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 TX 78753

Kintana # 4337763

Initials: TET Date: December 19, 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:

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Texas Medicaid Identification Form

☐ Please clarify how we are to enroll you by checking the appropriate boxes.

Section A Provider of Service Information

☐ Please provide a valid National Provider Identifier (NPI)/Atypical Provider Identifier (API).

☐ The entity type for the NPI does not match the type of provider enrolled with TMHP. The NPI Final rule defines an Entity type 1 as a person and Entity type 2 as providers that are organizations (not individuals), such as hospitals, clinics, laboratories, ambulance companies, and provider groups.

☐ Please provide the primary taxonomy code.

☐ The name of the group, company, or last name should be that of the individual, group, or facility that is applying.

☐ The Social Security number (SSN) is required for individuals.

☐ The professional license number and the issue date, in MM/DD/YY format, are required for individuals and licensed entities.

☐ A Certified Respiratory Nurse Anesthetist (CRNA) must provide both licenses (a nurse's license and either Council on Certification of Nurse Anesthetist (CCNA) license or CCNA Recertification Card).

☐ The selections you made on the Texas Medicaid Identification Form require that you provide your Medicare information.

☐ The employer's Taxpayer ID Number (TIN) is the number we use to report disbursements to the Internal Revenue Service (IRS).

☐ The legal name must match the number reported on the IRS W-9 Form and the Disclosure of Ownership and Control Interest Statement.

☐ Please provide the physical address. PO Boxes are not an acceptable physical address.

☐ Answer all of the questions that pertain to your specific provider types (facility, hearing aid, School Health and Related Services [SHARS], and hospital providers).

Section B Owners, Partners, Officers, Directors, and Principals (Each person listed in this section should also have a Principal Information Form (PIF-2) attached.)

☐ Indicate your driver's license number and issue date in the MM/DD/YY format.

☐ The SSN is required for individuals enrolling in a group.

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Section C Group Practice (Each person listed in this section should also have an agreement and Provider Information Form PIF-1 attached.)

☐ A professional license number and the issue date, in MM/DD/YY format, are required.

☐ A CRNA must provide both licenses (a nurse's license and either a CCNA license or a CCNA Recertification Card).

☐ An SSN is required for individuals enrolling in a group.

☐ A Medicare number is required for individuals enrolling in a group with Medicare.

Section D Required Information for Specific Provider Types

☐ Attach a current copy of the provider's professional license and/or certification that will not expire within 30 days

As stated in the Texas Medicaid Reimbursement section of the *Texas Medicaid Provider Procedures Manual* (TMPPM), out-of-state providers must meet the criteria specified in Title 1 *Texas Administrative Code* (TAC) §355.8083 before they can enroll in the Texas Medicaid Program. Please indicate which of the following criteria applies:

☐ A medical emergency has been documented by the attending physician or another provider.

☐ The client's health is in danger if he or she is required to travel to Texas.

☐ Services are more readily available in the state where the client is located.

☐ The customary or general practice for clients in a particular locality is to use medical resources in the other state.

☐ All of the services are provided to adopted children who receive adoption subsidies (these children are covered for all services, not just emergency).

☐ The out-of-state medical care has been prior authorized.

Please submit a signed letter and documentation that proves which of the six criteria the provider meets. Please fax this deficiency letter and all other documentation to (512)-514-4214.

HHSC Medicaid Provider Agreement (All of the pages of the HHSC Medicaid Provider Agreement are required-it is a contract).

☐ An individual's name or group must be provided.

☐ The signature is missing. Please sign or sign again.

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Provider Information Form

☐ A Provider Information Form (PIF-1) must be completed for each practitioner/individual group that is applying.

☐ Indicate your driver's license number, issuer (state), and an expiration date in MM/DD/YY format.

☐ Complete all of the questions. You must answer "yes" or "no" (N/A is not acceptable).

Principal Information Form (PIF-2)

☐ A Principal Information Form (PIF-2) must be completed for each person that meets the definition of "principal."

☐ Indicate your driver's license number, issuer (state), and an expiration date in MM/DD/YY format.

☐ Complete all of the questions. You must answer "yes" or "no" (N/A is not acceptable).

Disclosure of Ownership and Control Interest Statement

☐ The legal name according to the IRS in Section A Provider of Service Information, the name in the Disclosure of Ownership and Control Interest Statement, and the name on the top line of the IRS W-9 Form must match.

☐ Complete the entire Disclosure of Ownership and Control Interest Statement and answer all of the questions with a "yes" or "no" (N/A is not acceptable).

