TEAM HEALTH SOUTHWEST

6750 West Loop South., Suite 460
Bellaire, TX 77401

713-383-4343 or 800-558-8499 ext. 4343
FAX 713-383-4349

February 24, 2005

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

Enclosed is an application for a new group number for the emergency physician groups at Austin Surgical Hospital and the Heart Hospital of Austin.

ALL APPLICATIONS ARE PROCESSED FROM THIS ADDRESS. IF THESE APPLICATION NEED TO BE RETURNED, PLEASE SEND THEM TO MY ATTENTION AT THE ABOVE ADDRESS.

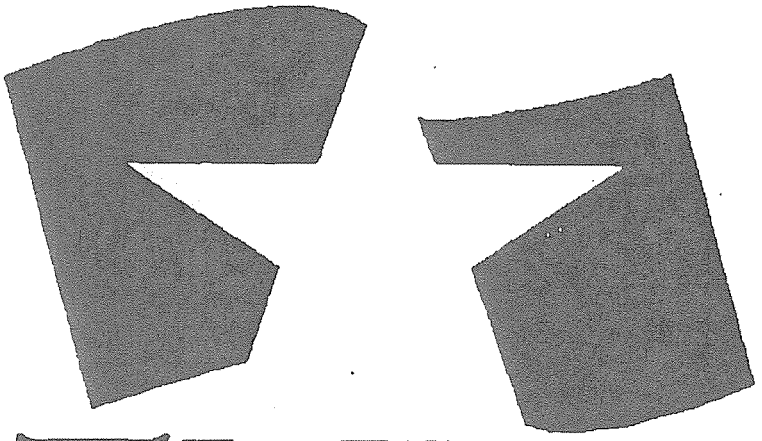
If you have any questions, please call me at 713-383-4343.

Thanks.

Sheila Foster
Provider Enrollment

Enclosure

DCN: 200505900010479



TMHP

TEXAS MEDICAID
&
HEALTHCARE PARTNERSHIP

A STATE MEDICAID CONTRACTOR

Provider Enrollment Application

REV. X

Texas Medicaid Identification Form

Please check only the appropriate boxes to ensure proper enrollment. For assistance in choosing the appropriate provider type, please refer to Appendix A on pages 22.1 through 22.7 of the instructions.

Legend: * Medicare number required; ◎ Medicare number may be assigned, but not required; ◆ Palmetto number required; • Must designate if public provider

Traditional Services

- ☐ * Advanced Practice Nurse
- ☐ * * Ambulance / Air Ambulance
- ☐ * * Ambulatory Surgical Center (ASC)
- ☐ * Audiologist
- ☐ Birthing Center
- ☐ * Catheterization Lab
- ☐ * Certified Nurse Midwife (CNM)
- ☐ * Certified Registered Nurse Anesthetist (CRNA)
- ☐ Chemical Dependency Treatment Facility (TCADA)
- ☐ * Chiropractor
- ☐ * Community Mental Health Center
- ☐ * Comprehensive Health Center (CHC)
- ☐ * Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Dietitian
- ☐ ◆ Durable Medical Equipment (DME)
- ☐ Durable Medical Equipment / Home Health
- ☐ * Family Planning Agency
- ☐ * Federally Qualified Health Center (FQHC)
- ☐ * Federally Qualified Look-alike (FQL)
- ☐ * Federally Qualified Satellite (FQS)
- ☐ * * Freestanding Psychiatric Facility
- ☐ * Freestanding Rehabilitation Facility
- ☐ * Genetics
- ☐ Hearing Aid
- ☐ * Home
- ☐ * * Hospital — In-State
- ☐ * Hospital Ambulatory Surgical Center (HASC)
- ☐ * Hospital — Military
- ☐ * * Hospital — Out-of-State
- ☐ ◆ Hyperalimentation
- ☐ * * Independent
- ☐ Licensed Professional Counselor (LPC)
- ☐ Licensed Vocational Nurse
- ☐ * Maternity Service Clinic (MSC)
- ☐ ◎ Occupational Therapist (OT)
- ☐ * Optician
- ☐ * Optometrist
- ☐ ◎ Physical Therapist (PT)
- ☒ * Physician (M.D, DO) *OB/GYN and Pediatricians not required to have a Medicare Number*
- ☐ * Physiological Lab
- ☐ * Podiatrist
- ☐ * Portable X-Ray
- ☐ * Psychologist
- ☐ * Radiation Treatment Center
- ☐ Radiological Lab
- ☐ Registered Nurse
- ☐ * * Renal Dialysis Facility
- ☐ Respiratory Care Practitioner
- ☐ * * Rural Health Clinic – Hospital, Freestanding
- ☐ * Skilled Nursing Facility
- ☐ ◎ Social Worker (LMSW-ACP)
- ☐ Speech Therapist
- ☐ * SHARS — School-Co-op or School District
- ☐ SHARS — Non-School
- ☐ * TB Clinic
- ☐ ◆ Vision Medical Supplier (VMS)
- ☐ Multi-Specialty Group

