Primary Care Case Management (PCCM) Texas Standard Credentialing Application Addendum Submit with Initial Enrollment Application

ection I Panel Capacity Verification	Proposition and Commence of the Commence of th
omplete the requested Service Area(s) information for each region from which you are willing to accept clients	S.
☐ Southeast: Chambers, Jefferson, Hardin, Liberty, and Orange counties	
Panel Capacity	
Accepting New Patients?	
The state of the s	
PCCM Service All counties not in the Southeast Region or listed below are included in PCCM Area:	
The following counties are not included in the PCCM Service Area Atascosa, Bexar, Brazoria, Collin, Comal, Crosby, Dallas, Denton, Ellis, El Paso Floyd, Fort Bend, Galveston, Garza, Guadalupe, Hale, Harris, Hockley, Hunt, Johnson, Kaufman, Kendall, Lamb, Lubbock, Lynn, Medina, Montgomery, Navarro, Nueces, Rains, Rockwell, Terry, Waller, and Wilson.	Э,
Panel Capacity	
Accepting New Patients?	
ection II Provider Practice Information	
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Theard MD. Franz C Provider Last Name First Name Middle Initial	
Age range of patients seen. From / to 5 o	
Are you a currently enrolled Texas Health Steps (THSteps) provider?	
If Yes, please provide your Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Number:	
If you are not currently enrolled as Texas Health Steps (THSteps) Provider, are you interested in becoming a Texas Health Steps (THSteps) provider?	
Do you provide any of the following specialized services?	
☐ HIV ☐ Children with ☐ High risk ☐ OB/GYN ☐ Other Disabilities (CIDC) OB/GYN Care/Delivery	
Practice limited to: Male only Female only No limitation	
ection III Ethnicity	
	animeten control or trans
☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic	
☐ Asian, Pacific Islander ☐ American Indian or Alaskan ☐ Unknown/Other	
the Individual filling out this form: ry individual has the right to make inquiries about this form and the right to review the information submitted on. (There are a few exceptions). If the information is wrong, submit a request to correct it. The Health and Hur	on the



PCCM Credentialing MC-B05 P.O. Box 204270 Austin, TX 78720-0420 1-800-925-9126

Addendum B

Primary Care Case Management (PCCM) Primary Care Provider Addendum

This PCCM Primary Care Provider Addendum, an addendum to the Health and Human Services Commission Medicaid Provider Agreement (Medicaid Agreement), as amended, sets forth the duties and responsibilities of a primary care provider who agrees to provide medical services to Medicaid-eligible recipients enrolled in the Texas Medicaid PCCM Program who have selected or been assigned to the primary care provider. By signing this Addendum, the primary care provider agrees to comply with the conditions, policies, and procedures set forth in the Medicaid Agreement and in the Texas Medicaid Provider Procedures Manual (Medicaid Manual), the PCCM provider policies and procedures (PCCM Policies), as provided by the Health and Human Services Commission (HHSC) and ACS State Healthcare, LLC (ACS), and all updates published in the Texas Medicaid Bulletin, all of which are incorporated by reference into this Addendum.

1.0 PARTIES

Health and Human Services Commission (HHSC): The single state agency designated to administer the Medical Assistance Program (Medicaid) in the state of Texas.

Primary care provider: The primary care provider identified below by signature and Texas Provider Identifier number.

2.0 DEFINITIONS

The terms used in this Addendum have the same meaning as they have in the *Medicaid Manual* and the PCCM Policies, unless the context clearly indicates otherwise. If there is a conflict between the *Medicaid Manual* and the PCCM Policies, the PCCM Policies control.

ACS State Healthcare, LLC, means the primary contractor for the Texas Medicaid & Healthcare Partnership, under contract with HHSC to administer the PCCM program for the state of Texas (ACS/TMHP).

Medical Home means a primary care or specialty care provider who has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to Members participating in the Texas Medicaid managed care program.

Member means a Medicaid-eligible recipient who is currently enrolled in the PCCM program.

PCCM means the Texas Medicaid managed care delivery system that delivers care to enrolled Members through a contracted network of primary care providers and inpatient facilities.

Primary care provider means a Medicaid-enrolled physician or other provider, who has agreed with HHSC to provide a Medical Home to Medicaid recipients who are Members of the PCCM program, and who is responsible for providing unitial and primary care to these Members, maintaining continuity of patient care, and initiating referrals for care.

3.0 DUTIES and RESPONSIBILITIES of Primary Care Provider

3.1 Referral to Specialists The primary care provider must assess the medical needs of Members and make medically necessary referrals to specialty care providers who are currently enrolled as participating providers in the Texas Medicaid Program. Members cannot access specialty care (excluding OB/GYN and behavioral health) without a primary care provider referral.



- 3.2 Emergency and After Hours Access The primary care provider must ensure that he/she will be available or accessible, or arrange to have another qualified medical professional available or accessible, twenty-four (24) hours a day, seven (7) days a week. The primary care provider must arrange to have an answering service that is answered after hours by a person or an answering machine that provides the Member with a number where live, interactive advice from a qualified medical professional can be obtained.
- 3.3 Timeliness The primary care provider must ensure that the following timeliness standards are met when providing services to Members:
 - Emergency Services must be provided upon member presentation at the time the service delivery site, including at non-network and area facilities.
 - Urgent care, including urgent specialty care, must be provided within twenty-four (24) hours of request.
 - Routine primary care must be provided within fourteen (14) days of request.
 - Initial outpatient behavioral health visits must be provided within fourteen (14) days of request.
 - Routine specialty care referrals must be provided within thirty (30) days of request.
 - Pre-natal care must be provided within fourteen (14) days of request, except for high-risk pregnancies or new Members in the third trimester for whom an appointment must be offered within five (5) days, or immediately, if an emergency exists.
 - Preventative health services for children, including well-child check-ups, should be offered to Members in accordance with the THSteps Program periodicity schedule. For newly enrolled members from birth to age 20, overdue or upcoming well-child checkups, including THSteps medical check-ups, should be offered as soon as practicable, but in no case later than fourteen (14) days of enrollment for newborns, and no later than sixty (60) days of enrollment for all other eligible child members.
- 3.3 Texas Health Steps (THSteps) The primary care provider must ensure that Members under the age of 21 receive all services required by the THSteps program (formerly EPSDT). All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.
- 3.4 Licensing/Certification The primary care provider agrees to submit a current copy of his/her malpractice insurance at the time of enrollment, recredentialing, and upon request by ACS/IMHP.

4.0 DUTIES and RESPONSIBILITIES of HHSC

- 4.1 Case Management Fee HIISC will pay the primary care provider a monthly case management fee per member per month based on the total number of Members on the primary care provider's panel. The case management fee rate is published in the Texas Medicaid Provider Procedures Manual, with updates in the Texas Medicaid Bulletin.
- 4.2 Panel Reports HHSC will provide the primary care provider with a monthly list of Members enrolled with the primary care provider.

5.0 TERM and TERMINATION

This Addendum is effective from the date executed and terminates 90 days after receipt by either party of certified written notice of the other party's intent to terminate the Addendum or on termination of the primary care provider's Medicaid Agreement. All efforts must be made to establish acceptable continuity of care for Members during and after termination.



Primary Care Provider's TPI Number:	133825308
Primary Care Provider's Printed Name:	FRANZ C. TheARD MD.
Primary Care Provider's Signature:	-towi heavon
Date of Execution:	10.21.01.

