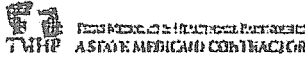


TMHP

11/8/2011 3:42:02 PM PAGE 2/008 Fax Server

(Page 1 of 7)

DCN: 201134110000271



P O Box 200795
Austin, TX 78720-0795
1 800-925-9126
Fax: 1-512-514-4214

WHOLE WOMANS HEALTH OF AUSTIN LLC
8401 NORTH IH 35 STE 200
AUSTIN T 78753

Kintana # 4337763

Initials: TET Date: November 6, 2011

Dear WHOLE WOMANS HEALTH OF AUSTIN LLC,

Thank you for your application to enroll in the Texas Medicaid Program. The attached forms are being returned to obtain additional information. To continue processing your application, we must receive the requested information within 30 days of the date of this letter.

If your application was submitted online through the TMHP Provider Enrollment on the Portal (PEP), you can submit updates through PEP by choosing "View Existing Transactions", selecting the portal ticker number of the application you wish to update, and clicking "Edit". After making the necessary revisions, submit the application by navigating to the "Final Acknowledgement" screen at the end of the application and click "I Accept".

If you submitted a paper enrollment application, you must submit revisions, along with a copy of this letter, to:

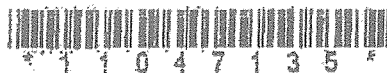
Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment Department
PO Box 200795
Austin, TX 78720-0795

Pages that do not require your signature can be faxed to 1-512-514-4214.

If you have any questions, please call the TMHP Contact Center at 1-800-925-9126, and select Option 2.

Please do not submit claims for services provided to eligible Medicaid clients until you have completed your enrollment with TMHP and received a letter with your Texas Provider Identifier (TPI). After you have received your TPI, please submit claims promptly to ensure that claims are received within 95 days of the date of your enrollment in the Texas Medicaid Program.

Your application is being returned because your application is missing information on one or more of the following documents:



512-

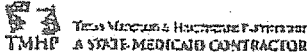
10:54:30 12-14-2011

9/10

TMHP

11/8/2011 3:42:02 PM PAGE 7/008 Fax Server

(Page 6 of 7)
DCN: 2011D1131000271



Comments:

~~MISSING PAGE 8.4 FOR THE BOOYAH GROUP- MUST COMPLETE AND SUBMIT~~

~~MISSING PAGE 8.4 FOR AMY HAGSTROM- MUST COMPLETE AND SUBMIT~~

~~MISSING PAGE 8.4 FOR T PATRICK AND ASSOCIATES- MUST COMPLETE AND SUBMIT~~

~~MISSING PAGE 8.4 FOR THOMAS WILCOX- MUST COMPLETE AND SUBMIT~~

~~PAGE 9.2- MUST REMOVE THE X FROM "CORPORATION" AND LEAVE ONLY THE X FOR "OTHER" LLC~~

MUST COMPLETE AND SUBMIT A PIF-1 FOR EACH PERSON LISTED ON PAGE 5.4

MUST COMPLETE AND SUBMIT A PROVIDER AGREEMENT FOR EACH PERSON LISTED ON PAGE 5.4. MUST INCLUDE AN ORIGINAL SIGNATURE FOR EACH.

~~MUST SUBMIT COPY OF CLIA CERTIFICATE~~

Thank you for participating in the Texas Medicaid Program. If you have any questions about your application, please call the TMHP Contact Center at 1-800-925-9126.

Enclosures

512-

Handwritten: KIN... 700/100

10:54:54 12-14-2011

10/10

Texas Medicaid Provider Enrollment Application

Hospital providers only:	Are you a hospital facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	If Yes, indicate the type of hospital facility: <input type="checkbox"/> Children's <input type="checkbox"/> Teaching Facility <input type="checkbox"/> Long Term <input type="checkbox"/> Short Term <input type="checkbox"/> Private Full Care <input type="checkbox"/> Private Outpatient <input type="checkbox"/> Psychiatric <input type="checkbox"/> Rehabilitation <input type="checkbox"/> State-owned <input type="checkbox"/> Non-profit				
	Date of Construction?				
	If you are a hospital facility, what is your average daily room rate for private and semi-private? <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Private</td> <td style="width: 50%; border: none;">Semi-Private</td> </tr> <tr> <td style="border: none;"> </td> <td style="border: none;"> </td> </tr> </table>		Private	Semi-Private	
Private	Semi-Private				
Public/Private entities: (required of all providers)	Definition — Public entities are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds.				
	Are you a private or public entity? <input checked="" type="checkbox"/> Private <input type="checkbox"/> Public				
	If you are a public entity, are you required to certify expended funds? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Name and address of a person certifying expended funds:				

Section B — Owners, Partners, Officers, Directors, and Principals

Identify sole proprietor or owners, partners, officers, directors, and principals (as defined in Principal Information Form (PIF-2)) of the applicant by providing, social security number, date of birth, driver's license # and state, and list the percentage of ownership, if applicable. Total ownership should equal 100%. As it relates to owners, include all individuals with 5% or more ownership in the company, whether this ownership is direct or indirect.

1	Name:	Title:	Percentage Owned:
	<i>The Booyah Group, LLC</i>	<i>owner</i>	<i>100%</i>
	Social Security Number:	Date of birth: MM/DD/YYYY	Drivers license number/State issuer:
	<i>20-0627534</i>		
2	Name:	Title:	Percentage Owned:
	Social Security Number:	Date of birth: MM/DD/YYYY	Drivers license number/State issuer:
3	Name:	Title:	Percentage Owned:
	Social Security Number:	Date of birth: MM/DD/YYYY	Drivers license number/State issuer:
4	Name:	Title:	Percentage Owned:
	Social Security Number:	Date of birth: MM/DD/YYYY	Drivers license number/State issuer: