NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C
11044 Research Boulevard
(800) 252-9224

DECEMBER 08, 1989

ZQQQFX679
BAYLOR MEDICAL CENTER AT
WAXAHACHIE
1405 JEFFERSON
WAXAHACHIE, TX 75165

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BASCO, MICHAEL A. MD, PERFORMING PROVIDER NUMBER PQ85G4412, 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.

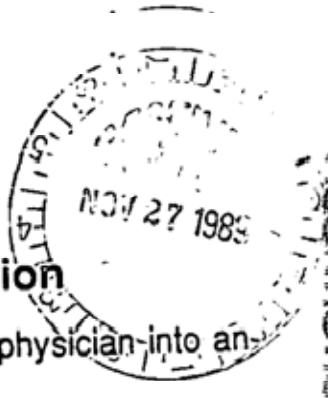
IF THIS PROVIDER SHOULD CHOOSE TO LEAVE YOUR GROUP, PLEASE NOTIFY THE PROVIDER ENROLLMENT DEPARTMENT IMMEDIATELY.

THANK YOU FOR YOUR PARTICIPATION IN THE TEXAS MEDICAID PROGRAM.

SINCERELY,

PROVIDER ENROLLMENT

Not on Disk
11/28/89



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:

Physician's Name: Michael A. Basco, M.D.

Group Number: FX67

Physician's Specialty: ER Medicine

Physician's Medicare Number: 856441

License Number: A5151
(If "temporary", attach a copy)

Please enroll me with the group practice listed above.

Michael A Basco by Sig Nat
Physician's Signature

11-21-89
Date

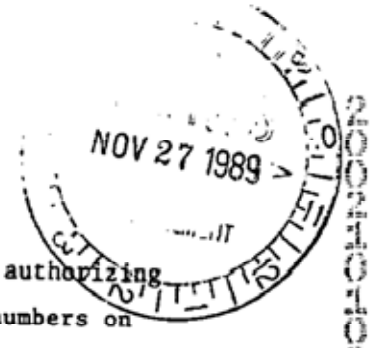
GROUP NAME AND ADDRESS:

Baylor Medical Center at Waxahachie
1405 W. Jefferson
Waxahachie, Texas 75165

DO NOT WRITE IN THIS AREA

County	Spec	Type	Locality	Effective Date

Enrollment Date: 12-4-89 Initials: [illegible]



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

26 Apr 89
Date

Michael C. Basco M.D.
Signature

Michael Basco, M.D.
Print Name Please

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C
11044 Research Boulevard
(800) 252-9224

NOON FOUNDATION

DECEMBER 08, 1989

ZGUOCT119
NORTH TEXAS MEDICAL CENTER
1800 N GRAVES ST
MCKINNEY, TX 75069

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BASCO, MICHAEL A. MD, PERFORMING PROVIDER NUMBER PG8GF1976, 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 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:

Physician's Name: Michael A. Basco, M.D.

Group Number: 2000CT119

Physician's Specialty: ER Medicine

Physician's Medicare Number: B80F19760

License Number: H5151
(If "temporary", attach a copy)

Please enroll me with the group practice listed above.

Michael A Basco by Sue Hall
Physician's Signature

Date 11-28-89

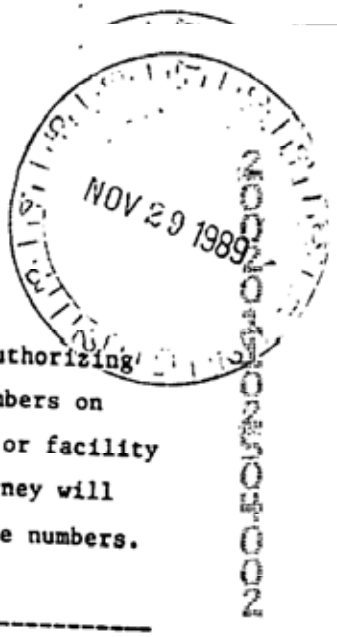
GROUP NAME AND ADDRESS:

North Texas Medical Center
1800 North Graves Street
McKinney, Texas 75069

DO NOT WRITE IN THIS AREA

County	Spec	Type	Locality	Effective Date

Enrollment Date: 12-4-89 Initials: KC



POWER OF ATTORNEY

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POWER OF ATTORNEY

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

26 Apr 89
Date

Michael O Basco MD
Signature

Michael Basco, M.D.
Print Name Please

TEXAS MEDICAID

PROVIDER ENROLLMENT APPLICATION

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

A PROVIDER OF SERVICE INFORMATION NORTH TEXAS MEDICAL CENTER

APPLICANT NAME (INDIV., GROUP, INC., DBA-SHOW AS LICENSED) Basco, Michael A. M.D. Last or Group's or Company / First / Initial / Title-Degree	ADDRESS NO. 1 (Practice Location) 1800 N. GRAVES ST. Number / Street / Room/Suite
TELEPHONE NUMBER Area Code (800) 962-3303	McKINNEY TX 75069 City / State / Zip
TYPE OF PROVIDER (PRIMARY SPECIALTY) EMERGENCY MEDICINE	ADDRESS NO. 2 (Accounting Address/Will Check To:) EMERGENCY PHYSICIANS BILLING SERVICE, INC. P.O. BOX 96118, S.E. STATION Number / Street or P.O.Box
PHYSICIAN LICENSE # (Attach copy if Temporary) H5151	FISCAL YEAR END
	OKLAHOMA CITY OK 73143 City / State / Zip

B BILLING INFORMATION

Name and Signature of Person Authorized to Sign for Provider SIGNATURE ON FILE	IRS Employer's I.D. # 73-1230653 / Social Security # 552-35-0350
What is your MEDICARE or BLUE SHIELD Provider Number? 00D94Z	If you will never bill the Medicare Program due to your specialty or practice, check here.

C GROUP PRACTICE INFORMATION: List all physician members of your group.

LICENSE #	NAME	Title	Medicare "800000" series #

D OTHER INFORMATION

Is this location: Full Time X Part Time	In addition to other Practice locations? Yes X No	Located within a hospital? Yes X No	If yes, is this application for the purpose of billing as an Emergency Room Physician? YES

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

Michael A. Basco by Sue Hall
Signature

MD
Title

5/21/90
Date

DO NOT WRITE IN THIS AREA

County | Spec | Type | Locality | Effective Date

Enrollment Date: _____ Initials: _____

RETURN FORM TO:

N.H.I.C.
Provider Enrollment
11044 Research Blvd., Bldg. "C"
Austin, Texas 78759

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

26 Apr 89
Date

Michael O Basco M.D.
Signature

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

P000D94Z2
BASCO, MICHAEL A. MD
1800 N GRAVES ST
MCKINNEY, TX 75069

DEAR PROVIDER

THIS LETTER NOTIFIES YOU OF YOUR ENROLLMENT IN THE TEXAS MEDICAID PROGRAM. YOUR NINE-DIGIT PROVIDER NUMBER IS P000D94Z2.

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 MEDICAID PROGRAM.

SINCERELY,

PROVIDER ENROLLMENT

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C
11044 Research Boulevard
(800) 252-9224

DECEMBER 08, 1989

ZQ00CT283
BAYLOR MEDICAL CTR AT ENNIS
803 WEST LAMPASAS ST
ENNIS, TX 75119

DEAR PROVIDER

WE HAVE COMPLIETED THE ENROLLMENT OF [illegible]ASCO, MICHAEL A. MD, PERFORMING PROVIDER NUMBER P [illegible], 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

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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,

J Thompson
Irving TX 75119

Provider Enrollment

PHYSICIAN'S INFORMATION:

Physician's Name: Michael A. Basco, M.D.

Group Number: 22CT28 B

Physician's Specialty: ER Medicine

Physician's Medicare Number: K876395

License Number: H5151
(If "temporary", attach a copy)

Please enroll me with the group practice listed above.

Michael A. Basco by Sri Nair
Physician's Signature *Date*
11-21-89

GROUP NAME AND ADDRESS:

Baylor Medical Center at Ennis
P. O. Box 1420
Ennis, Texas 75119

52-055-0350

DO NOT WRITE IN THIS AREA

11/5/89

County	Spec	Type	Locality	Effective Date
				11/15/89

Enrollment Date: 12-4-89 Initials: KC

9/8. mc

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

24 Apr 89
Date

Signature

Michael Basco, M.D.
Print Name Please

NHIC

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, Option 1#.** Thank you for your prompt response.