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Texas Standardized Credentialing Application (Please type or print) Section I-Individual Information TYPE OF PROFESSIONAL MO LAST NAME FIRST MIDDLE UR. SR. ETC.) Theard Franz C MAIDEN NAME YEARS ASSOCIATED (YYYY YYYY) OTHER NAME YEARS ASSOCIATED (YYYY-YYYY) n/a HOME MAILING ADDRESS CITY STATE/COUNTRY POSTAL CODE El Paso TX/USA 79902 HOME PHONE NUMBER SOCIAL SECURITY NUMBER ☐ Female Male CORRESPONDENCE ADDRESS PO Box 9520 City STATE/COUNTRY POSTAL CODE El Paso TX/USA PHONE NUMBER FAX NUMBER E-MAIL 915-783-8162 915-783-8187 DATE OF BIRTH (MM/DD/YYYY) PLACE OF BIRTH C:TIZENSHIP U.S IF NOT AMERICAN CITIZEN. VISA NUMBER & STATUS ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? Yes 🗌 No U.S MILITARY SERVICE/PUBLIC HEALTH DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY) TAST TOCATION 07/01/1976 08/01/1988 William Beaumont-El Paso BRANCH OF SERVICE ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? Army ☐ Yes 🗵 No Education PROFESSIONAL DEGREE (MEDICAL DENTAL CHIROPRACTIC ETC.) Issuing Institution: The George Washinton University ADDRESS 2300 I Street NW STATE/COUNTRY POSTAL CODE Washington DC/USA 20037 DEGREE ATTENDANCE DATES (MM/YYYY) TO MM/YYYY) MD 09/1968 05/1972 Please check this box and complete and submit Attachment A II you received other professional degrees. POST-GRADUATE EDUCATION SPECIAL TY Mariniship Residency Fellowship Teaching Appointment District of Columbia General ADDRESS 110 Irving Street, NW CITY STATE/COUNTRY POSTAL CODE Washington **DC/USA** 20010 ATTENDANCE DATES (MM/YYYY 10 MM/YYYY) Program successfully completed 06/1972 06/1973 PROGRAM DIRECTOR CURRENT PROGRAM DIRECTOR (IF KNOWN) POST-GRADUATE EDUCATION SPECIALTY ☐ Internship ☑ Residency ☐ Fellowship ☐ Teaching Appointment INSTITUTION Washington Hospital Center ADDRESS 110 Irving Street MW CITY STATE /CYNINTRY POSTAL CODE Washington **DC/USA** 20010 Education continued

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LICENSE TYPE Physician Permit	LICENSE NUMBER 79-228		STATE OF REGISTRATION NM		
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☑ DEA Number: AT9162809	ORIGINAL DATE OF ISSUE 11/17/2008	(MM/DD/YYY)	EXPIRATION DATE (MM/DD/YYYY) 11/30/2011		
☑ DPS Number: N0040059	ORIGINAL DATE OF ISSUE 10/08/2008	(MM/DD/YYY)	EXPIRATION DATE (MM/DD/YYYY) 10/31/2010		
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Professional/Specialty Information cont.	nura	
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PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE IN	ITEREST OR FOCUS (HIV/AIDS, E°C.)	
Work History Please provide a chronological work	rk history. You may submit a Curriculum Vitae as	
a supplement. Please explain all gaps in employment CURRENT PRACTICE/EMPLOYER NAME	that lasted more than six months.	
Texas Tech University Health Sciences Center		START DATE/END DATE (MM/YYYY TO MM/YYYY) 04/2009
ADDRESS		
4800 Alberta Ave		
City	STATE/COUNTRY	POSTAL CODE
El Paso	TXUSA	79905
PREVIOUS PRACTICE/EMPLOYER NAME Franz C Theard, M D		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		05/1503
1201 E Schuster, Ste 2B		
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PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
Paso Dal Norte OBGYN		11/1999 05/2003
ADDRESS 1900 N. Mesa		1
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ity	STATE/COUNTRY	POSTAL CODE
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Hospital Affiliations	Please Include all	hospitals where you currently	y have or have previou	isly had privileges.	***************************************	
DO YOU HAVE HOSPITAL PR	WILEGES?	IF YOU DO NOT HAVE ADMITTH	NG PRIVILEGES, WHAY A	DMITTING ARRANGEMENT	S DO YOU HAVE?	
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3 NAME/TITLE Juan Rolan, MD			PHONE NUMBER 915-533-2228	
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CITY		TATE/COUNTRY X/USA		POSTAL CODE 78752
PHONE NUMBER 512-452-4370	POLICY NUMBER MP002970	EFFECTIVE DATE (MM/DD/YYYY) 10/01/2003	EXPIRATION 10/01/200	DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE \$200,000.00	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE ☑ Individual ☐ Shared	LENGTH OF 5 years	TIME W 14 CARRIER
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NODRESS P.O. Box 9520						
El Paso	***************************************			STATE/COUNTRY TX		POSTAL CODE 79995
HONE NUMBER 315-783-8100 ext.	 253	FAX NUMBER 915-783-818	37	E-MAIL	•	
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Dallas	,			STATE/COUNTRY TX 75320-2211		POSTAL CODE
HONE NUMBER 015-783-8199	-	FAX NUMBER 915-783-818	37	E-MAIL	-	· · · · · · · · · · · · · · · · · · ·
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	Office Hours		am-5:00 pm	Afternoon:		Evening:
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S THIS LOCATION ACCESSIBLE BY PUBL ⊠BUS ☐ Regional Train ☐Other					
DOES THIS LOCATION PROVIDE CHILDCA	RE SERVICES?		DOES THIS LOCATION QUALIFY AS A MIR	NORITY BUSINESS ENTERPRISE?	
WHO AT THIS LOCATION HAVE THE FOLL	OWNG CURREN	T CERTIFICATIONS? (PLEASE LI	ST ONLY THE APPLICANT'S CERTIFICATION EXPIRA	TION DATES)	-
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dvanced Trauma Life Support	☐ Staff	Provider Exp	Cardio-Pulmonary Resuscitation	Staff Provider Ex	
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Socti Lice	ion II <mark>-Disclosuro Questions</mark> - Please <i>provide</i> an explanation for any question answered yes-except 16-on pag nsure	e 10.
1	Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?	
2	Have you ever received a reprimand or been fined by any state licensing board?	☐ Yes 🛛 No
		Yes 🛛 No
	oltal Privileges and Other Affiliations	
3	Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	
		☐ Yes ☒ No
Ą	Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	
5	Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	Yes 🛭 No
e**	alles Verlates and an arm of	Yes 🛛 No
6 6	ation, Training and Board Certification Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an	
	internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	
7	Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes No
8	Have any of your board certifications or eligibility ever been revoked?	☐ Yes ☒ No
_		☐ Yes 🔯 No
9	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	☐ Yes 🔯 No
000	0.00	
10	or OPS Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied,	
	suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	
		☐ Yes ☒ No
Medic	care, Medicald or other Governmental Program Participation	
11	Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	T Van Tale
		Yes No
Other	Sanctions or Investigations	
12	Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority. DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	
		☐ Yes ☒ No

Sectle Othe	on II - Disclosure Questions - continued r Sanctions or Investigations	
13	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	
14	Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	☐ Yes 🖾 No
15	Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or	☐ Yes 🖾 No
	voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?	☐ Yes ⊠ No
Malp	ractice Claims History	
16	Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?	⊠ Yes □ No
	☑ If yes, please check this box and complete and submit Attachment G.	₩ 103 [] 110
Crimi	nel	
17	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional	
18	Management and the second of plants of the second of the s	☐ Yes 🔯 No
10	Have you ever been convicted of, pled guilty to, or pled noto contendere to any felony including an act of violence, child abuse or a sexual offense?	
19	Have you been court-martialed for actions related to your duties as a medical professional?	☐ Yes ☒ No
		☐ Yes 🖾 No
Ability	to Perform Job	
20	Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act. 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	
21	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and	☐ Yes 🔯 No
	perform the functions of your job with reasonable skill and safety?	☐ Yes 🖾 No
Ability 22	to Perform Job	
44	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	☐ Yes ⊠ No
23	Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?	7 W W
		☐ Yes 🛛 No

Please use the space on page 10 to explain yes answers to any question except #16.

