems prior to August 6, 2001.

Please keep this information for your records

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If you have any questions regarding your TPI numbers, or billing questions, please call Customer Service at 800-925-9126, Option 1#.

NHIC

National Heritage Insurance Company

12545 Riata Vista Circle Austin, Texas 78727 (512) 514-3000 An EDS Company

Date: 02/22/01

MICHEAL A BRASCO MD 4100 HERITAGE AVE STE 102 GRAPEVINE, TX 76057

The NHIC Provider Enrollment Department has received a request to update your file; we are unable to process it because of the following reason(s).

- ☐ We are unable to locate the name you have given us in our files.
- Information provided does not match the information in our files.
- We must have the provider's signature. The signature of an authorized representative (excluding providers) is required if you are a group or facility. W-9 Sugress

15-2912950 IRS W9 Form is required to change accounting name and/or Tax I.D. number select only one Tax I.D. number). POODH 78V6

- We must have your nine digit (alpha, numeric) Texas Medicaid provider number to process your request. If you have more than one Medicaid provider number, please include all of the numbers applicable to this request.
- Please submit the certificate that is titled, Certification of Mammography Systems, administered through the Bureau of Radiation Control.
- Other:

Please provide all the required information and return it to the Provider Enrollment Department. You may contact NHIC's Telephone Inquiry Unit at 1-800-925-9126 if you have any questions. Thank you for your continued participation in the Texas Medicaid Program.

Enclosures

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NHIC

National Heritage Insurance Company

12545 Riata Vista Circle Austin, Texas 78727 (512) 514-3000

An EDS Company

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