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: (Completed by Provider)***
PROVIDER #	P087G3952	
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: **(if name change submit W9)**	PO BOX 1420 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 www.eds-nhic.com for instruction.**

☐ Please **CANCEL** the provider number listed on this form. _____ _____
(Provider signature or authorized individual if a group or facility) Date

☐ My provider specific information contained on this form is correct (response not necessary).

☐ My provider specific information contained on this form is incorrect, and I have made the necessary corrections on this form for update.

Provider Signature: _____ _____
(or authorized individual if a group or facility) Date

Provider Name (printed): _____ _____
(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.

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C
11044 Research Boulevard
(800) 252-9224

JANUARY 05, 1990

Z000HV333
HOOD GENERAL HOSP ER PHYS
1310 PALUXY RD
GRANBURY, TX 76048

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BASCO, MICHAEL A. MD, PERFORMING PROVIDER NUMBER P089G3324, 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

DEC 1989

2000210102500700

TEXAS
MEDICAID
Group Practice Enrollment Application

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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:

Physician's Name: Basco, Michael Md

Group Number: Z000HV333

Physician's Specialty: OB Gen

Physician's Medicare Number: B0 89G332 4

License Number: H5151

(If "temporary", attach a copy)

Please enroll me with the group practice listed above.

Michael Basco MD 12-15-89

Physician's Signature *Date*

GROUP NAME AND ADDRESS:

Hood General Hospital ER

1310 Paluxy Rd

Granbury, TX 76048

DO NOT WRITE IN THIS AREA

County | Spec | Type | Locality | Effective Date

Enrollment Date: 1-3-90 Initials: C S

Section C — REQUIRED INFORMATION FOR:

All Licensed Providers: DPS - 5007150, DEA - BB179 - 4797,
Must attach a copy of license

Must attach a copy of license

Ambulance: N/A
Must attach a copy of the permit/license from TDH

Birthing Center Providers Only: N/A
Must attach a copy of the certification permit from TDH

Certified Registered Nurse Anesthetist Providers Only: N/A
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: #45D0708223
Must attach a copy of CLIA license with approved specialty services as appropriate

FQHC Providers Only: N/A
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 a copy of grant award

Mammography Services Only:
Certification Number: N/A
Must attach a copy of certification of mammography systems from the Texas Department of Bureau of Radiation Control (BRC)

MHMR Providers Only: N/A
Must attach a copy of approval letter from the Texas Department of MHMR

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 Health for the purpose of issuing a Medicaid provider number.

Signature of applicant
(or an authorized representative if you are enrolling as a provider group/supplier)

Michael [illegible]
Signature

Title

12/28/98
Date

Do Not Write In This Area
(For Office Use Only)

#_____

Date:_____

Initials:_____

SB30 Re-Enrollment
MAR 08 1999
Received

Notification of your assigned Texas Medicaid provider number will be mailed to the **PHYSICAL** address listed on your application.

SB30 Re-Enrollment
FEB 01 [illegible]
Received

TEXAS DEPARTMENT OF HEALTH (TDH) - TEXAS MEDICAL ASSISTANCE PROGRAM (MEDICAID) PROVIDER AGREEMENT

TEXAS DEPARTMENT OF HEALTH (TDH) - TEXAS MEDICAL ASSISTANCE PROGRAM (MEDICAID) PROVIDER AGREEMENT

Name of Provider Michael A. Basco MD. *Medicaid Provider I.D. # P000H7846

(Doing Business As) OB/Gyn Medicare Provider I.D. # 00H178V

Physical Address 1600 W College St. LL30 Grapevine, TX 76051 Mailing Address 1600 W College St #LL30 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 space blank.

1524772

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.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services 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.

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires TDH to withhold contract 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 ineligible 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.

1.2.8 Cost Report, Audit, and Inspection. Provider agrees to comply with all state and federal laws

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

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and 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.

1.3.2 Provider must submit encounter data required by TDH or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by an HMO or IPA.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by 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.

1.3.4 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).

1.3.5 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 for covered services. (42 C.F.R. §447.15).

1.3.6 Provider must refund any overpayments, duplicate payments, and erroneous payments which are paid to Provider by Medicaid or a third party as soon as the payment error is discovered.

1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by TDH or its agent and implement an effective method to track submitted claims against payments made by 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.

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

2.7 The Provider must provide [illegible]

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.

V. TERM AND TERMINATION

This Agreement will be effective from the date finally executed until the date the Agreement is terminated by either party. Either party may terminate this Agreement by providing the other party with thirty (30) days advance notice of intent to terminate. TDH may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificate, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. TDH may terminate this Agreement without notice if the Provider has not submitted a claim to the Medicaid program for 12 months.

Provider Signature _____ Date 12/28/98

Printed Name and Title of Person signing for Provider

Michael A. Basco, M.D.

ADDENDUM STATEMENT

The numbers listed below are to be associated with the above-signed agreement, application, and provider information form. I understand that by signing this addendum I am reporting that these provider numbers are fully represented by the information contained in the enclosed documents and that all provisions included in the agreement are also applicable to these provider numbers. **List all provider numbers:**

P0H78V
P000H78V6

Print Name Michael A. Basco Sign Name _____

Date 12/28/98 M.D.

RRR 10-1-99

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:

1. 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.

2. 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.

3. 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? ☐ Yes ☑ No

5. 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 CONTRACTS

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

☑ The potential contractor certifies, by submission of this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded form participation in this contract by any federal department or agency or by the State of Texas.

☐ The potential contractor is unable to certify to one or more of the terms in this certification. In this instance, the potential contractor must attach an explanation for each of the above terms to which he is unable to make certification. Attach the explanation(s) to this certification.

Name of Potential Contractor	Vendor ID No. Or Social Security No.	HHSC Contract No. (if applicable)
Michael A. Basco, M.D	75-245 7772	

Signature of Authorized Representative — Date: 12/28/98

Printed Typed Name and Title of Authorized Representative: Michael A. Basco, M.D

SB30 Re-Enrollment MAR 0 8 1999 Received

SB30 Re-Enrollment FEB 0 1 1999 Received

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

PROVIDER ENROLLMENT APPLICATION

NHIC'S RECEIPT OF APPLICATION: 20000220

A PROVIDER OF SERVICES INFORMATION

APPLICANT NAME (INDIV., GROUP, INC., DBA) AS IT APPEARS ON LICENSE: BASCO MICHAEL A. M.D. (Last Name/Group/Company, First, Initial, Title/Degree)			ADDRESS OF PHYSICAL LOCATION (NOT A P.O. BOX): 1305 Airport Freeway Suite 220 (Number, Street, Room/Suite)
TELEPHONE NUMBER Area Code (817) 545-4850	DO YOU WANT TO BE A LOCK-IN PROVIDER? YES (NO)		Bedford Tx 76021 (City, State, Zip Code)
TYPE OF PROVIDER (PRIMARY SPECIALTY): OB/GYN			
IS THIS APPLICATION FOR THE PURPOSE OF BILLING AS AN EMERGENCY ROOM PHYSICIAN YES (NO)	IF AMBULANCE COMPANY OR CRNA, ATTACH A COPY OF YOUR CERTIFICATION		ACCOUNTING ADDRESS/MAIL CHECK TO: 1305 Airport Freeway Suite 220 (Number, Street/P.O. Box, Room/Suite)
IRS TAXPAYER IDENTIFICATION NUMBER (TIN): 752457772 IS THIS AN X EMPLOYER'S TAX ID OR ___ SOCIAL SECURITY NUMBER?			Bedford Tx 76021 (City, State, Zip Code)
PLEASE INDICATE THE NAME OF THE ABOVE TIN AS SHOWN ON I.R.S. FILES: MICHAEL A. BASCO M.D.			
LICENSE # (Attach copy if temporary) H5151 Issue Date:	MEDICARE PROVIDER #: P000H78V6		HAVE YOU EVER BEEN ASSIGNED A MEDICAID PROVIDER NUMBER? (YES) NO

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

B GROUP PRACTICE INFORMATION - List all members of your group.

LICENSE #	NAME	TITLE	MEDICARE 800,000 #	SPECIALTY OF PRACTICE

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 Health for the purpose of issuing a Medicaid provider number.

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

Michael A Basco MD
Signature

Owner / M.D — 3/28/96
Title — Date

DO NOT WRITE IN THIS AREA

#_____

County	Spec.	Type	Locality	Effective Date

Enrollment Date:_____ 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

RECEIVED
APR 0 3 1996
PROV. ENR.

P000H78VG

MICHAEL A. BASCO, M.D.