' Section II - Disclosure Questions-continued

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER PLEASE EXPLAIN

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)
I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

IPLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEHEINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")
Primary Care Case Management (PCCM)

and any of the Entity's affiliated entities. I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing, I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I piedge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member. I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity, I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Llability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization. Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

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ANT'S INITIALS AND DATE (MM/DO/Y

DCN: 200934100003525

Section III - Standard Authorization, Attestation and Release - continued party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity. Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance w

this Authorization, Attestation and Release is not and will not be a viole	ation of my privacy.	onice in accordance with the provisions o
I certify that all information provided by me in my application is true, or notify the Entity and/or its Agent(s) within 10 days of any material chan released pursuant to the credentialing process. I understand that corrof Participation by the Entity, and must be submitted on-line or in writing signature). I understand and agree that any material misstatement of application from consideration; denial or revocation of Participation; a be disclosed to the Entity and/or its Agent(s).	iges to the information I have pro ections to the application are per ng, and must be dated and signe of Omission in the application, ma	vided in my application or authorized to be mitted at any time prior to a determination of by me (may be a written or an electronic viconstitute grounds for withdrawal of the
I further acknowledge that I have read and understand the foregoin facsimile or photocopy of this Authorization, Attestation and Release sl	ng Authorization, Aftestation and hall be as effective as the original	Release. I understand and agree that a
	SIGNATURE	an, ~
	Franz C. Theard, MD NAME (PLEASE PRINT OR TYPE)	MR08
	Last 4 digits of SSN or NPI (PLEA	SE PRINT OR TYPE)
	DATE (MM/DDYYY)	£
Required Attachments or Supplemental Information - Please attach ha Copy of DEA or state DPS Controlled Substances Registration Certific Copy of other Controlled Dangerous Substances Registration Certific Copy of current professional liability insurance policy face sheet, she Copies of IRS W-9s for verification of each tax identification number Copy of workers compensation certificate of coverage, if applicable Copy of CLIA certifications, if applicable Copies of radiology certifications, if applicable Copy of DD214, record of military service, if applicable	cate cate(s) Dwing expiration dates, limits and	-
	Reproduction of	this form without any changes is allowed.
Notice About Certain Information Laws and Practices Pe With few exceptions, you are entitled to be informed about the informospital). Under sections 552.021 and 552.023 of the Texas Government yourself, including private information. However the state government right to privacy. Under section 559.004 of the Texas Government Conformation that it has about you that is incorrect. For information aborappropriate state governmental body to which you have submitted this a	rmation that a state governmen ent Code, you have a right to revi- tal body may withhold information de, you are entitled to request the out the procedure and costs for c	tal body collects about you (i.e. a state ew or receive copies of information about in for reasons other than to protect your that the state dovernmental body correct
Texas Standardized Credentialing Application Att	achment A - Other Profession	onal Degrees
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Texas Standardized Credentialing Application	Attachment B - Other Post Graduate Education	
OTHER POST GRADUATE EDUCATION	SPECIALTY	
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment		
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Texas Standardized Credentialing Application

Attachment C - Other Work History

PREVIOUS PRACTICE/EMPLOYER NAME	STAR	T DATE/END DATE (MM/YYYY TO MM/YYYY)
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Texas Standardized Credentialing Application Attachment D - Other Current Hospital Affiliations

OTHER HOSPITAL WHERE YOU HAVE PRIN	VILEGES	START DATE (MM/YYY)
Sierra Medical Center ADDRESS		11/1983
1625 Medical Center Dr.		
CITY El Paso	STATE/COUNTRY TX/USA	POSTAL CODE 79902
PHONE NUMBER 915-747-4000	FAX	-
FULL UNRESTRICTED PRIVILEGES?	TYPES OF PRIVILEGES IPPOVISIONAL LIMITED CONDITIONAL ETC.) ACTIVE-OBGYN	ARE PRIVILEGES YEMPORARY?
OF THE TOTAL NUMBER OF ADMISSIONS	TO ALL HOSPITALS IN THE PAST YEAR, WHAT PENCENTAGE IS TO THIS SPECIFIC HOSPITAL	
OTHER HOSPITAL WHERE YOU HAVE PRIV Las Palmas Medical Center	PLEGES	START DATE (MM/YYYY) 10/1983
ADDRESS 1801 N. Oregon		
CITY El Paso	STATE/COUNTRY TX/USA	POSTAL CODE 79902
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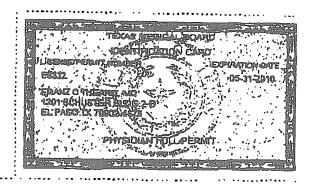
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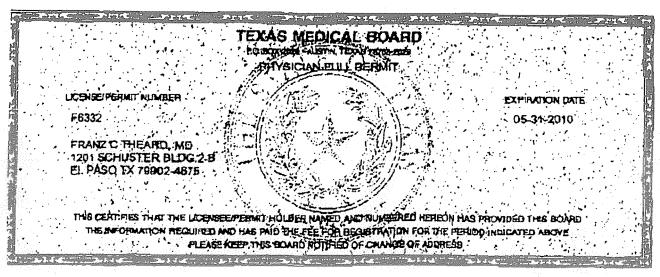
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LHL234 Rev.01/07

INCIDENT DATE (MM/DD/YYYY) 08/13/2003	DATE CLAIM WAS FILED (MM/DD/YYYY)	t @ - Malpractice Claims History CLAMA/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED	08/12/2005	Pending
(See Attached)		
ADORESS	- Constitution of the contract	
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER		
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METHOD OF RESOLUTION Dismissed	Settled (with prejudice)	
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U Judgment for Defendent(s)	U Judgment for Plaintiff(s)	Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS Plaintiff alleges that she presented with spontar	neous rupture of membrane at 38 weeks on	August 13, 2003 and on same delivered by vacuum extrac
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DESCRIPTION OF ALLEGED INJURY TO THE PATIENT	<u>i</u>	
Rectal vaginal fistula requiring surgical interven	tion	
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PLEASE NOTE OUR NEW ADDRESS AND PHONE NUMBER P.D. BOX 2018. AUSTIN, TX. 78788-2018 PHONES 512/305-7010





Texas Department of Public Safety - Controlled Substances Registration

Page 1 of 1



Texas Department of Public Safety

Courtesy - Service - Protection

Controlled Substances Registration

Current date/time: 10/27/2009

7:40:36 PM

This registrant information was last updated at: 10/26/2009 8:31:44 PM

Detailed View - THEARD, FRANZ CARL MD

DPS Number:

L0068566

Address:

WOMEN'S REPRODUCTIVE CENTER 500

EAST SCHUSTER BLDG 8 EL PASO TX 79902

Business Activity:

PRACTITIONER

Brd. Lic. #:

F6332

Schedule:

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Exp. Date:

10-31-2010

Original Date Entered: 03-24-1988

DPS Number:

N0040059

Address:

1201 EAST SCHUSTER SUITE 2 B EL PASO

TX 79902

Business Activity:

PRACTITIONER

Brd. Lic. #:

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Schedule:

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10-31-2010

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11/17/2008



TEXAS TECH UNIVERSITY SYSTEM

August 28, 2009

Office of General Counsel (Professional Liability Division)

CERTIFICATE OF SELF-INSURANCE

COVERED: All TTUHSC Faculty and Resident Physicians and Medical Students .~

EFFECTIVE DATE:

Date of employment - Date of Termination Date of enrollment - Date enrollment ends

This is to advise you that the Board of Regents of Texas Tech University has approved a Plan for Professional Medical Malpractice Self-Insurance, pursuant to the authority granted by Tex. EDUC CODE ANN. § 59.02 (Vernon Supp. 1994), providing full-time medical doctors, doctors of osteopathy, oral surgeons, student health doctors, podiatrists, interns, residents, fellows and medical students of Texas Tech University Health Sciences Center with medical professional liability protection in the following amounts, unless lower liability limits are set by law, in which case the lower limits set by law shall apply.