☐ Select one type of entity; it must match the entity on the IRS W-9 Form.

☐ An original signature is required.

IRS W-9 Form

☐ The TIN in Section A must match the TIN listed on the Internal Revenue Service (IRS) W-9 Form.

☐ Indicate the TIN or SSN, but not both (only one number).

☐ Indicate "Exempt" on the IRS W-9 Form.

☐ The address is required.

Corporate Board of Directors Resolution

☐ The entire form must be completed.

☐ The form must be notarized.

☐ An original signature and notarization are required. Please sign or sign again.

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☐ The application must be signed or signed again by an individual given authority on the Corporate Board of Director's Resolution.

☐ The notary expiration date cannot be handwritten. If it is handwritten, you must provide a letter from the state that specifies the expiration date.

Electronic Funds Transfer Authorization Agreement

☐ Please provide the provider name and accounting address.

☐ Please provide the American Bankers Association (ABA)/Transit Number.

☐ Please provide the bank name, address, city, state, and phone number.

☐ Please provide the account number.

☐ Please provide the type of account (checking or savings).

☐ Please provide the signature and date.

☐ Attach a preprinted copy of a voided check or a letter from your bank that is signed by a bank representative.

Additional Forms

☐ Please provide the Medicaid audit information.

☐ Please provide a copy of the Clinical Laboratory Improvement Amendments (CLIA) with the correct physical address.

☐ Please provide the Dental Specialty Form.

☐ Please provide a copy of the Certification of Mammography or certification number.

☐ Please provide a Certificate of Good Standing.

☐ Please provide a copy of the approval letter from Children and Pregnant Women (CPW) case management.

☐ Please provide the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation approval form.

☐ Please provide the Texas Vaccines for Children Program (TVFC) Provider Enrollment.

☐ Please provide the Certificate of Formation/Certificate of Filing.

☐ Please provide a Medicare Letter or a Medicare Remittance Advice Notice (MRAN) issued within the last 30 days.

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Comments:

PAGE 5.4- MUST ADD BROOK RANDAL TO THIS PAGE SINCE A PIF-1 WAS COMPLETED.

MUST COMPLETE AND SUBMIT A PROVIDER AGREEMENT FOR SHERWOOD LYNN, WILLIAM WEST AND DALLAS JOHNSON. MUST SUBMIT WITH AN ORIGINAL SIGNATURE FOR EACH.

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


11047135

Kintana # 4337763

HHSC Medicaid Provider Agreement

Name of provider enrolling
Sherwood C. Lynn, Jr. MD

Medicaid ID# (if applicable)	Medicare provider ID number (if applicable)

Physical address: Number & Street	Suite	City	State	ZIP
8401 NIH 35, Suite 200		Austin,	TX	78753

Accounting/billing address (if applicable): Number & Street	Suite	City	State	ZIP
8401 N I H 35, SUITE 1A		AUSTIN,	TX	78753

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 CD 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. **The Provider Manual, bulletins and notices may be accessed via the Internet at www.tmhp.com. Providers may obtain a copy of the manual by calling 1-800-925-9126.** Provider has a duty to become educated and knowledgeable 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 governing or regulating Medicaid, and provider further acknowledges and agrees that the provider is responsible for ensuring that all employees and agents of the provider also comply. Provider is specifically responsible for ensuring that the provider and all employees and agents of the Provider comply with the requirements of Title 1, Part 15, Chapter 371 of the *Texas Administrative Code*, related to waste, abuse and fraud, and provider acknowledges and agrees that the provider and its principals will be held responsible for violations of this agreement through any acts or omissions of the provider, its employees, and its agents. For purposes of this agreement, a principal of the provider includes all owners with a direct or indirect ownership or control interest of 5 percent or more, all corporate officers and directors, all limited and non-limited partners, and all shareholders of a legal entity, including a professional corporation, professional association, or limited liability company. Principals of the provider further include managing employee(s) or agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations.

1.2 State and Federal regulatory requirements.

1.2.1 By signing this agreement, Provider certifies that the provider and it's principals have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal contracting. Provider further certifies that the provider and its principals have also not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal health-care program. Provider must notify the Health and Human Services Commission (HHSC) or its agent within 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) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal contracts and grants.

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 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Texas Attorney General's Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC 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, phone number, or provider business addresses, at least 10 business days before making such changes. Provider also agrees to notify HHSC or its agent within 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 HHSC complete information related to any such suspension or restriction.