Targeted Case Management Services

- ☐ * Early Childhood Intervention (ECI)
- ☐ * MH Case Mgmt / MR Case Management
- ☐ MH Rehab
- ☐ * Children and Pregnant Women (CPW)
- ☐ Texas Commission for the Blind
- ☐ Women, Infants & Children (WIC) – Immunization Only

Comprehensive Care Services (CCP)

- ☐ Dietitian
- ☐ Licensed Vocational Nurse
- ☐ Occupational Therapist (OT)
- ☐ Pharmacy
- ☐ Physical Therapist (PT)
- ☐ Registered Nurse
- ☐ Social Worker (LMSW-ACP)
- ☐ Speech Therapist (SLP)

Texas Health Steps (THSteps) Services (EPSDT)

Eligible providers will be automatically enrolled in the THSteps program. If you do not wish to be a THSteps provider, check the box below.

☐ I do NOT wish to be a THSteps provider.

Texas Vaccines for Children Program

Do you currently receive free vaccines from the State of Texas: ☐ Yes ☐ No *(if "no," please answer the next question).*

Does your clinic / practice provide routinely recommended vaccines to children ages 0 to 18 years?

☐ No ☐ Yes *(if "yes," complete pages 21.1 — 21.3 of this application to become a Texas Vaccines for Children provider).*

NOT VALIDATED

Texas Medicaid Provider Enrollment Application

- Original signatures only; copies or stamped signatures not accepted.
- All information must be completed or marked "N/A" and contain a valid signature to be processed.
- Please use blue or black ink.

APPLICANT ENROLLED AS: ☐ Individual ☒ Group ☐ Facility

SECTION A — Provider of Service Information

Existing Medicaid Texas Provider Identifiers (TPIs)		
Please list all other assigned Texas Medicaid TPIs in boxes to the right		

Group/Company, or Last Name	First	Initial	Title/Degree	Do you want to be a limited provider? (See page 4)
ACS Primary Care Physicians Southwest, PA				☐ Yes ☒ No

Telephone Number	Social Security Number (For Individual Enrollment Only)	License Number Copy of License/Temporary License Required.	Issue Date	Expiration Date
(713) 383 - 4343				

Medicare Intermediary	Medicare Number	Medicare Certification Date
Trailblazer	00882X	12/15/2004

Employer's Tax ID No.	Legal Name According to the IRS (Identical to W-9)	Primary Specialty	Sub-Specialty
75-2582784	ACS PRIMARY CARE PHYSICIANS SOUTHWEST, PA	EMERGENCY MEDICINE	

Physical Address – *Where notification and provider information are to be sent (No PO Box addresses)*

Number Street	Suite	City	State	ZIP
3801 Lamar BL & 3003 Bee Caves Road		Austin	TX	78759 & 78746

Accounting Street or PO Box Address — *If different from above*

Number Street	Suite	City	State	ZIP
PO Box 636018		CINCINNATI	OH	45263-6018

Group Medicare Number:	Or group nine-character Texas Medicaid TPI:
00882X	

Facilities Only:

Is this a freestanding facility?	☐ Yes	☐ No	☒ N/A
NOTE: Freestanding RHCs must attach a copy of encounter rate letter from Medicare.			
Is this a hospital-based facility?	☐ Yes	☐ No	☒ N/A
Is this an ESRD facility?	☐ Yes	☐ No	☒ N/A
If yes, what is your composite rate?			

Hearing Aid Providers Only:

Are you a physician?	☐ Yes	☐ No	☒ N/A
Are you a fitter/dispenser?	☐ Yes	☐ No	☒ N/A
Are you an audiologist?	☐ Yes	☐ No	☒ N/A
Will you be conducting evaluations?	☐ Yes	☐ No	☒ N/A
Will you be dispensing hearing aids?	☐ Yes	☐ No	☒ N/A

NOT VALIDATED

Texas Medicaid Provider Enrollment Application

SECTION A *Continued*

School Health and Related Services (SHARS) Providers

If enrolling as a special education co–op, attach a list of all school districts in the co–op that will be providing SHARS services. Provide the following information for each school district:
- complete address
- School District Number
- T.E.A. number

Are you a enrolling as a school district?	☐ Yes	☐ No	☒ N/A
If yes, give school six–digit T.E.A. number:			
Are you enrolling as a special education co–op?	☐ Yes	☐ No	☒ N/A
If yes, give fiscal agent number:			
Are you enrolling as a non–school SHARS provider?	☐ Yes	☐ No	☒ N/A

Hospital Providers

Are you a hospital facility?	☐ Yes	☒ No	☐ N/A
If yes, what is your average daily room rate?	Private	Semi–Private	

Public/Non–Public Providers

Definition — Public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds.