	Occurrence Coverage		
Category	Per Claim	Aggregate per Participant	
Faculty Physician	\$400,000.00	\$1,200,000.00	
Resident or Fellow	100,000.00	300,000.00	
Student	25,000.00	75,000.00	

The limits of liability set out above were approved by the Board of Regents of Texas Tech University Health Sciences Center on August 2, 1985, effective September 1, 1985. This schedule applies only to causes of action arising from incidents or actions occurring on or after September 1, 1985.

The Self-Insurance Plan's liability is limited to the lesser of the individual physician's(s') coverage or \$1,000,000 per incident for claims filed prior to September 1, 2003, or \$300,000 per incident for claims filed after September 1, 2003.

Conditions for participation are described in the text of the plan which is available to you in the handbook. Among the conditions for participation are the following:

 Coverage as stated above shall commence on the effective date shown above and shall cease on the day when employment with, or assignment to, Texas Tech University Health Sciences Center is terminated;

3601 Jth Street STOP 6237 - Carries Team 79430 6237 + f 806 743 9921 ₁ 1: 808 244 9925

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- Coverage shall extend to all duly authorized off-campus assignments;
- 3) Coverage for "moonlighting" under the Plan is excluded and prohibited;
- It is mandatory that the insured, upon becoming aware of any injury, actual or alleged, whether by direct knowledge or written notification thereof, shall advise their department chairperson, who in turn shall notify the Dean/Associate Dean for appropriate contact with Texas Tech University/Texas Tech University Health Sciences Center Office of General Counsel (refer to Professional Medical Malpractice Self-Insurance Handbook).

This Certificate is intended only for your immediate information, being only the advice that such protection has been effected subject to the particular terms, conditions and limitations of the approved Plan of Self-Insurance and the interpretation thereof by the Board of Regents or its authorized representative.

Kent R. Hance, Chancellor Texas Tech University System

Pat Campbell

Vice Chancellor and General Counsel

<u>Authentication</u>

This is to certify that this, a true and correct copy which witness my hand and seal on this 28th day of September 2008, was provided to: JoAnn Cruz, TTUHSC El Paso, MPIP Business Operations, 4800 Alberta Ave., El Paso, TX 79905

SHEILA ROBINSON
Notary Public State of Texas
My Commission Expires
JAN 29 2013

Notary Without Bond

MRGG

Joanna Harkey
Director, Professional Liability Division

Sheila Robinson, Notary Public in and for the State of Texas

OB/GYN Department 915-545-6730-Call Coverage

TAX ID#S: 75-2674893 / 75-2668018

Texas Tech Physician Associates / Texas Tech University Health Sciences Center (915) 545-6730

Lizabeth J. Berkeley, CHES

Wreatha Carner, CNM

Kayla E. Castaneda, WHNP

Harvey Greenberg, MD

Heidi A. Lyn, MD

Carla Ann Martinez, M.D.

Zuber D. Mulla, PhD

Ghulam Murtaza, MD

Ha H. Nguyen, RNC

Bahij S. Nuwayhid, MD

Elizabeth Ann Portugal, CNM

Sonia Rebeles, M.D.

Jose Salvador Saldivar, MD

Antonio Santillan, MD

William H. Scragg, MD

Claudia Suarez-Martinez, MD

William R. Sullivan, MD

Franz C. Theard, MD

Robert W. Vera, MD

(Page 1 of 22)

DCN: 201003339000233



Portal Ticket #: 10390843

Date Printed:

Tuesday, February 02, 2010

NPI:

1770633216

Provider Name: THEARD, FRANZ

www.tmhp.com



For Provider Records Only - Not to be sent to TMHP Portal Ticket # 10390843

Provider Enrollment: Texas Standardized Credentialing Application

If any information found on the application is incorrect, please save the application and update your information through the Online Provider Lookup (OPL). Do not continue with application until information is accurate.

Individual Information				
🕅 Re-Credentialli	ng:			
Type of Profession	al: Physician (MD)			
	THEARD & First Name: FRANZ			
Middle: C	fliddle: C Jr., Sr., etc:			
Maiden Name: Years Associated: (YYYY-YYYY)				
Other Name:	Years Associa	ted:(YYYY-YYYY)		
Home Mailing Addr	Correspondence			
Street:	Street:	1		
Address Line 2:	Suite:			
City:	City:			
State:	State:			
Zip:	Zip:			
Home Phone Numb	per: ext.			
Phone Number:	ext.			
Fax Number:		Email Address:		
Social Security Number: @ Gender: @ Male @ Female				
Date of Birth:		Place of Birth:	1	
Citizenship: United States				
If not American Citizen/Visa Number: - Status: General				
Are you eligible to	work in the United St	ates: @ Yes @	No	
Military Service Pub	olic Health:	∉ Yes ∉	No	
Dates of Service: - Last Location:				
Are you currently on active or reserve Military Duty: $~\oplus_{Yes}~\oplus_{No}$				

Issuing Institute:	THE GEORGE WASHINGTON UNIVERSITY			
Institution Address:				
Street:				
Suite:				
City:	CONTRACTOR			
State:				
ZIP Code:				
Degree:	MD			
Attendance From Dates:	9/1/1968			
Attendance To Dates:	5/31/1972			

Post-Graduation Edu	ation	
	ancy @ Fellowship @ Teaching Appointment	
Speciality:	N/A	
Institution	DISTRICT OF COLUMBIA GENERAL	

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Portal Ticket # 10390843

Institution Address:	
Street:	
Suite:	
City:	
State:	
ZIP Code:	-
Attendance From Dates:	6/1/1972
Attendance To Dates:	6/30/1973
Program Successfully Comp	pleted?
Program Director:	
	MET AND THE STATE
	Fellowship □ Teaching Appointment
Current Program Director:	Fellowship € Teaching Appointment
	N/A
	N/A
	N/A
⊕ Internship	N/A
⊕ Internship Residency € Speciality: Institution: Institution Address: Street: Suite: City:	N/A
⊕ Internship ∰ Residency €	N/A
@ Internship @ Residency € Speciality: Institution: Institution Address: Street: Suite: City: State: ZIP Code:	N/A
@ Internship @ Residency € Speciality: Institution: Institution Address: Street: Suite: City: State:	N/A WASHINGTON HOSPITAL CENTER
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@ Internship @ Residency € Speciality: Institution: Institution Address: Street: Suite: City: State: ZIP Code: Attendance From Dates: Attendance To Dates:	N/A WASHINGTON HOSPITAL CENTER - 6/1/1973 6/30/1976