Medical Plaza Professional Building
800 Eighth Avenue, Suite 616
Fort Worth, Texas 76104
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.

SINCERELY,

Michael A Basco MD

MICHAEL A BASCO, MD

RECEIVED
JAN 28 1993
PROV. ENR.

GYNECOLOGY
OBSTETRICS
INFERTILITY

Already Chg AB 2-1-93

P0001H78V6

MICHAEL A. BASCO, M.D.
Medical Plaza Professional Building
800 Eighth Avenue, Suite 6
Fort Worth, Texas 76104
Phone: (817) 33

RECEIVED
JAN 20 1993
PROV. ENR.

P0001H78V6 0000000

TO WHOM IT MAY CONCERN:

EFFECTIVE JANUARY 01, 1993 NEW TAX ID # FOR MICHAEL A. BASCO, MD IS: Provider # P0001H78V6

75-2457772 (PREVIOUS #552350350)

ANY QUESTIONS, PLEASE CONTACT THIS OFFICE.

SINCERELY,

Michael A Basco MD

MICHAEL A BASCO, MD

GYNECOLOGY
OBSTETRICS
INFERTILITY

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C
11044 Research Boulevard
(800) 873-6768

MAY 01, 1992

P000H78V6
BASCO, MICHAEL A. MD
800 8TH AVE # 616
FORT WORTH, TX 76104

DEAR PROVIDER

THIS LETTER NOTIFIES YOU OF YOUR ENROLLMENT IN THE TEXAS MEDICAID PROGRAM. YOUR NINE-DIGIT PROVIDER NUMBER IS P000H78V6.

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 MEDICAID PROGRAM.

SINCERELY,

PROVIDER ENROLLMENT

TEXAS MEDICAID PROVIDER ENROLLMENT APPLICATION

NHIC'S RECEIPT OF APPLICATION
RECEIVED
APR 2 0 1992
PROV. ENR.

A PROVIDER OF SERVICE INFORMATION

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

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

B GROUP PRACTICE INFORMATION - List all members of your group.

LICENSE #	NAME	TITLE	MEDICARE 800,000 #	SPECIALTY OF PRACTICE
	N/A			

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 you are enrolling as a provider group/supplier)

Michael O Basco MD
Signature

M.D.
Title

4/17/92
Date

DO NOT WRITE IN THIS AREA

P000H78V 6

County Spec. Type Locality Effective Date

Enrollment Date: 4-27-92 Initials: [illegible]

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

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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 bar, and then go manage provider accounts, click on the link titled Provider Information Management System. Click on the Medicaid Waiver Programs section of the Provider Information Changes screen.**

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.

12/11/2000 04:02 FAX 001

PROVIDER INFORMATION CHANGE FORM

FAXED DEC 11 2000 BY: BY:

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.

Date: 12-11-00 Nine-digit Medicaid provider number: P000H78V6

If you have more than one Medicaid number that will also be using this same information, list the other provider numbers:

Physical Address (Cannot be a P.O. Box)	Accounting/Mailing Address (W-9 Form Required)	Secondary Address (Plan Use Only)
Micheal A. Basco		
4100 Heritage Ave Ste 102		
Grapevine TX 76051		
817-318-0966 Telephone	Telephone	Telephone
817-318-0931 Fax	Fax	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 75-245-7772 Effective Date: 12-A-00

List the exact name reported to the IRS for the above Tax ID number: Micheal A. Basco M.D.

Must be signed and dated or changes cannot be completed:

Provider Signature: Micheal A Basco MD Date: 12-11-00

Email Address: _____

Send your completed change forms to:

NHIC
Attn: Provider Enrollment/Melvina
12545 Riata Vista Circle
Austin, TX 78727-6404
Fax: (512) 514-~~4214~~ 4224

If Managed Care, please send this form via mail or fax to NHIC c/o your respective plan.

Received
JAN 12 2001
Provider Enrollment

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 Signed
- 75-2912950 ☒ IRS W9 Form is required to change accounting name and/or Tax I.D. number select only one Tax I.D. number). P000H78V6
- ☒ 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:

Received
MAR 1 3 2001
Provider Enrollment

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

12/98

2001079805006002

NHIC

National Heritage Insurance Company

11044 Research Boulevard, Building C
Austin, Texas 78759-5239
(512) 343-4900
An EDS Company

Date:

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 (or the signature of an authorized representative if you are a group or facility)
- ☐ IRS W9 Form required to change accounting name and Tax I.D. number.
- ☒ We must have your nine digit Texas Medicaid provider number before your request can be processed. If you have more than one Medicaid provider number, please include all of the numbers applicable to the request.
- ☐ 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

Received
FEB 16 2001
Provider Enrollment

Received
MAR 13 2001
Provider Enrollment

12/98

2000709800000

Mail this postcard to businesses and people who send you mail.

Bosco [illegible] A. M.D.

1600 W. College St #10-25

Grapevine TX 76051

4100 Heritage Ave 102

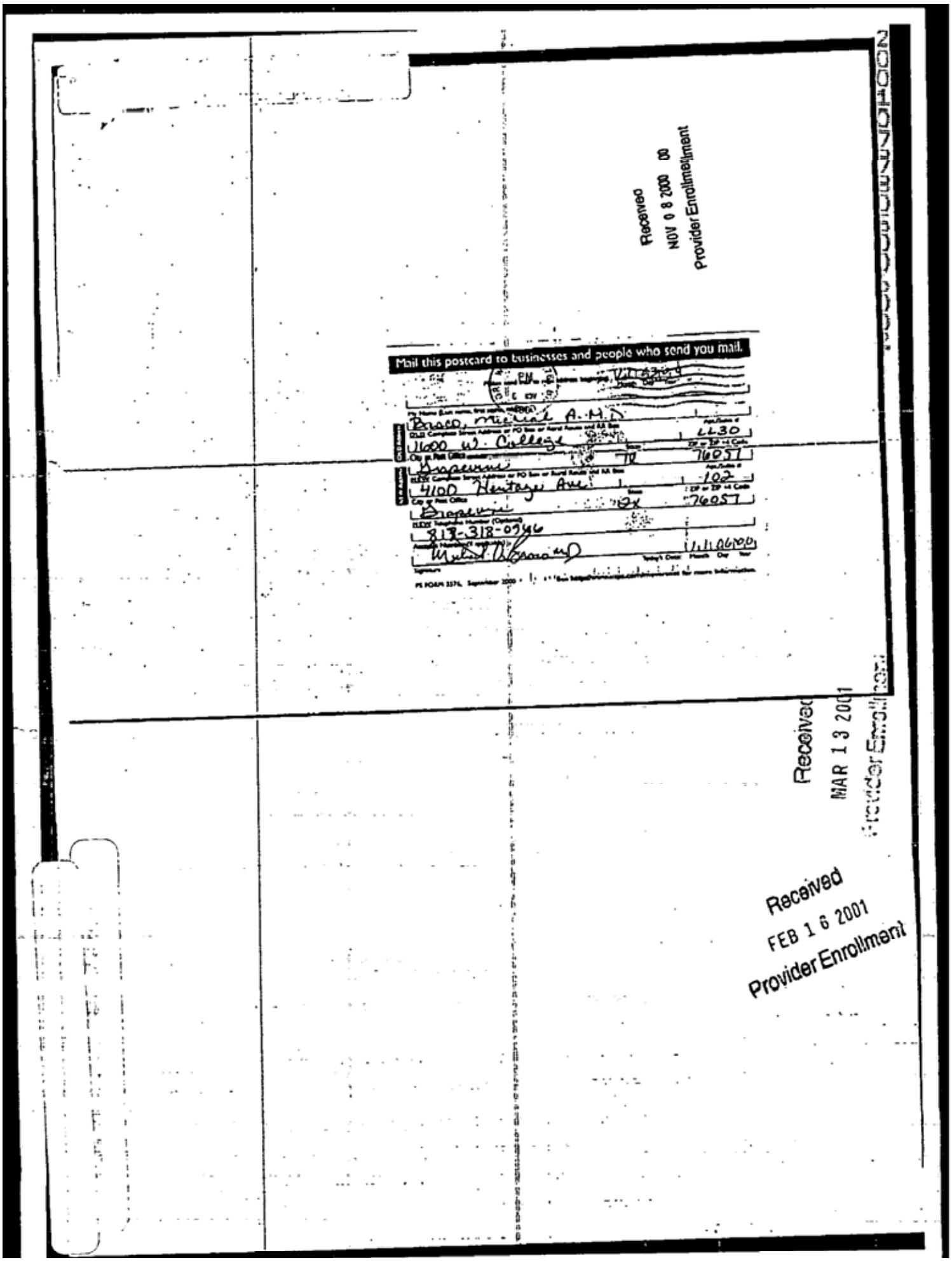
Grapevine TX 76051

817-318-0966

Received
NOV 0 8 2000
Provider Enrollment

Received
MAR 1 3 2001
Provider Enrollment

Received
FEB 1 6 2001
Provider Enrollment


Mail this postcard to businesses and people who send you mail.
Braco, Michael A. M.D.
11000 W. College
Ste
LL30
76057
Grapevine
4100 Heritage Ave
102
76057
Grapevine
817-318-0946
11/11/06
Received
NOV 08 2000
Provider Enrollment
Received
MAR 13 2001
Received
FEB 16 2001
Provider Enrollment

Form **W-9** (Rev. March 1994) Department of the Treasury Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Please print or type

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 2.)
Michael A. Basco M.D

Please check appropriate box: ☒ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▸ ....

