TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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 ticket 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:

11047135

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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 ORIIGINAL 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- 10:54:54 12-14-2011 10/10

Kintaila 4 4537163

Texas Medicaid Provider Enrollment Application

Hospital providers only:	**Are you a hospital facility?**	☐ Yes ☐ No
	If Yes, indicate the type of hospital facility. ☐ Children's ☐ Teaching Facility ☐ Long Term ☐ Short Term ☐ Private Full Care ☐ Private Outpatient ☐ Psychiatric ☐ Rehabilitation ☐ State-owned ☐ Non-profit	
	Date of Construction?	
	If you are a hospital facility, what is your average daily room rate for private and 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?	☒ Private ☐ Public
	If you are a public entity, are you required to certify expended funds?	☐ Yes ☐ 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.

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