Provider agrees to disclose all convictions of Provider or Provider's principals within 10 business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs. Send the information to Office of Inspector General, P.O. Box 85211 – Mail Code 1361, Austin, Texas 78708. Fully explain the details, including the offense, the date, the state and county where the conviction occurred, and the cause number(s).

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity 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. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, DARS, DADS, DFPS, DSHS and 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 a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all audit or audit exceptions are resolved; whichever period is longest. Provider must cooperate and assist HHSC 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 their agents unconditional and unrestricted access to its records and premises as required by Title 1 TAC, §371.1643. Provider understands and agrees that payment for goods and services under this agreement is conditioned on the existence of all records required to be maintained under the Medicaid program, including all records necessary to fully disclose the extent and medical necessity of services provided, and the correctness of the claim amount paid. If provider fails to create, maintain, or produce such records in full accordance with this Agreement, provider acknowledges, agrees, and understands that the public monies paid the provider for the services are subject to 100% recoupment, and that the provider is ineligible for payment for the services either under this agreement or under any legal theory of equity.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of Inspector General (OIG), and internal and external auditors for the state and federal government may conduct interviews of Provider employees, agents, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, agents, subcontractors and their employees, witnesses, and clients must not be coerced by Provider or Provider's representative to accept representation from or 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 with in the form and the manner requested. Provider will ensure by contract or other means that its agents, employees and subcontractors cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit or the Texas Health and Human Services Commission's Office of Inspector General or its designee. Subcontractors include those persons and entities that provide medical or dental goods or services for which the Provider bills the Medicaid program, and those 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 clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to grant Medicaid recipients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the Medicaid program for Medicaid recipients and discounted services to the general public must not be billed to Medicaid for a Medicaid recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed 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 HHSC'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 HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in court-ordered child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation. (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 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 percent is not eligible to receive the specified grant, loan, or payment. (3) If HHSC is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied.

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 HHSC, or other appropriate payer, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. 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 HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.

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 HHSC 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 HHSC 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 HHSC 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.

1.3.4 Federal and state law prohibits Provider from charging a client or any financially responsible relative or representative of the client for Medicaid-covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR §447.20).

1.3.5 As a condition of eligibility for Medicaid benefits, a client assigns to HHSC all rights to recover from any third party or any other source of payment (42 CFR §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (*Texas Administrative Code* Title 1 Part 15 Chapter 354 Subchapter J), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 CFR §447.15).

1.3.6 Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct and are received by HHSC or its agent, and to implement an effective method to track submitted claims against payments made by HHSC or its agents.

1.3.7 Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund any overpayments, duplicate payments and erroneous payments that are paid to Provider by Medicaid or a third party as soon as any such payment is discovered or reasonably should have been known.

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, and receive electronic claim status inquiries, remittance and status (R&S) 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 R&S report. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to HHSC 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 HHSC, 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.

1.3.9 Reporting Waste, Abuse and Fraud. Provider agrees to inform and train all of Provider's employees, agents, and independent contractors regarding their obligation to report waste, abuse, and fraud. Individuals with knowledge about suspected waste, abuse, or fraud in any State of Texas health and human services program must report the information to the HHSC Office of Inspector General (OIG). To report waste, abuse or fraud, go to www.hhs.state.tx.us and select "Reporting Waste, Abuse, or Fraud". Individuals may also call the OIG hotline (1-800-436-6184) to report waste, abuse or fraud if they do not have access to the Internet.

II. ADVANCE DIRECTIVES – HOSPITAL AND HOME HEALTH PROVIDERS

2.1 The client 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 non-written 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 client has or has not executed an advance directive.

2.5 The Provider must provide written information to all adult clients on the provider's policies concerning the client's rights.

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

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

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

- School health and related services (SHARS)
- Case management for blind and visually impaired children (BVIC)
- Case management for early childhood intervention (ECI)
- Service coordination for mental retardation (MR)
- Service coordination for mental health (MH)
- Mental health rehabilitation (MHR)
- Tuberculosis clinics
- State hospitals

3.2 A school district that is the sponsoring entity for a non-school SHARS provider is required to reimburse HHSC, according to established HHSC procedures, the non-federal portion of payments to the nonschool SHARS provider, since nonschool SHARS providers are paid the lesser of the provider's billed charges and 100% of the published fee for the service (i.e., both federal and state shares). To enroll in Texas Medicaid, a nonschool SHARS provider must submit in its enrollment packet an affiliation letter that meets the requirements in *Texas Medicaid Provider Procedures Manual*, School Health and Related Services.