Address (number, street, and apt. or suite no.)
4100 Heritage Ave, Ste 102

City, state, and ZIP code
Grapevine Tx 76051

Requester's name and address (optional)

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). For sole proprietors, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How To Get a TIN below.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number: [illegible]

OR

Employer identification number: 75-291[illegible]

Part II For Payees Exempt From Back[up] Withholding (See Part II instructions on page 2)

▶

Part III 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
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 ▸ [signature] Date ▸ 1/1/2001

RECEIVED MAR 1 3 2001 Provider Enrollment

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.*

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

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:

1. You do not furnish your TIN to the requester, or
2. The IRS tells the requester that you furnished an incorrect TIN, or
3. 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 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
5. 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 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 businesses and all other entities), from your local IRS office.

RECEIVED ... 16 2001 Provider Enrollment

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.
withholding, if applicable, will begin and continue until you furnish your TIN.

Cat. No. 10231X

Information Note for Internal Use Only

Note Date: 2001-03-19 14:34:43.000
Parent ICN: 200107805006002
Note ICN: 20010780500600214343 8.doc
Note type: DOC
User name: morose01

TWO TIN'S LISTED

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 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.
- ☒ IRS W9 Form is required to change accounting name and/or Tax I.D. number **select only one Tax I.D. number**).
- ☐ 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

Update CLIA FORM FOR

DR MICHAEL BASCO MD

1364358O7

DR Edward D Clark MD

1438954O3

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

MICHAEL A BASCO MD

CLIA ID NUMBER

45D0708223

EFFECTIVE DATE

09/01/2002

EXPIRATION DATE

08/31/2004

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

TEXAS MEDICAID

PROVIDER ENROLLMENT APPLICATION

MAR 12 1990 DEC 01 1989

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

A PROVIDER OF SERVICE INFORMATION

APPLICANT NAME (INDIV., GROUP, INC., DBA - SHOW AS LICENSED)
Emergency Medical Clinic
Last or Group or Co. | First | Initial | Title/Degree

TELEPHONE NUMBER
Area Code (214) 980-1010 Business 214-340 8910

TYPE OF PROVIDER (PRIMARY SPECIALTY) GP

PHYSICIAN LICENSE # (Attach copy if Temporary)
F2953

IF AMBULANCE COMPANY ATTACH A COPY OF YOUR CERTIFICATION FROM THE DEPARTMENT OF HEALTH

IRS EMPLOYER'S I.D. #
75-1990476

SOCIAL SECURITY #

ADDRESS NO. 1 (PRACTICE LOCATION - NOT P.O. BOX)
14902 Preston Rd #800
Number | Street | Room/Suite
Dallas Tx 75240
City | State | Zip

ADDRESS NO. 2 (ACCOUNTING ADDRESS/MAIL CHECK TO:)
9550 Skillman, L/B 107
Number | Street or P.O.Box
Dallas, Texas 75243
City | State | Zip

*** If name of applicant in "Section A" is a group practice, please fill out "Section B" below: ***

B GROUP PRACTICE INFORMATION: List all physician members of your group.

LICENSE #	NAME	M.D. or D.O.	SPECIALTY OF PRACTICE
F2940	SOLANKI, KIRIT	MD	GP
E1619	HOWE, ROBERT	MD	GP
C5441	PRICE, JOEL	MD	GP
C3120	LARSON, ARLAN	MD	GP
F5114	ZASTEROVA, INGRID	MD	GP
G5869	BUSHART, JAMES	MD	GP

C BILLING INFORMATION

What is your MEDICARE Provider Number? # 2000 LK-194

What is your MEDICARE Certification date?

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

Signature

MD 11-28-89
Title Date

DO NOT WRITE IN THIS AREA
all pos's attached emailed
#

County | Spec | Type | Locality | Effective Date

Enrollment Date: 3-20-90 Initials: C.S.

RETURN FORM TO:

N.H.I.C.
11044 Research Blvd., Bldg. "C"
Austin, Texas 78759

14293

F2953 DD Stringel P08817601
E1618 ROBERT L. HOWE, M. D. P0881839
C3120 ARLAN P. LARSON, M. D. P0881838 3
H5198 RONALD M. RAMUS, M. D. P0881836 7
F2940 KIRIT SOLANKI, M. D. P0881835 9
H4671 RICHARD L. SALSMAN, M. D. P0881833 3
F5114 INGRID ZASTEROVA, M. D. P0881832 5
G5869 JAMES BUSHART, M. D. P0881830 9
C5445 Michael Bosco MD P08818317
Joel Price M.D. Pending

MARCH 24, 1990.

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

DEAR PROVIDER

WE HAVE COMPLETED THE ENROLLMENT OF BUSHART, JAMES MD, PERFORMING PROVIDER NUMBER P08818309, 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

	1-08-20-001	4-17-80	Non Par
3	PD Strunzel	1-11-89	P08817601
	057-08-20-001		Non par
1618	ROBERT L. HOWE, M. D.		P08818391
	057-08-20-001	1-11-89	Non Par
C3120	ARLAN P. LARSON, M. D.		P08818383
	057-16-20-001	1-11-89	Non Par
H5198	RONALD M. RAMUS, M. D.		P08818367
	057-22-20-001	1-11-89	Non Par
F2940	KIRIT SOLANKI, M. D.		P08818359
	057-16-20-001	1-11-89	Non Par
H4671	RICHARD L. SALSMAN, M. D.		P08818333
	057-08-20-001	1-11-89	Non Par
F5114	INGRID ZASTEROVA, M. D.		P08818325
	057-08-20-001	1-11-89	Non Par
G5869	JAMES BUSHART, M. D.		P08818309
	057-16-20-001	1-11-89	Non Par
C5441	Michael Bosco MD		P08818317
	Joel Price M.D.		Pending

MAR 14 1990

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 P08818317, 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 01

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

facsimile transmittal

To: Provider Enrollment Fax: 512-514-4214

From: Kristen Date: 2-27-02

Re: TPI #5 Pages:

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Thank you,

MICHAEL A. BASCO M.D.

Michael BASCO TPI# 1364835807
Edward D Clark TPI# 1438895403

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Laboratory:	MICHAEL A BASCO MD	CLIA ID#:	45D0708223
Mailing Address:	1600 WEST COLLEGE STREET SUITE LL30		
Laboratory:	MICHAEL A BASCO MD	CLIA ID#:	45D0708223
Mailing Address:	1600 WEST COLLEGE STREET SUITE LL30 GRAPEVINE TX 76051		
		Effective Date:	September 01, 2000
Laboratory Director:	MICHAEL A BASCO	Expiration Date:	August 31, 2002
Physical Location:	1600 WEST COLLEGE STREET SUITE LL30 GRAPEVINE TX 76051		

CLIA LABORATORY CERTIFICATE FOR PROVIDER-PERFORMED MICROSCOPY PROCEDURES

Pursuant to Section 353 of the Public Health Service Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (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.

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

Judith A. Yost

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

02/06/2002 03:37 FAX 01

Edward D. Clark
1438 95403

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

Michael Basco
1364358 07

facsimile transmittal

To: Provider Enrollment Fax: 512-514 4214

From: Kristin Date: 12-14-01

Re: CLIA Certificate Pages: 2 including cover

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

NHIE
faxed to
12-14-01
KM 2:40

Thank you,

MICHAEL A. BASCO M.D.