Provider Enrollment: Texas Standardized Credentialing Application (Continued)

lcense Type:	MD, DO	License Numbe	er: F6332	
State Of Registration:	TX			
riginal Date of Issue:		Expiration Date: 5/31/2010		
o you currently practice is	n the State? ♠ Yes ♠ No			
Annic personal dela mission del more plante del 440 minute annique popular del anniente	SIGNEY 2150 NAMED IN THE PROPERTY OF THE PROPE			novembrahanianianianiani
License Type	· Number D	Original late of Issue	• Expiration 0	ate.
◆ DEA	AT9162809		11/30/2011	
• DPS	N0040059	***************************************	10/31/2010	
PIN:	1			
2.11		1716		
stional Provider Identifier	(when available): 1770633	210		
			Medicare Number:	
re you a participating Med	licare Provider?	∰Yes ∰No	Medicare Number:	13382530
ational Provider Identifier re you a participating Med re you a participating Med ducational Council for fore	licare Provider?	∰Yes ∰No Ƙayes Ƙay		13382530

Provider Enrollment: Texas Standardized Credentialing Application

Professional/ Speci	aity Information		
Specialty:	OB/GYN (MD) Board Certifi	ed: @Yes @No	
Name of Certifying Board:	ABMS Initial Certific	1/1/1978	
Re-Certification Date:	Expiration Da	ate: 12/31/9999	
	, indicate any of the follow	ving that applγ:	
⊕ I have taken exam,	results pending for	board.	
@ I have taken Part I a	ind am eligible for Part II of th	he	Exam.
@ I am intending to sit	for the Boards on		
⊕ I am not planning to			
	n the directory under this spec	laity?	
HMO: ∰ Yes	⊕ No		
PPO: @ Yes	⊕ No		
POS: ∉ Yes	⊕ No		
Please list other areas of p	rofessional practice interest or	r focus (HIV/AIDS, etc.)	
Decimal and Ottom 1	15_1		
Professional/Work I	-	e de la company de la compa	
Current Practice/Emplo	yer Name: TEXAS TECH UN	IVERSITY HEALTH SCIENCES CE	NTER
Start Date:	4/1/2009		
Street:			
Suite:			
City:	White do		
State:			
ZIP Code:	•		
Previous Practice/Employ	er Name:		
FRANZ C THREARD MD	The Control of the Co	MARIN AND AN ARROW OPPOSE OPPOSE TABLE SAMES MARIN MAR	
Start Date:	9/1/1983	Without the street of the stre	
End Date:	12/31/9999		
Street:	***************************************	***************************************	
Suite:	or period server their service classed behaved mounts beyond proper support the set opening behave consent	CANADA INDIA MARIA IN IN INDIA PARAMA MARIA MARIA JAPAN	
City:			
State:	The state of the s		
ZIP Code:	* .		
Reason for discontinuance	: PROVIDER IS STILL WOR	KING	
		······································	

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS IN WORK HISTORY.

 $ilde{f \varphi}$ Do you have hospital privileges? $ilde{f Q}$ Yes $ilde{f Q}$ No

If you do not have admitting privileges, what admitting arrangements do you have?

— Current Hospital Priv	ileges		
Primary hospital where y privileges?		€ Yes ← Na	
Hospital Name:	UNIVERSITY MEDICAL CENTER OF EL PASO	Start Date:	4/1/2009
Street:	4815 ALAMEDA		Minimum indeed thin
Suite:	e contra antico characteristic bases anno anno anno anno anno anno anno ann		Commission on the Commission of the Commission o
City:	EL PASO		FO.500 of MARL AN
State:	TX		
ZIP Code:	79905-	and the control of the control of the control of the control of	MOS Alband Spinips
Phone Number:			
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Fax Number:		***************************************	
Email:	Management (2000) 1900 rough rough response separat special annual shareys status 2004 1946 in	THE REAL VALLE AND THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AD	TO MOTION AND TO
Full unrestricted privileges?	₱ Yes ₱ No		
Types of Privileges:	Active	AND	TOWN TRACE Sea
Are privileges temporary	See artistic restate control allega describe security for any security security control account control accoun	THE STATE STORE S. P. S. Voluble Shiele albeids salahil anglas sayans sayang payag	NAME NAME (1984)
Of the total number of ad percentage is to primary i	missions to all hospitals in ti	ne past year, what	
Primary hospital where yo privileges?	ou have admitting	∰ Yes ∰ No	
Hospital Name:	PROVIDENCE MEMORIAL HOSPITAL	Start Date:	3/1/1984
Street:	2001 N OREGON		********
Suite:		and colored agents from property of the colored to the field distribution with a distribution of colored to the	PRP/14*4000004
City:	EL PASO		
State:	TX	a attenti tandica haditar tanding nghaqir phayang phagan yi pada pi ndok gabapit pilakani dibibah	Control Parison
ZIP Code:	79901-		
Phone Number:			
ext.			
Fax Number:			
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Emall:			ANN AREA
Full unrestricted	@ Yes @ No		77-13-14
Full unrestricted privileges?			And the second s
Full unrestricted privileges? Types of Privileges:	@ Yes @ No ACTIVE-OB GYN		
Full unrestricted privileges? Types of Privileges: Are privileges temporary?	© Yas © No ACTIVE-OB GYN © Yas © No Placetors to all hospitals in the		
Full unrestricted privileges? Types of Privileges: Are privileges temporary? Of the total number of adm	@ Yes @ No ACTIVE-OB GYN @ Yes @ No alssions to all hospitals in the		
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Portal Ticket # 16390843

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Fax Number:	<u> </u>			
Emali:				
Full unrestricted privileges?	♠ Yes ♠ No	NAS ASSESSIONS ASSESSI		
Types of Privileges:	ACTIVE-OB GYN	THE WAS LOUIS ASSOCIATED IN THE PARTY OF THE		
Are privileges temporary	? ♠Yes♠No			
Of the total number of ac percentage is to primary	fmissions to all hospitals in ti hospital?	ne past year, what	and white about the transit places and a sound, bear one one	
Primary hospital where y privileges?	ou have admitting	₩ Yes ₩ No		
Hospital Name:	LAS PALMAS MEDICAL CENTER	Start Date: 10/1	/1983	l
Street:	1801 N OREGON			
Suite:		THE PROPERTY OF THE PROPERTY O		
City:	EL PASO			
State:	TX	n viden Suddi Allian Alakat udada ulauku sisida kuda dada lauku kuda mudu kumo muun aluuk		
ZIP Code:	79902-	•		
Phone Number:			- Company	
ext.			applebus	
Fax Number:	I	A DESTRUCTIVE PERSON PROPERTY AND MARKET PROPERTY AND	от	
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Full unrestricted privileges?	€ Yes € No			
Types of Privileges:	ACTIVE-OB GYN			
Are privileges temporary	· @ Yes @ No			
	missions to all hospitals in th	e past year, what		
percentage is to primary	hospital?	Least reason are con-		
Previous Hospital Pris	ileges —			
References 7	e com processor acusto de dissensación esta de la companya de la c			
Self- Insured?	No			
Name of current malpracti		sured entity:		
TEXAS TECH UNIVERSITY: Address:	SYSTEM			
Street		♥ Policy Number:	N/A	
Suite		⊕ Effective Date:	9/1/1985	,

City		♠ Termination Date:	12/31/9999	
State				
ZIP Code		Amount of coverage per occura	,	
Phone Number:		Amount of coverage aggregate	: \$1,200,000.00	
Fax Number:		Type of Coverage:		
E-meil:		Length of time with carrier:	(YYYY-YYYY)	
◆ Current Insurance less that	n 5 years?	₱ No		
Name of previous malpractic	insurance carrier:			
Address:				
Street		Policy Number:		AND THE REAL PROPERTY AND THE PARTY AND THE
Suite		Effective Date:		
Clty		Termination Date:		
State				

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Portal Ticket # 10390843

DCN: 201003339000233

ZIP Code		Amount of coverage per occurance:	
Phone Number:	NA TO THE STREET THESE STREET STREET STREET STREET CORES STREET STREET STREET STREET STREET STREET STREET STREET	Amount of coverage aggregate:	
Fax Number:		Type of Coverage:	
E-mail:		Length of time with carrier:	(*************************************