IV. CLIENT RIGHTS

4.1 Provider must maintain the client's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

4.2 The client must have the right to choose providers unless that right has been restricted by HHSC or by waiver of this requirement from the Centers for Medicare and Medicaid Services (CMS). The client's acceptance of any service must be voluntary.

4.3 The client must have the right to choose any qualified provider of family planning services.

V. THIRD PARTY BILLING VENDOR PROVISIONS

6.1 Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within 5 working days of the initiation and termination of the contract and submitted in accordance with Medicaid requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Providers failure to provide timely notice.

Provider must have a written contract with any person or entity for the purpose of billing provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. The contract must be signed and dated by a Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according with the Medicaid records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

- Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.
- Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.
- Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients.
- Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or it's contractor.
- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program.
- Biller agrees to enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.
- Biller and Provider agree to notify the Medicaid program within 5 business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

VI. TERM AND TERMINATION

This Agreement will be effective from the date finally executed until the termination date, if any, indicated in the enrollment correspondence issued by HHSC or its agent. If the correspondence/notice of enrollment from HHSC or its agent states a termination date, this agreement terminates on that date with or without other advance notice of the termination date. If the correspondence/notice of enrollment from HHSC or its agent does not state a termination date, this agreement is open-ended and remains effective until either a notice of termination is later issued or termination occurs as otherwise provided in this paragraph. Either party may terminate this Agreement voluntarily and without cause, for any reason or for no reason, by providing the other party with 30 days advance written notice of termination. HHSC may immediately terminate this agreement for cause, with or without advance notice, for the reason(s) indicated in a written notice of termination issued by HHSC or its agent. Cause to terminate this agreement may include the following actions or circumstances involving the provider or involving any person or entity with an affiliate relationship to the provider: exclusion from participation in Medicare, Medicaid, or any other publicly funded health-care program; loss or suspension of professional license or certification; any circumstances resulting in ineligibility to participate in Texas Medicaid; any failure to comply with the provisions of this Agreement or any applicable law, rule or policy of the Medicaid program; and any circumstances indicating that the health or safety of clients is or may be at risk. HHSC also may terminate this agreement due to inactivity, with or without notice, if the Provider has not submitted a claim to the Medicaid program for 12 or more months.

VII. ACKNOWLEDGEMENTS AND CERTIFICATIONS

By signing below, Provider acknowledges and certifies to all of the following:

- Provider must notify TMHP if the Provider files or is the subject of a bankruptcy petition. The Provider must provide TMHP and HHSC with notice of the bankruptcy and must copy TMHP and HHSC with all the Provider's pleading in the case. A failure to notify TMHP and HHSC of a bankruptcy petition is a material breach of the Provider Agreement.
- Provider has screened all employees and contractors to determine whether any of them have been excluded before and after enrollment.
- Provider has carefully read and understands the requirements of this agreement, and will comply.
- Provider has carefully reviewed all of the information submitted in connection with its application to participate in the Medicaid program, including the provider information forms (PIF-1) and principal information form (PIF-2), and provider certifies that this information is current, complete, and correct.
- Provider agrees to inform HHSC or its designee, in writing and within 10 business days, of any changes to the information submitted in connection with its application to participate in the Medicaid program, whether such change to the information occurs before or after enrollment.
- Provider understands that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and state law. Fraud is a felony, which can result in fines or imprisonment.
- Provider understands and agrees that any falsification, omission, or misrepresentation in connection with the application for enrollment or with claims filed may result in all paid services declared as an overpayment and subject to recoupment, and may also result in other administrative sanctions that include payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

Name of Provider/Facility Sherwood C. Lynn, Jr.

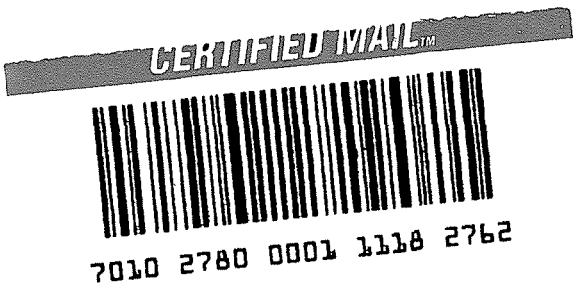
Provider Signature S C Lynn Jr. Date 30 Nov 2011

The applicant must sign the agreement if enrolling as an individual. If enrolling as a group or facility, an authorized representative with authority to sign on the applicant' behalf must sign. The individual who signs this document must also print their name legibly on the line where indicated below.

Printed Name Sherwood C. Lynn, Jr.

Position/Title Medical Director

MR14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