Edward Clark MD

FAXED
12/28/02 11:15 KM
AM

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Laboratory: y: MICHAEL A BASCO MD

Mailing Addrddress: 1600 WEST COLLEGE STREET SUITE LL30
GRAPEVINE TX 76051

CLIA ID#: 45D0708223

Effective Date: September 01, 2000

Expiration Date: August 31, 2002

Laboratory Dy Director: MICHAEL A BASCO

Physical Localocation: 1600 WEST COLLEGE STREET SUITE LL30
GRAPEVINE TX 76051

CLIA LABORATORY CERTIFICATE FOR PROVIDER-PERFORMED MICROSCOPY PROCEDURES

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

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

Judith A. Yost

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

rev. 11/02/94

FAX

Date 12/27/01

Number of pages including cover sheet 3

TO: Tracy M

Phone
Fax Phone 453-1859

FROM: NHIC/Andrea Danielp
PROVIDER
ENROLLMENT
12545 Riata Vista Circle
AUSTIN, TX 78727-6404

Phone (512)514-3000
Fax Phone (512)514-4214

CC:

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please Comment

Tracy:

This letter came to me & I really think it should have come to you. If you need to talk to me, I can be reached @ 5143077.

Andrea

Confirmation Report-Memory Send

Time : 12-27-01 10:57am
Tel line 1 : +
Name : NHIC P+E N12D015816
Name : NHIC P+E N12D015816

Job number	:	651
Date	:	12-27 10:56am
To	:	94531859
Document Pages	:	03
Start time	:	12-27 10:56am
End time	:	12-27 10:57am
Pages sent	:	03

Job number : 651 *** SEND SUCCESSFUL ***

FAX

Date 12/27/01

Number of pages including cover sheet 3

TO: Tracy M

Phone:
Fax Phone 453-1859

FROM: NHIC/Andrea Danielle
PROVIDER
ENROLLMENT
12545 Riata Vista Circle
AUSTIN, TX 78727-6404

Phone (512)514-3007
Fax Phone (512)514-4214

CC:

REMARKS: ☐ Urgent ☑ For your review ☐ Reply ASAP ☐ Please Comment

Tracy:
This letter came to me & I really think it should have come to you. If you need to talk to me, I can be reached @ 5143077.

Andrea

December 9, 2001

Texas State Board of Insurance
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

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

01/13/2003 03:48 FAX 01

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

[redacted]

To: Provider Enrollment Fax: 512 514 4214

From: KRISTEN M Date: 1-13-03

Re: CLIA Certificate Pages: Cover page plus ___

CC:

☒ Urgent ☐ For Review ☐ Please Comment X Please Reply ☐ Please Recycle

Thank you,

MICHAEL A. BASCO MD

Dr Michael A BASCO #1364535807
Dr Edward J Clark #1438595403

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

MICHAEL A BASCO MD

CLIA ID NUMBER

45D0708223

EFFECTIVE DATE

09/01/2002

EXPIRATION DATE

08/31/2004

Pursuant to Section 353 of the Public Health Services Act (42 USC 263a), as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
Centers for Medicare & Medicaid Services

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

Information Note for Internal Use Only

Note Date: 2003-01-21 14:56:28.000
Parent ICN: EN1030135396000
Note ICN: EN10301353960000145620.rtf
Note type: NOTE
User name: tmille01

DUP

DCN: 200826139001206

Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐	Date: 9/17/2008
Nine-Digit Texas Provider Identifier (TPI): 136435807	Provider Name: Michael A. Basco
National Provider Identifier (NPI): 1467647776	Primary Taxonomy Code:
Atypical Provider Identifier (API):	Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address 1713 S. Fm 51 Suite 201	City Decatur	County Wise	State Tx	Zip Code 76234		
Telephone: (940) 626-3746	Fax Number: (940) 627-4709	Email: michaelbasco@medscape.com				

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address 1713 S.FM 51 Suite 201	City Decatur	State Tx	Zip Code 76234	
Telephone: (940) 626-3746	Fax Number: (940) 627-4709	Email: michaelbasco@medscape.com		

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, telephone, and/or fax number
☐	Change/add secondary address, telephone, and/or fax number
☐	Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
☐	Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number: 552-35-0350	Effective Date: 9/17/2008
Exact name reported to the IRS for this Tax ID: Michael A. Basco	

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English: Spanish			
Provider office hours by location: M-F 9-5			
Accepting new clients by program (check one):	Accepting new clients ☒	Current clients only ☐	No ☐
Patient age range accepted by provider:	Additional services offered (check one):	HIV ☒	High Risk OB ☒
Participation in the Woman's Health Program? Yes ☒ No ☐	Patient gender limitations:	Female ☒	Male ☐ Both ☐

Signature and date are *required* or the form will *not* be processed.

Provider signature: Michael Basco MD	Date: 9/17/2008

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

DCN: 200826139001206

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above
Michael A. Basco .M.D

Check appropriate box: ☒ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
1713 S. FM 51 Suite 201

Requester's name and address (optional)

City, state, and ZIP code
Decatur Tx 76234

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number
552 | 35 | 0350

or

Employer identification number
| |

Part II 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
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 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 ▶ Michael Basco Date ▶ 9/17/2008

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 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,

DCN: 200826239000653

Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐	Date: 9/17/2008
Nine-Digit Texas Provider Identifier (TPI): 136435807	Provider Name: Michael A. Basco
National Provider Identifier (NPI): 1467647776	Primary Taxonomy Code: 207V00000X
Atypical Provider Identifier (API):	Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address 1713 S. FM 51 Suite 201 City Decatur County Wise State Tx Zip Code 76234

Telephone: (940) 626-3746 | Fax Number: (940) 627-4709 | Email: michaelbasco@medscape.com

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address 1713 S.FM 51 Suite 201 City Decatur State Tx Zip Code 76234

Telephone: (940) 626-3746 | Fax Number: (940) 627-4709 | Email: michaelbasco@medscape.com

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, telephone, and/or fax number
- ☐ Change/add secondary address, telephone, and/or fax number
- ☐ Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
- ☐ Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number: 552-35-0350 | Effective Date: 9/17/2008

Exact name reported to the IRS for this Tax ID: Michael A. Basco

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English: Spanish

Provider office hours by location: M-F 9-5

Accepting new clients by program (check one): Accepting new clients ☒ Current clients only ☐ No ☐

Patient age range accepted by provider: | Additional services offered (check one): HIV ☒ High Risk OB ☒

Participation in the Woman's Health Program? Yes ☒ No ☐ | Patient gender limitations: Female ☒ Male ☐ Both ☐

Signature and date are *required* or the form will *not* be processed.

Provider signature: Michael Basco MD | Date: 9/17/2008

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

DCN: 200826239000653

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above
Michael A. Basco .M.D

Check appropriate box: ☒ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
1713 S. FM 51 Suite 201

Requester's name and address (optional)

City, state, and ZIP code
Decatur Tx 76234

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number
552 | 35 | 0350

or

Employer identification number
| |

Part II 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
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 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 ▶ Michael Basco Date ▶ 9/17/2008

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 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,

DCN: 200834339002255

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

DCN: 200834339002255

Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐	Date: 12 / 8 / 2008
Nine-Digit Texas Provider Identifier (TPI): 13643580 7	Provider Name: Michael A. Basco MD PA
National Provider Identifier (NPI): 1467647776	Primary Taxonomy Code: 207V00000X
Atypical Provider Identifier (API):	Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address 1713 S. FM 51 Suite 201 City Decatur County Wise State Tx Zip Code 76234

Telephone: (940) 626-3746 Fax Number: (940) 627-4709 Email: michael.basco@medscape.com

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address 1713 S. FM 51 Suite 201 City Decatur State TX Zip Code 76234

Telephone: (940) 626-3746 Fax Number: (940) 627-4709 Email: michael.basco@medscape.com

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, telephone, and/or fax number
- ☐ Change/add secondary address, telephone, and/or fax number
- ☐ Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
- ☐ Other (e.g., panel closing, capacity changes, and age acceptance)

Comments: address on file is correct

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number: 75-2912950 Effective Date:

Exact name reported to the IRS for this Tax ID: Michael A. Basco M.D. PA

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English: Spanish

Provider office hours by location:

Accepting new clients by program (check one): Accepting new clients ☒ Current clients only ☐ No ☐

Patient age range accepted by provider: Additional services offered (check one): HIV ☒ High Risk OB ☒

Participation in the Woman's Health Program? Yes ☒ No ☐ Patient gender limitations: Female ☒ Male ☐ Both ☐

Signature and date are *required* or the form will not be processed.

Provider signature: Michael A Basco MD Date: 12 / 8 / 2008

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

DCN: 200834339002259

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.