Provider Enrollment : Texas Standardized Credentialing Application : Call Coverage

First Name:	LIZABETH	Specialty:	General surgery	
Last Name:	BERKELEY		II BAAA ahad a maa fumaa amaa amaa amaa amaa amaa am	
Middle Initial:				
First Name:	WREATHA	Specialty:	General surgery	NAME THE RE
Last Name:	CARNER	Million actions research	name in the second seco	
Middle Initial:	M perhaps referre region region region region appearance and the second second region and the second	ACADE TARREST MADE AT		
				~~~
First Name:	KAYLA	Specialty:	General surgery	
Last Name:	CASTANEDA			
Middle Initial:	and to the chart of the course was a grown property or property of the	to AWAII Almost Charac		
First Name:	HARVEY	Specialty:	General surgery	
Last Name:	GREENBERG		to the contract of the contrac	
Middle Initial:	1			
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First Name:	HEIDI	Specialty:	General surgery	
.ast Name:	LYN	· · · · · · · · · · · · · · · · · · ·	. automorphism and a second	
diddle Initial:		***********		

Please list full names of all partners in your practice:

Practice Lo	cations				
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1	Yes	Yes	4800 ALBERTA AVE	<u>Update</u>	
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Primary Practice Loca	ition	Management of the second secon		al balance d'accompliance propriet en constitute de la co
	wing questions for each practice	location.		
	vided: Solo Specialty Care € Group Prima	y Care 🕏 Group Single Specia	ilty  Group Multi-Specialty	
Group Practice Name:		Group/Corporate Nar it appears on IRS W-	ne as 9:	
Practice Location Address:				
Street	4800 ALBERTA AVE	₹ Phone Number:	(915)545-7501	
Suite		Fax Number:	(915)545-7537	
◆ City	EL PASO	E-mail address:	Married to the second s	
State	Texas	No. of the State o		
	79905-2709	tions below rate		
Back Office Phone Number/ Private Phone Number:	ext.	Site-Specific Medicald Number:		
Group number corresponding to Tax ID number (if applicable):			752668018	
Are you currently practicing at this location?	∰ Yes ௸ No	If no, expected start date:	«болу боло и реформу выгодовогодогодор.	
Do you want this location listed in the directory? Office Manager or Staff Contact:	⊕ Yes ♠ No	****		
Phone Number:	ext.		·	
Fax Number:	The state of the s	arraite.		
Credentialing Contact Ad	idress:			
Street		Phone Number:	ext.	
Suite		Fax Number:	STATE AND ADDRESS OF THE PARTY	
City	urrani makan dan dan dan panjanjanja ja kin koronopin dan ingenerabihan mada pataman inga a apada andara	E-mail:	Milyskifeferer producederromakusmanurussans	
State		THE PARTY OF THE P		
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Billing Company's Name: (If applicable)	AND MANY THAT AND ENGLY STATE THE THE STATE THAT THE THAT THE THAT AND THAT AND THE THE THAT AND THE THAT AND THE THAT AND THE	Billing Representative:		
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City		E-mall:		
State		11112		
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Department Name If Hospital-based:		Check payable to:		
Can you bill electronically?	€ Yes € No			
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!	ontinued							
Hours patients are seen	244							7 PR 6-7 PR 1 APRIL 2
Monda	Start Time: 08:00	AM	End Time: 05	0:00 PM				
Tuesday	Start Time: 08:00	AM	End Time: 05	:00 PM	_			
Wednesday	Start Time: 08:00	AM	End Time: 05	:00 PM	_			
Thursday	Start Time: 08:00	AM	End Time: 05	:00 FM				
Friday	Start Time: 08:00	АМ	End Time: 05	:00 PM				
Saturday	Start Time: Closed		End Time: Cid	sed				
Sunday	Start Time: Closed		End Time: Cla	osed				
Does this location provide 24 h	our/7 day a week p	hone cove	rage?		rocery)			
翩 Answering service 聞 Voicemall with other instruction	麗 Voice mail v	with instructi	ons to call ans	waring servic	ie.			
This practice location accepts:								
關 All new patients	爾 Existing patients	with change	of navor					
M New Medicare patients	New Medicald pat		ы рауы					
III New patients with referral								
If new patient acceptance varie	s by health plan in	eace nroul	de evolanatio					
	z c, nearth plant, p	cusc prom	ou explanació	••••				
III Other Practice Limitation:								
Do nurse practitioners, physician as	eletante midwiyae da	atal hydanict	c or other non-	shuddan n	auddaua aaua fa			
⊕ Yes ⊕ No	sisterita, matrica, aci	ntai nygeniat	3 Of Other Holl-	-риумскай рі	oviders care in	i patients	at this practice location?	
If yes, provide the following informa		mber:						
Languages spoken by health	care providers:		***************************************					
III Other III Vietnamese III Ja	panese 🏻 Indian	擓 Russian	🕅 Norwegian	∏ Danish	₩ Hungarian	🏗 Italian	III Dutch	
English Fakistani Ko		爾 Polish	🕅 Finnish	III German	∰ Greek	層 Arabic	翔 Sign	
屬 Spanish 展 Chinese 展 Th		₩ Swedish	· · · · · · · · · · · · · · · · · · ·			·····		
Languages spoken by office Other Wietnamese #Ja		III Director	III Norwegian	M Danish	E Una roda	FIR TANKS	ET COLLE	
爾 English 爾 Pakistani			Finnish	III German		## Italian	<b>i</b>	
图 Spanish 图 Chinese 图 Th	-	∰ Swedish		777	777 327 327	WH 14 CIDIC	7.51 J.	
Language Interpreters: Are Interpreters available?			······································					
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羅 Spanish 匯 Chinese 題 Th	el French	膜 Swedish						
	a annual little control de col	s? ⊕ yes (	₽ No					
Does this practice location meet ADA	accessibility standard				ren			
Does this practice location meet ADA Which of the following facilities are h		, E Suildir	ig III Restroon	n 脚 Parking	## Other:		latin this late and the response over the personal men and and	
	andicapped accessible:						I/Physical Impairment S	
Which of the following facilities are h	andicapped accessible:	Ø Text T		∰ American				
Which of the following facilities are h  Does this location have other service	andicapped accessible:  for the disabled?  ansportation?	Ø Text T	elephony TTY E Regional Trai	∰ American				