Are you a private entity?	☐ Yes	☒ No
Are you a public entity?	☐ Yes	☒ No
If yes, are you required to certify expended funds?	☐ Yes	☐ No ☒ N/A

Name and address of a person certifying expended funds:

SECTION B—GROUP PRACTICE *Individual performing provider's part of a group to be added*

Group Medicare Number	Or group 9–digit Texas Medicaid TPI
00882X	

Name	License Number	License Issue Date	Social Security Number	Medicare Number	Title/ Degree
Julie Graves Moy	G5110	8/27/1983	[redacted]	8D0345	MD
Carl Pevoto	D1005	9/18/1963	[redacted]	8D0344	MD
H. Brook Randal	G3943	2/27/1983	[redacted]	D0346	MD

NOT VALIDATED

Texas Medicaid Provider Enrollment Application

SECTION C — *REQUIRED INFORMATION for Specific Provider Types*

All Licensed Providers	You must attach a copy of your license
Ambulance Services Providers	You must attach a copy of your permit/license
Birthing Center Providers	You must attach a copy of your certification permit
Certified Registered Nurse Anesthetist Providers	You must attach a copy of your CRNA certification or re-certification card
Chemical Dependency Treatment Facility Providers	You must attach a copy of your license
CLIA Providers	You must attach a copy of your CLIA license with approved specialty services as appropriate
ECI Providers	You must attach a copy of your approval letter from the Interagency Council on Early Childhood Intervention
FQHC Providers	You must attach a copy of your contracted providers, names and addresses of your satellite centers that have been approved by the Public Health Service, and a copy of your grant award
Mammography Services Providers	You must attach a copy of the certification of your mammography systems from the Bureau of Radiation Control (BRC) and enter your certification number in the box below *Certification Number:*
MH/MR Providers	You must attach a copy of your approval letter from the State of Texas
Case Management for CPW Providers	You must attach a copy of your approval letter from the State of Texas
Non-School SHARS Providers	You must attach a copy of your letter of good standing
Freestanding RHC Providers	You must attach a copy of your encounter rate letter from Medicaid

To the best of my knowledge, the information supplied in this document is accurate and complete and is hereby released to Texas Medicaid & Healthcare Partnership (TMHP) and HHSC for the purpose of issuing a Medicaid TPI.	Do Not Write In This Area (For Office Use Only)
(Signature of applicant or an authorized representative if you are enrolling as a provider group/supplier)	Number:
William C. Heymann, MD Signature	Date:
President Title — 2/24/05 Date	Initials:

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

HHSC Medicaid Provider Agreement

Name of Provider ACS Primary Care Physicians Southwest, PA *Medicaid Provider ID Number _____

Doing Business As _____ Medicare Provider ID Number 00882X

Physical Address

3801 LAMAR BLVD AND 3003 BEE CAVES ROAD

AUSTIN, TX 78756 AND 78746
Mailing Address

PO BOX 636018

CINCINNATI, OH 45263-6018

* *Please list additional Texas Provider Identifiers (TPIs) on the Addendum Statement for this Agreement. New applicants should leave this space blank.*

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 **Agreement and documents constituting Agreement.**

A copy of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. Provider has a duty to become familiar with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state and federal laws and amendments governing and

1.2 **State and Federal regulatory requirements.**

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a–7), or Executive Order 12549. Provider has also not been excluded or debarred from participation in any other state or federal health care program. Provider must notify 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), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 C.F.R. Part 76, "Government–wide Debarment and Suspension (Non–procurement) and Government–wide Requirements

This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion–Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to HHSC or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 C.F.R. Part 76 by participants in lower tier covered transactions.

HHSC Medicaid Provider Agreement

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to the Texas Department of Health, Texas Health and Human Services Commission, Texas Department of Human Services, Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing 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, 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.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. § 431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. § 431.107 and copies of those records free of charge to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for five years from the date of service (six years for freestanding 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/or their agents access to its

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of the Inspector General, and internal and external auditors for the state/federal government and/or HHSC may conduct interviews of Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and their employees, witness, and clients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit and/or the Texas Health and Human Services Commission's Office of the Inspector General. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and 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 child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25% ownership interest is delinquent in any child support obligation. Provider must attach a list of the names, Social Security numbers, and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25% ownership interest in the Provider. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified grant, loan, or payment. (3) If 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% ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws 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 payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true and accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

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

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with 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. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a client for a covered service.