Name (as shown on your income tax return)
Michael A. Basco M.D. PA

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☒ Other (see instructions) ▶ PA

☐ Exempt payee

Address (number, street, and apt. or suite no.)
1713 S. Fm 51 Suite 201

Requester's name and address (optional)

City, state, and ZIP code
Decatur Tx 76234

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number

or

Employer identification number
75 2912950

Part II 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
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 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** ▶ Michael Basco MD | **Date** ▶ 12/08/2008

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 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

June 22, 2009

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

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

Enclosures

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

This Certification pertains to the following Billing Provider:

Name of Billing Provider: BASCO, MICHAEL A

Tax ID Number 752912950

TPI Number (list all TPI numbers associated with the Billing Provider)

136435807

NPI Number: 1467647776

The Provider's billing address is:

Street Address 1713 S FM 51 Ste 201

Street Address

City/State/Zip Decatur, Tx 76234

Phone Number 9406263746

The Billing Provider's physical address is:

Street Address Same

Street Address

City/State/Zip

Phone Number

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

My name is Kim Mc. I am the Billing Provider or, if the Billing Provider is not an individual, I am the Billing Provider's (title or position) billing manager. I am of sound mind, capable of making this Certification, and personally acquainted with the facts stated here. If I am representing the Billing Provider, I am authorized to make this Certification on the Billing Provider's behalf.

HHSC has identified the Billing Provider as providing services 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, each Billing Provider must complete this Certification within thirty days from the date of this 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 Medicaid Women's Health Program during calendar years 2008 and 2009:

(1) The Billing Provider has not performed elective abortion[1] 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.

[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 arising 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

Tax ID Number 752912950

TPI Number (list all TPI numbers associated with the Billing Provider)

136435807

NPI Number: 1467647776

(5) None of the funds the Billing Provider has received under the Medicaid Women's Health Program has been used to pay costs associated with referring women for elective abortion 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 abortion 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 Health Program are authorized services under Human Resources Code section 32.0248(a).

b. In addition, I understand and acknowledge that:

(1) 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 b(5) **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 Part a of this Certification, the Billing Provider may be ineligible to receive Medicaid Women's Health Program funds;

(3) if HHSC has reason to believe that the Billing Provider 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 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 on 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 Women's Health Program until it ceases every activity listed in Part a;

(5) the Billing Provider must notify HHSC at least 30 days prior to implementing any of the activities listed in Part a of this Certification; and if the Billing Provider fails to do so, HHSC 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 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 to my or my organization's exclusion from participation in the Medicaid program.

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

☐ I affirm that the statements listed in Part a are not true and correct

Signature Michael Basco MD

Printed Name _____

Title _____

Date _____

MR12

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

This Certification pertains to the following Billing Provider:

Name of Billing Provider:
Tax ID Number 752912950
TPI Number (list all TPI numbers associated with the Billing Provider)
136435807

NPI Number:

The Provider's billing address is:
Street Address 1903 Doctors Hospital Dr Ste 3C
Street Address
City/State/Zip Bridgeport, Tx 76426
Phone Number 9406683027

The Billing Provider's physical address is:
Street Address
Street Address Same
City/State/Zip
Phone Number

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

My name is Michael Base. I am the Billing Provider or, if the Billing Provider is not an individual, I am the Billing Provider's (title or position) MD. I am of sound mind, capable of making this Certification, and personally acquainted with the facts stated here. If I am representing the Billing Provider, I am authorized to make this Certification on the Billing Provider's behalf.

HHSC has identified the Billing Provider as providing services 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, each Billing Provider must complete this Certification within 30 days from the date of this request and must return the completed Certification to:

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

MR20

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[1] 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.

[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 arising 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 Michael Basco

Tax ID Number 752912950

TPI Number (list all TPI numbers associated with the Billing Provider)
136435857

NPI Number

(5) None of the funds the Billing Provider has received under the Medicaid Women's Health Program has been used to pay costs associated with referring women for elective abortion 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 abortion 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 Health Program are authorized services under Human Resources Code section 32.0248(a).

b. In addition, I understand and acknowledge that:

(1) 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 b(5) **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 Part a of this Certification, the Billing Provider may be ineligible to receive Medicaid Women's Health Program funds;

(3) if HHSC has reason to believe that the Billing Provider 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 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 on 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 Women's Health Program until it ceases every activity listed in Part a;

(5) the Billing Provider must notify HHSC at least 30 days prior to implementing any of the activities listed in Part a of this Certification; and if the Billing Provider fails to do so, HHSC 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 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 to my or my organization's exclusion from participation in the Medicaid program.

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

☐ I affirm that the statements listed in Part a are not true and correct

Signature Michael Basco MD

Printed Name Michael A. Basco, M.D., PA

Title MD M.D. PA

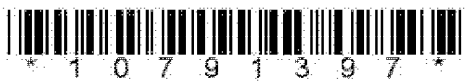
Date 12-2-10

MR20

DCN: 201106039004260

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Portal Ticket #:	10791397
Date Printed:	Tuesday, March 01, 2011
NPI:	1467647776
Provider Name:	BASCO , MICHAEL



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 **BASCO , MICHAEL**
Federal Tax ID Number
National Provider Identifier (NPI) Number **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:

(1) The provider does not perform elective abortion[1] 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 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 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 Medicaid Women's Health Program until it ceases every activity listed in Part a;

(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 mail it to TMHP by the end of each calendar year.)

☐ Terminate WHP Certification

Effective Date:

Signature _____

Printed Name _____

Title _____

DCN: 201107300004064

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Portal Ticket #: 10791397
Date Printed: Tuesday, March 01, 2011
NPI: 1467647776
Provider Name: BASCO , MICHAEL

10791397

3/1/2011 4:29:57 PM

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 **BASCO , MICHAEL**

Federal Tax ID Number

National Provider Identifier (NPI) Number **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:

(1) The provider does not perform elective abortion[1] 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 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 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 Medicaid Women's Health Program until it ceases every activity listed in Part a;

(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 mail it to TMHP by the end of each calendar year.)

☐ Terminate WHP Certification

Effective Date:

Signature _____

Printed Name Michael A. Basco MD.

Title physician / owner

MR20

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

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.

Name (as shown on your income tax return)
Michael A. Basco M.D. PA

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☒ Other (see instructions) ▶ PA

☐ Exempt payee

Address (number, street, and apt. or suite no.)
2451 S. FM 51 Ste 300

Requester's name and address (optional)

City, state, and ZIP code
Decatur TX 76234

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number

or

Employer identification number
75 2912950

Part II 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
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 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 ▶ Michael Basco MD Date ▶ 12/08/2008

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 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,

From: 02/23/2012 16:14 #016 P.003/003
02/23/2012 17:47 FAX ☑ 002/002
From: 02/23/2012 15:15 #014 P.002/002

Provider Information Change Form

Texas Medicaid fee-for-service, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐ Date: 2/23/2012

Nine-Digit Texas Provider Identifier (TPI): 136435857 Provider Name: Dr Michael Basco

National Provider Identifier (NPI): 1467647776 Primary Taxonomy Code 207USOSOX

Atypical Provider Identifier (API): Benefit Code:

List any additional TPIs that use the same provider information:

TPI: 136435857	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address 2451 S Em St Ste 300 City Decatur County Wise State TX Zip Code 7623

Telephone: (940) 6274216 Fax Number: (940) 6274709 Email:

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address 2451 S Em St Ste 300 City Decatur TX State 7623 Zip Code

Telephone: (940) 6274216 Fax Number: (940) 6274709 Email:

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, telephone, and/or fax number
- ☐ Change/add secondary address, telephone, and/or fax number
- ☐ Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
- ☐ Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number: 752912950 Effective Date: 12-1-2011

Exact name reported to the IRS for this Tax ID: Dr Michael Basco

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English:

Provider office hours by location:

Accepting new clients by program (check one): Accepting new clients ☐ Current clients only ☐ No ☑

Patient age range accepted by provider: Additional services offered (check one): HIV ☐ High Risk OB ☐ Hearing Services for Children ☐

Participation in the Woman's Health Program? Yes ☑ No ☐ Patient gender limitations: Female ☑ Male ☐ Both ☐

Signature and date are required or the form will not be processed.