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Portal Ticket # 10390843

Advanced Traume Life Support:    Staff   Provider   Pro	rocedures provided (including				
Advanced Trauma Life Support:  Advanced Trauma Life Support:  Exp:    Cardio-Pulmanary					
Advanced Traums Life Support:  Advanced Traums Life Support:  Advanced Traums Life Support:  Advanced Cardiac Life Support:  Description:  Advanced Life Support:  Description:  Advanced Life Support:  Description:  Descr	🛮 Other:				
Advanced Traume Life Support:  Advanced Traume Life Support:  Exp: Cardio-Pulmanary Resuscitation:  Exp: Cardio-Pulmanary Resuscitation:  Exp: Cardio-Pulmanary Resuscitation:  Exp: Cardio-Pulmanary Resuscitation:  Exp: Support:  Advanced Cardiac Life Support:  Exp: Podiatric Advanced Life Support:  Neonatal Advanced Life Support:  Exp: Other:  Exp: Other		爾 IV Hydration/Treatments	爾 Cardiac Stress Tests	III Physical Theraples	
Advanced Trauma Life	ppropriate	III Flexible Sigmaidoscopy		# Asthma Treatments	
Advanced Traume Life  Staff Provider  Exp: Cardio-Pulmanary Resuscitation;  Advanced Cardiac Life Support:  Meanatal Advanced Life S	<i>7</i> ·	願 Allergy Skin Tests	III Routine Office Gynecology	III Venipuncture	
Advanced Trauma Life Support:  Advanced Trauma Life Support:  Advanced Trauma Life Support:  Advanced Cardiac Life Support:  Advanced Cardiac Life Support:  Advanced Cardiac Life Support:  Advanced Cardiac Life Support:  Advanced Life Support:  A		<b>⊞</b> EKG	III Care of Minor Lacerations	匯 Pulmonary Function Tests	
Advanced Trauma Life Support:  Advanced Trauma Life Support:  Exp: Cardio-Pulmanary Resuscitation:  Exp: Pediatric Advanced Life Support:  Meanatal Advanced Life Sup	ther Services:	· · · · · · · · · · · · · · · · · · ·			
Advanced Trauma Life		ns:			
Advanced Life Support:  Advanced Life Support	aboratory Services; please list				
Basic Life Support:		Staff  Provider E	(P): Other:	Staff Provider	Ēxp:
Basic Life Support:		師 Steff 岡 Provider	The State of the Control of the Cont	III Staff III Provider □	Exp:
Basic life Support: III Staff III Provider Exp: Advanced Life Support in OB: III Staff III Provider Exp:	Advanced Trauma Life Support:	∰ Staff  Provider E	: 'baratalana' (1981)	■ Staff ■ Provider	Exp:
	Basic Life Support:	Staff Filt Provider	xp: Advanced Life Support in (	原 Staff 間 Provider 「E	Exp:

Section I: Capacity V	erification
Complete the requested S	Service Area information for each region.
Southeast:	Chambers, Jefferson, Hardin, Liberty, and Orange counties.
Second Control	10
	? 催Yas 作No
PCCM Service Area:	All counties not in the Southeast Region or listed below are included in PCCM.
	The following counties are not included in the PCCM Service Area: Atascosa, Bexar, Brazoria, Collin, Comal, Crosby, Dallas, Denton, Ellis, El Paso, Floyd, Fort Bend, Galveston, Garza, Guadalupe, Hale, Harris, Hockley, Hunt, Johnson, Kaufman, Kendall, Lamb, Lubbock, Lynn, Medina, Montgomery, Navarro, Nueces, Rains, Rockwell, Terry, Waller, and Wilson.
Capacity:	1500
Accepting New Patients:	? ∉ Yes ∉ No
Section II: Provider F	Practice Information
Provider Last Name: THE	EARD
First Name: FRA	ANZ
Middle Initial: C	
	een: 12 to 90
Are you a currently enr	olled Texas Health Steps (THSteps) provider?
If yes, please provide you	ur Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Number:
Practice Limitations:	
圖 HIIV 醞 Children w/ Di	sabilities 歴 High Risk OB/GYN 题 OB/GYN Care/Delivery
M Other	
	ale Only @ Both
Section III: Ethnicity	
White, Non-Hispanic	Black, Non-Hispanic     Bispanic
American Indian or	
	arte
wrong, submit a request to	out this form: ght to make inquiries about this form and the right to review the information submitted on the form. (There are a few exceptions). If the information is a correct it. The Health and Human Services Commission has a method for asking for corrections. The procedure is located in Title 1 Texas Administrative 7 to 351.23. For information about this form or to request corrections, call the PCCM Provider Helpline at 1-888-834-7226 or write to:
TMHP - Provider Helpline PO Box 204270 Austin, Texas 78727-4270	

# Provider Enrollment: Texas Standardized Credentialing Application: Section II - Disclosure Questions

- E-	icensure and Controlled Substance Certificates		
91	Has your license or certification to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily or involuntarily surrendered, or have you ever been subject to a consent order, probation, or any conditions or limitations by any state licensing board?  If Yes, please explain below	₹ No	
Φ2	Have you ever been reprimanded or fined by any state licensing or certification board?  If Yes, please explain below	₹ No	
H	ospital Privileges and Other Affiliations		
<b>93</b>	Have your clinical privileges or professional staff membership at any hospital or health care institution ever been involuntarily terminated, surrendered, limited, reduced, denied, suspended, revoked, restricted, denied renewal, or subjected to probationary or to other disciplinary conditions (for reasons other than automatic action based on non-completion of medical records), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board?  If Yes, please explain below		. Pes . Pe No
94	Have you voluntarily surrendered or withdrawn an application, limited your privileges, or not reapplied for privileges?  If Yes, please explain below		⊕ Yes ♠ No
<b>\$</b> 5	Have you ever been terminated for cause from participation, or been subject to any disciplinary action, by any managed c (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?  If Yes, please explain below	are organizations	⊕ Yes ∰ No -
yer		NEED-VOTTO-NEED-WEST-VOSTON ON LANCE SERVICE AND SERVICE SERVICE AND SERVICE S	rational intervals and accommon manufactures or interval and an accommon accommon
<b>⊕</b> 6	ucation, Training and Board Certification  Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?  If Yes, please explain below		® Yes ∰ No
	Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or empresidency, fellowship, preceptorship, or other clinical education program?  If Yes, please explain below	oloyee in any internship,	କେ Yes କି No
	Have any of your board certifications or eligibility ever been revoked? If Yes, please explain below		© Yes ♥ No
	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?  If Yes, please explain below		母 Yes 帶 No
re	A or DPS		***************************************
≆10	A of Lin's  Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?  If Yes, please explain below	No	

# Provider Enrollment: Texas Standardized Credentialing Application: Section II - Disclosure Questions Continued

- Medicare, Med	cald or other Governmental Program Participation	
\$11 Have you ever disqualified, or to other federa If Yes, please	been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard  使 Yes 係 No I or state governmental health care plans or programs?	
Other Sanction	s or Investigations	
atio canonon	Will daily during	
institution, lice	dy or have you ever been the subject of an investigation by any hospital or health care using authority, DEA or DPS authorizing entity, education or training program, Medicare or im, or any othe rprivate, state or federal health program?	⊕ Yes ⊕ No
If Yes, please o	xplain below	
913 To your knowle Protection Data	dge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Bank?	€ Yes € No.
If Yes, please e	xplain below	
		oraces
914 Have you over	eceived sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	***************************************
		⊕ Yes ♠ No
If Yes, please e	xplain below	abeli
***************************************		
@15 Have you ever I	peen investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or	
resigned while i	inder investigation by a hospital or healthcare facility of any military agency?	🦈 Yes 🗭 No
If Yes, please e	cplain below	
— Malpractice Clai	ms History	
#16 Have you had a	Wy paglayachica achigna within his a wash F washe Carachian	
litigated?	ty malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or	
If Yes, click to a	® Yes	

- Medical Malpractice Claims Hi	story
Incident Date:	8/13/2003 Date Claim was Filed: 8/12/2005
Date Notice of Claim Given:	Claim/Case Status: PENDING
Professional Liability Carrier Involved:	And the state of t
Liability Carrier Address:	30 ANG 20
Street:	
Suite:	
City: Policy Number:	
State: Award or Settlement:	*
Zip Code: - Amount of Award or Sett	element Paid:
Method of Resolution:	
	tte before Filing
	Igment for Plaintiff(s) @ Mediation or Arbitration
Description of Allegations:	years to the state of the state
SEE ATTACHMENT	
Were you Primary Defendant or C	o-Defendant?
Primary Defendant	Number of other Co-Defendants:
⊕ Co-Defendant	namba o cara so carandara.
Your Involvment (Attending, Cons	ulting, Etc.)
Description of Alleged Injury to th	e Patient:
room	
W	
To the Best of Your Knowledge, is to the Yes ® No	this Case Included in the National Practitioner Data Bank (NPDB)?
10 - 4 Nation 10 - 12334	
***************************************	