1.3.4 Federal 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 C.F.R. §447.20).

1.3.5 As a condition for eligibility for Medicaid benefits, a client assigns all rights to recover from any third party or any other source of payment to HHSC (42 C.F.R. §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (25 TAC Chapter 28), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 C.F.R. §447.15).

HHSC Medicaid Provider Agreement

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

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

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP 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.

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.

HHSC Medicaid Provider Agreement

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 children and pregnant women (CPW)
- 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 Public schools that are the sponsoring entity for a non-school SHARS provider are also required to reimburse HHSC, according to established HHSC procedures, the non-federal portion of expenditures made by HHSC. A non-public school SHARS provider must submit a letter from the sponsoring public school acknowledging this relationship and indicating that the public school understands that it will be billed for the state portion of the fee paid to the non-public SHARS provider.

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. TERM AND TERMINATION

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

Provider Signature William C Heymann Date 2/21/05

William C. Heymann, MD
Printed Name and Title of Person Signing for Provider

Certification

THIS FORM IS REQUIRED FOR ALL APPLICANTS

ATTACHMENT 1

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor; "contract" refers to both contract and subcontract.
By signing and submitting this certification the potential contractor accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or the HHSC may pursue available remedies, including suspension and/or debarment.
2. The potential contractor will provide immediate written notice to the person to whom this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
3. The words "covered contract," "debarred", "suspended," "ineligible," "participant," "person," "principal," "proposal," and "voluntarily excluded," as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.
4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract? ☒ Yes ☒ No

5. The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.
6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.
7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

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

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

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

Name of Potential Contractor	Vendor ID or Social Security Number	HHSC Contract Number *(if applicable)*
ACS Primary Care Physicians Southwest, PA	75-2562784	N/A

William C. Heymann

Signature of Applicant/Provider — Date — Printed Name and Title of person signing form

William C. Heymann, MD 2/2/05

William C. Heymann, MD

NOT VALIDATED

Provider Information Form

☒ 1A. All Groups, Partnerships, IPAs, Individual Practitioners, and Non-corporate Entities, including Associations, must complete this form before enrollment in the Texas Medicaid Program.

☐ 1.B. If you, the provider, are part of a corporation and this form is for one of the following individuals, including, but not limited to: Directors of Clinics/Facilities, Directors of Management Companies, and for each corporation, the following individuals: owners, officers, directors, and shareholders with at least 25 percent share.

☐ 1.C. All other providers not covered by 1.A. or 1.B.

Name	Doing Business As (DBA) Name
ACS Primary Care Physicians Southwest, PA	N/A
Other Name	*For additional names or addresses, please attach necessary pages*

Physical Address (No PO Box Addresses)

Number Street	Suite	City	State	ZIP
3003 BEE CAVES RD & 3801 LAMAR BL		AUSTIN	TX	78746 & 78756

Accounting Address (PO Box or Street Address)

Number Street	Suite	City	State	ZIP
PO BOX 636018		CINCINNATI	OH	45263-6018

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

☒ Billing Agent ☐ Management Company ☐ Employer ☐ Self ☐ Other (explain below)

Explain if "Other" was selected.

License Number and Issuer	License Issue Date / License Expiration Date
Social Security Number	Employer's Tax ID 75-2562784
Specialty of Practice EMERGENCY MEDICINE	Medicare Intermediary Trailblazer Health Enterprises
Medicare Provider Number 882	Medicare Effective Date 12/15/2004
Driver's License Number and Issuer	Driver's License Expiration Date
Date of Birth	Gender ☐ M ☐ F

Previous Physical Address (No PO Box Addresses)

Number Street	Suite	City	State	ZIP

Previous Accounting Box Address (PO Box or Street Address)

Number Street	Suite	City	State	ZIP

NOT VALIDATED

Provider Information Form

List all physical locations where Medicaid services are rendered using noted TPI(s).

Do you plan to use a billing agent to submit your Medicaid claims?