Provider signature: Date: 02/23/12

Mail or fax the completed form to: Texas Medicaid & Healthcare Partnership (TMHP) Fax: 512-514-4214

Effective Date_01012009/Revised Date_01212010

DCN: 200911239000704

FROM (WED) APR 22 2009 10:07/ST. 10:04/No. 7516098033 P 1

[redacted]

Michael A. Basco M.D.
1713 S. FM 51 Suite 201
Decatur, Texas 76234
Phone: (940) 626-3746 Fax: (940) 627-4709
E-Mail: michaelbasco@medscape.com

fax

Date: 4.22.09

Send To: TMHP

Attention:

Office Location:

From: Kim

Office Location:

Phone Number: 5125141214

Total Pages Including Cover:

Urgent ☐ Reply ASAP ☐ Please Comment ☐ Please Review ☐ For Your Information ☐

Comments:

Our NPI # is 1467447776
for your records

DCN: 200911239000704

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES

LABORATORY NAME AND ADDRESS

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

CLIA ID NUMBER
45D0708223

EFFECTIVE DATE
09/29/2008

EXPIRATION DATE
09/28/2010

LABORATORY DIRECTOR
MICHAEL A BASCO MD

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

DCN: 200900739000892

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

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

FAX COVER SHEET

TO: Provider Enrollment DATE: 1-7-09

FROM: Kim FAX: 5125144214

PAGES: 2 RE:

Comments:

Please put this claim on file for NPI # 1467647776

Thanks

DCN: 200900739000892

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES

LABORATORY NAME AND ADDRESS

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

LABORATORY DIRECTOR

MICHAEL A BASCO MD

CLIA ID NUMBER

45D0708223

EFFECTIVE DATE

09/29/2008

EXPIRATION DATE

09/28/2010

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS

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

DOCUMENT VERIFICATION SHEET

Provider #: _____

Initials: _____

Date: _____

Checklist for Texas Health Steps-Medical Case Management:

Enrollment Application

Provider Agreement for TH Steps Case Management services

NATIONAL HERITAGE INSURANCE CO.

Austin, Texas 78759-5239

Building C
11044 Research Boulevard
(800) 873-6768

2002057037763006

OCTOBER 04, 1996

EPSD31655
BASCO, MICHAEL A. MD
1305 AIRPORT FRWY STE 220
BEDFORD, TX 76021

DEAR PROVIDER

THIS LETTER NOTIFIES YOU OF YOUR ENROLLMENT IN THE TEXAS MEDICAID 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 MEDICAID PROGRAM.

SINCERELY,

PROVIDER ENROLLMENT

TEXAS MEDICAID
PROVIDER ENROLLMENT APPLICATION

EPSDT MEDICAL

NHIC'S RECEIPT OF APPLICATION

Number:

A PROVIDER OF SERVICE INFORMATION

APPLICANT NAME (INDIV., AGENCY, CLINIC) AS IT APPEARS ON LICENSE: BASCO (Last Name / Group / Company) MICHAEL (First) A (Initial) MD (Title/Degree)

TELEPHONE NUMBER: Area Code (817) 545-4850

WILL YOU ACCEPT REFERRALS FOR EPSDT SCREENS (I.E., PATIENTS WHO ARE NOT CURRENTLY UNDER YOUR CARE)? YES ✓ NO

TYPE OF PROVIDER (PRIMARY SPECIALTY): OB/Gyn

NAME AND LICENSE NUMBER OF THE SUPERVISING PHYSICIAN (IF APPLICABLE): MICHAEL A. BASCO MD Tx H5151 Issue Date: 2/24/84

IS THE SUPERVISION PHYSICIAN ON SITE? IF NO, REFER TO "REQUIRED FORMS FOR MEDICAID ENROLLMENT." YES ✓ NO

IF YOU HAVE MORE THAN ONE OFFICE LOCATION COMPLETE THE ATTACHED "LOCATION INFORMATION SHEET." N/A

EMPLOYER'S TAX ID NUMBER (FOR YEARLY TAX REPORTING): 75245 7772

SOCIAL SECURITY NUMBER (IF TAX ID IS NOT APPLICABLE): 552 35 0350

LICENSE # (ATTACH COPY, IF TEMPORARY): Tx H5151

MEDICARE PROVIDER # (IF APPLICABLE): 00H78V

ADDRESS OF PHYSICAL LOCATION (NOT P.O. BOX): 1305 (Number) Airport Freeway (Street) Suite 220 (Room / Suite) Bedford (City) Tx (State) 76021 (Zip Code)

ACCOUNTING ADDRESS / MAIL CHECK TO: 1305 (Number) Airport Freeway (Street / P.O. Box) Suite 220 (Room / Suite) Bedford (City) Tx (State) 76021 (Zip Code)

HAVE YOU EVER BEEN ASSIGNED A MEDICAID PROVIDER #? YES ✓ NO (P00014 78V6)

DO YOU WANT TO BE A LOCK-IN PROVIDER? YES NO

B SCREENING PROVIDER INFORMATION

Please list all professionals who will be performing EPSDT screenings.

LICENSE #	ISSUE DATE	NAME	TITLE
Tx H5151	2/24/84	Michael A. Basco MD	physician

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 Health for the purpose of issuing a Medicaid provider number.

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

Michael A Basco MD
Signature

owner / physician — 9/27/96
Title — Date

Office Contact: Michael A. Basco MD
Phone: (817) 545-4850

DO NOT WRITE IN THIS AREA

County	Spec.	Type	Locality	Effective Date

Enrollment Date: _____ Initials: _____

RETURN FORM TO:

N.H.I.C.
Provider Enrollment
11044 Research Blvd., Bldg. "C"
Austin, Texas 78759

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

SEP 30 1996

DTOL ENR.

DCN: 201120039002731

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
TMHP A STATE MEDICAID CONTRACTOR

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.

DCN: 201120039002731

TEXAS MEDICAL BOARD

P.O. BOX 2029 • AUSTIN, TEXAS 78768-2029

PHYSICIAN FULL PERMIT

LICENSE/PERMIT NUMBER
H5151

EXPIRATION DATE
08-31-2013

MICHAEL ANGELO BASCO, MD
1903 DOCTOR S HOSPITAL DRIVE STE. 36
BRIDGEPORT TX 76426-2277

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

NHIC

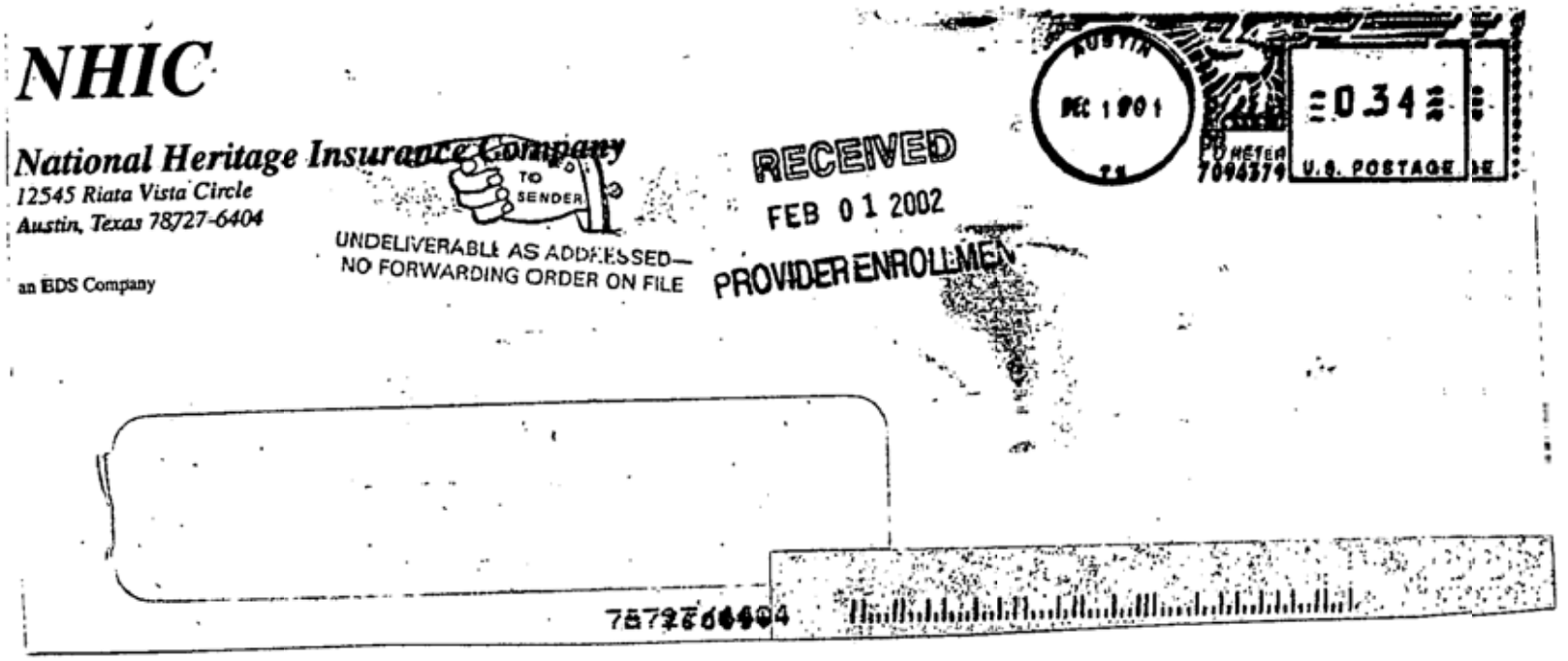
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6404

an EDS Company

RETURN TO SENDER
OVERAGE ... POSTAGE
FORWARDING ORDER ON F...