# Provider Enrollment: Texas Standardized Credentialing Application: Section II - Disclosure Questions continued

	/IIIII/18	
1	Thave you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional.  If Yes, please explain below	∰Yes ∰No
918	8 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense? If Yes, please explain below	®Yes ®No
<b>⊉19</b>	9 Have you been court-martialed for actions related to your duties as a medical professional?  If Yes, please explain below	∉Yes ∉No
At	bility to Perform Job	
	O Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)  If Yes, please explain below	⊕ yes ® No
<b>∌21</b>	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?  If Yes, please explain below	€ Yes € Na
<b>₩22</b>	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?  If Yes, please explain below	⊕ Yes ♠ No
⊕23	Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?  If Yes, please explain below	Ø Yes Ø No

#### Final Acknowledgement

#### * Agreement

By submitting this application for provider enrollment or credentialing, as well as the information provided in connection with this application, I acknowledge that I intend to become enrolled or credentialed as a provider in the Texas State Programs. I also agree to adhere to all applicable laws, administrative rules, policies, and guidelines, and I understand that under these authorities I must adhere to standards of behavior that, if not met, can result in administrative, civil and/or criminal sactions.



Once the application is accepted and submitted, you will not be able to make modifications during TMHP processing.

#### Credentialing Print Screen

Application Status PEP Ticket Number

Submitted

10390843

Thank you for submitting your application to TMHP.com. You can check the status of your application by logging onto TMHP.com and clicking View Existing Transactions.

To obtain a copy of your electronic online application please allow a 24 hour processing time. To print for your personal records, log onto TMHP.com to View Existing Transactions and navigate to the Messages screen for the Portal Ticket # of the submitted application.

Adobe Acrobat 7.0 or greater is required to view and print from Provider Enrollment on the Portal. In order to complete the application process <u>you must print the required documentation and cover letter</u> to submit to TMHP.

#### Prot lessured locaumentation

To expedite processing, please print cover letter and send it in with the required supporting documentation.

Frint Cover Letter in

Print the final checklist to confirm that all applicable documentation is included for TMHP to complete processing of your application.

Fina Checklist

Provider Enrollment : Texas Standardized Credentialing Application : Supplemental Information Checklist

1		uired for Supplement Information se attach hard copy or scanned documents of the following:
	$\dot{\Box}$	Copy of other Controlled Dangerous Substances Registration Certificate(s)
	П	Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
***************************************	П	Copies of IRS W-9s for verification of each tax identification number used
		Copy of workers compensation certificate of coverage, if applicable
		Copy of CLIA certifications, if applicable
	П	Copies of radiology certifications, if applicable
	П	Copy of DD214, record of military service, if applicable
		Call Coverage List, If applicable

# Tooltips

Page	Field	ToolTip
Individual Information	Date of Birth	MM/PD/YYYY
License Certificates	DEA Number	Drug Enforcement Agency
License Certificates	DPS Number	Department of Public Safety
License Certificates	UPIN	Unique Physician Identification Number
Professional Specialty Info	HMO:	Health Maintenance Organization
Professional Specialty Info	PPO:	Preferred Provider Organization
Professional Specialty Info	POS:	Point of Service
Practice Locations Page 1	Group number corresponding to Tax ID number (if applicable):	Group Texas Provider Identifier
Practice Locations Page 1	Tax ID Number:	Use the Tax ID or SSN used for enrollment in Texas Medicaid: If enrolling as a group, enter the Tax ID If enrolling as an individual, enter either the Tax ID or SSN If enrolling a performing provider, enter the group Tax ID



3817910

12357-B Riata Trace Parkway, Ste. 150 Austin, Texas 78727

March 2, 2010

FRANZ THEARD 4800 ALBERTA AVE EL PASO, TX 799052709

TPI: 133825308

NPI: 1770633216

Dear Provider:

The Texas Medicaid & Healthcare Partnership (TMHP) is pleased to inform you that the TMHP Credentialing Committee has approved your application for participation in Primary Care Case Management (PCCM).

Your effective date of participation is March 1, 2010. Participation as a primary care provider in PCCM is for three years based on your date of birth. Your re-credentialing date will be converted to your date of birth in the second year of your participation. TMHP will request all documents necessary for re-credentialing consideration in the second year.

The following publications and services are offered to PCCM providers:

Community Health Services – Community Health Services (CHS) coordinators assist PCCM clients by utilizing available resources to meet established needs, and to promote the highest available level of health and independence in living. You may refer clients to CHS by completing the "Primary Care Case Management (PCCM) Community Health Services Referral Request Form" located in the Texas Medicaid Provider Procedures Manual. You may fax the form to 1-512-302-0318 or call the Community Health Services Intake staff at 1-888-276-0702. Coordinators are also available to provide health education services in an office setting.

Nurse Helpline - PCCM provides a toll-free clinical Nurse Helpline at 1-800-304-5468 for its clients. The Nurse Helpline is staffed (nationally) by registered nurses who use physician-developed, symptom-based algorithms and 1,200 sets of self-care instructions to provide information, triage, and clinical assessment services for health plan clients 24 hours a day, 7 days a week. Nurse Helpline nurses do not diagnose; they assess the client's symptoms and guide the client to the most appropriate care setting.

Panel Reports – The panel report, prepared for each PCCM primary care provider, details the number of assigned PCCM clients. Panel reports are updated at the beginning of each month and are available to all providers electronically on the TMHP website. To view your secure report online, go to www.tmhp.com, and click Activate My Account from the "I would like to...." link on the upper right side of the TMHP.com home page. If you require assistance with the account activation process, contact the TMHP Electronic Data Interchange (EDI) Helpdesk at 1-888-863-3638 from 7 a.m. to 7 p.m. (CST). You may request to have a panel report mailed each month by calling the PCCM Provider Helpline at 1-888-834-7226.



12357-B Riata Trace Parkway, Ste. 150 Austin, Texas 78727

Provider Relations – TMHP conducts provider seminars and workshops to present the latest information on Medicaid program policies and procedures, claims processing requirements, and federal and state regulations affecting the Medicaid program. TMHP Provider Relations representatives are also available to assist you with program issues, problem resolution, and on-site visits. Visit <a href="www.tmhp.com">www.tmhp.com</a> for workshop dates and to locate the provider representative in your area or call the PCCM Provider Helpline at 1-888-834-7226.

Provider Website - The TMHP provider website (<a href="www.tmhp.com">www.tmhp.com</a>) offers access to electronic publications. announcements, schedules for workshops and upcoming events. Providers can also check claims status, verify eligibility, web chat, update office demographic information, and find contact information for Provider Relations representatives.

Texas Medicaid Bulletins - Texas Medicaid bulletins are published bi-monthly and serve as updates to Medicaid policies and procedures published in the Texas Medicaid Provider Procedures Manual.

Texas Medicald Provider Procedures Manual – Reading, understanding, and adhering to the policies outlined in this manual will greatly assist you in properly fulfilling your responsibilities as a Managed Care primary care provider. This comprehensive guide is available on the TMHP website. The manual contains information for specific provider types as well as appendices with additional reference materials, forms, and claim examples. If you are unable to access the website, a hard-copy manual, Medicaid bulletins, forms, or any other PCCM information may be requested by calling the PCCM Provider Helpline at 1-888-834-7226.

Welcome and thank you for your participation in PCCM. If you have any questions or concerns, please contact the PCCM Provider Helpline at 1-888-834-7226.

Sincerely,

Contracting/Credentialing Department