RECEIVED
FEB 01 2002
PROVIDER ENROLLMENT

78732664494



NHIC

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

an EDS Company

RETURN TO SENDER
UNDELIVERABLE AS ADDRESSED—
NO FORWARDING ORDER ON FILE

RECEIVED
FEB 01 2002
PROVIDER ENROLLMENT

AUSTIN
DEC 1901
PB METER 7044379
0.34
U.S. POSTAGE

78727-6404

NHIC

National Heritage Insurance Company

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Laboratory:	MICHAEL A BASCO MD
Mailing Address:	1600 WEST COLLEGE STREET SUITE LL30 GRAPEVINE TX 76051
Mailing Address:	1600 WEST COLLEGE STREET SUITE LL30 GRAPEVINE TX 76051
Laboratory Director:	MICHAEL A BASCO
Physical Location:	1600 WEST COLLEGE STREET SUITE LL30 GRAPEVINE TX 76051

CLIA ID#: 45D0708223

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

CLIA LABORATORY CERTIFICATE FOR PROVIDER-PERFORMED MICROSCOPY PROCEDURES

Pursuant to Section 353 of the Public Health Service Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (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.

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

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

RECEIVED
FEB 01 2002
PROVIDER ENROLLMEN

01/28/2002 00:08 FAX 01

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

facsimile transmittal

To: Provider Enrollment Fax: 512-514 4214

From: Kristin Date: 12-14-01

Re: CLIA Certificate Pages: 2 including cover

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

NTIE faxed to 12-14-01 KM 2:40

Thank you,

MICHAEL A. BASCO M.D.

Edward Clark MD

FAXED 1/28/02

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Laboratory: y: MICHAEL A BASCO MD

Mailing Addrddress: 1600 WEST COLLEGE STREET SUITE LL30
GRAPEVINE TX 76051

CLIA ID#: 45D0708223

Effective Date: September 01, 2000

Expiration Date: August 31, 2002

Laboratory Dy Director: MICHAEL A BASCO

Physical Locaocation: 1600 WEST COLLEGE STREET SUITE LL30
GRAPEVINE TX 76051

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

rev. 11/02/94

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

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.

Please submit:

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- ☐ Other:

If you have any questions please call Customer Service at (800)-925-9126.

Enclosures

12/14/2001 03:37 FAX 01

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

facsimile transmittal

To: Provider Enrollment *Fax:* 512-514 4214

From: Kristin *Date:* 12-14-01

Re: CLIA Certificate *Pages:* 2 including cover

CC:

☐ *Urgent* ☐ *For Review* ☐ *Please Comment* ☐ *Please Reply* ☐ *Please Recycle*

Thank you,

MICHAEL A. BASCO M.D.

Edward Clark MD

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Laboratory: y: MICHAEL A BASCO MD

Mailing Addrddress: 1600 WEST COLLEGE STREET SUITE LL30
GRAPEVINE TX 76051

CLIA ID#: 45D0708223

Effective Date: September 01, 2000

Expiration Date: August 31, 2002

Laboratory Dy Director: MICHAEL A BASCO

Physical Locaocation: 1600 WEST COLLEGE STREET SUITE LL30
GRAPEVINE TX 76051

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

rev. 11/02/94

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.?

[illegible]

Note Date: 2001-12-18 16:48:23.000
Parent ICN: EN1013485273000
Note ICN: EN101348527300164755.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

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

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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

NHIC

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 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.
- ☒ IRS W9 Form is required to change accounting name and/or Tax I.D. number **select only one Tax I.D. number).**
- ☐ 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

Form **W-9**
(Rev. March 1994)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Department of the Treasury
Internal Revenue Service
send to the IRS.

Please print or type

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 2.)
Michael A. Basco M.D

Please check appropriate box: ☒ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ►

Address (number, street, and apt. or suite no.)
4100 Heritage Cir, Ste 102

City, state, and ZIP code
Grapevine Tx 76051

Requester's name and address (optional)

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). For sole proprietors, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How To Get a TIN below.

Social security number
5 5 2 4 3 5 7 0 3 5 7 0

OR

Employer identification number
7 5 2 9 1 2 9 5 1 0

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Part II For Payees Exempt From Backup Withholding (See Part II instructions on page 2)

►

Part III 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
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 ► [signature] Date ► 4/1/2001

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:

1. You do not furnish your TIN to the requester, or
2. The IRS tells the requester that you furnished an incorrect TIN, or
3. 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
5. 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 businesses 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.

Information Note for Internal Use Only

Note Date: 2001-04-04 16:19:50.000
Parent ICN: 200109405002022
Note ICN: 20010940500202216193l.rtf
Note type: NOTE
User name: mokeefe01

INQ SNT FOR PROV NUM AND INDICATE ONE ITEM ON W9

NHIC

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

An EDS Company

May 1, 2001

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.

Please keep this information for your records

	Texas Provider Identifier (TPI) 9-characters	
Column 1	Column 2 characters	Column 3
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**
EPSD31655	1364358	08
P085G4412	1364358	01
PCCE20049	1364358	09
P000H78V6	1364358	07
P08818317	1364358	06
P087G3952	1364358	04
P000D94Z2	1364358	03
P080F1976	1364358	02
P089G3324	1364358	05

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

Please keep this information for your records

NHIC

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

An EDS Company

May 1, 2001

Not at this address

Baylor Medical Center - Ellis County

BASCO, MICHAEL A. MD
1405 W JEFFERSON
WAXAHACHIE, TX 75165

IMPORTANT NOTICE
NEW MEDICAID NUMBERS ENCLOSED

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Column 1	Column 2 characters	Column 3
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EPSD31655	1364358	08
P085G4412	1364358	01
PCCE20049	1364358	09
P000H78V6	1364358	07
P08818317	1364358	06
P087G3952	1364358	04
P000D94Z2	1364358	03
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NHIC

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

An EDS Company

May 1, 2001

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

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NHIC

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

An EDS Company

May 1, 2001

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

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NHIC

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

An EDS Company

National Heritage Insurance Company May 1, 2001

May 1, 2001

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

* IMPORTANT NOTICE*
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NHIC

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

An EDS Company

National Heritage Insurance Company May 1, 2001

May 1, 2001

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

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Please keep this information for your records

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 Signed
- ☒ IRS W9 Form is required to change accounting name and/or Tax I.D. number select only one Tax I.D. number). P000H78V6 75-2912950
- ☒ 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:

Received
MAR 13 2001
Provider Enrollment

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

Received
MAR 30 2001
Provider Enrollment

12/98

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

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Enclosures

12/98

Form W-9
Rev. March 1999
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Please print or type

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 2.)
Michael A. Basco M.D

Please check appropriate box: ☒ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶

Address (number, street, and apt. or suite no.)
4100 Heritage Grv. Ste 102

City, state, and ZIP code
Grapevine Tx 76051

Requester's name and address (optional)

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). For sole proprietors, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How To Get a TIN below.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number
515 23 1570

OR

Employer identification number

Part II For Payees Exempt From Backup Withholding (See Part II Instructions on page 2)

▶

Part III 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
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. (See Part III Instructions on page 2.)

Sign Here — Signature ▶ [signature] 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:

1. You do not furnish your TIN to the requester, or
2. The IRS tells the requester that you furnished an incorrect TIN, or
3. 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
5. 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 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 businesses 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.

Received MAR 13 2001 Provider Enrollment

Received MAR 16 2001 Provider Enrollment

Received MAR 2 2001 Provider Enrollment

Cat No 10231X

Form W-9 (Rev. 3-99)