☒ Yes ☐ No *If yes, provide the following information about the billing agent:*

Billing Agent Name	Address
IMBS, Inc.	2620 RIDGEWOOD RD. STE 300
Tax ID Number	
65-0622847	AKRON OH. 44313
Contact Person Name	Telephone Number
KATHLEEN LISTON	330-865-6060

List all Texas Medicaid TPIs under which you have billed in the past 12 months *(attach additional sheets if necessary):*

UNKNOWN

List all contractual relationships with medical entities and the TPIs of those entities *(attach additional sheets if necessary):*

N/A

Have you ever been excluded, debarred, or sanctioned from any state or federal program?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):*

Is your license currently suspended or restricted?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occured, and any adverse action against your license (attach additional sheets if necessary):*

NOT VALIDATED

Provider Information Form

Have you ever been convicted of a crime (excluding minor traffic citations)? ☐ Yes ☒ No

a) Conviction or Convicted — a judgment of conviction or deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding.
b) A person has been found guilty by a federal, state, or local court;
c) A person has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
d) A person has entered a first offender or other program and judgment of conviction has been withheld.

If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):

Are you currently behind 30 days or more on your child support payments? ☐ Yes ☒ No

If yes, provide details (attach additional sheets if necessary):

Laboratory – CLIA (Clinical Laboratory Improvement Act)

CLIA Certification Number* and approved specialty services: *Please enclose a copy of your CLIA Certificate*

N/A

Mammography Facility Certification

Radiation Control Certification Number: *Please enclose a copy of your Certification*

N/A

NOT VALIDATED

Provider Information Form

THIS SECTION MUST BE COMPLETED, SIGNED, AND NOTARIZED BY ALL PROVIDERS

I certify that the above constitutes true and correct information. I agree to inform HHSC or its designee, in writing, of any changes, or if additional information becomes available.

William C Heymann
Signature of Provider

William C. Heymann, MD
Printed or Typed Name of Provider

Subscribed and Sworn before me, Sheila Foster a Notary Public for the State of Texas, on the 24th day of February, 20 05

Sheila Foster
Signature of Notary Public

Texas
State of

Notary [illegible] SHEILA M. FOSTER
Notary Public, State of Texas
My Commission Expires
September 24, 2008

MESSAGE TO NOTARY:
PLEASE BE SURE TO COMPLETE ALL OF THE BLANKS IN THIS NOTARY

MR23

Reminder: This form must have original signatures and be notarized before returning to TMHP.

Disclosure of Ownership and Control Interest Statement

This Form is Required for Individuals or Groups Enrolling Under a Tax ID as a Corporation

I. Identifying Information

(a) Name of Entity		D/B/A		Telephone No
ACS Primary Care Physicians Southwest, PA				(713) 383 - 4343
Street Address	**Suite**	**City**	**State**	**Zip**
6750 W. LOOP SOUTH	460	BELLAIRE	TX.	77401

(b) Chain Affiliate No.: *(To be completed by HCFA Regional Office)*

II. Answer the following questions by checking "Yes" or "No."

If any of the questions are answered Yes list names and addresses of individuals or corporations under Remarks on Page 12. Identify each item number to be answered.

(a)	Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?	☐ Yes	☒ No
(b)	Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?	☐ Yes	☒ No
(c)	Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary, or carrier within the previous 12 months? (Title XVIII providers only)	☐ Yes	☒ No

III. (a) List names, addresses, for individuals, or the EIN for organizations having direct or indirect ownership of a controlling interest in the entity.

See Instructions for Completing the Disclosure of Ownership and Control Interest Statement on page 10. List any additional names and addresses under Remarks on page 11.3. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
N/A		

(b) Type of Entity: (SELECT ONLY ONE ENTITY)

☐ Sole Proprietorship ☐ Partnership ☐ Corporation

☐ Unincorporated ☒ Association ☐ Other *(Specify):*

Please Note: When claiming "Corporation" providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form (page 14) must be completed with signature and notary stamp or seal
- Certificate of Incorporation or Certificate of Authority
- Letter of Good Standing from the Texas State Comptroller's Office. It is a requirement of H.B. 175. A certificate can be obtained by contacting:

State Comptroller's Office — Tax Assistance Section
Interstate WATS Telephone Number 1-800-252-5555
Austin Telephone Number 1-512-463-4600

There is no charge for this request. The request may be made by telephone, and the certificate will be mailed to the requestor. Callers must have the taxpayer's name, taxpayer's identification number, and charter number available at the time of the request. If the corporation has a 501c Internal Revenue Exemption, Letter of Good Standing is not required. Please indicate this by signing below:

Do you have a 501c Internal Revenue Exemption? ☐ Yes ☒ No

Corporate Name	Name (Written/Typed)
Signature	Date

NOT VALIDATED

Disclosure of Ownership and Control Interest Statement

This Form is Required for Individuals or Groups Enrolling Under a Tax ID as a Corporation

III. (Continued)

(c) If the disclosing entity is a corporation, list names, addresses of the directors, and EINs for corporations in remarks. *(Attach additional pages if needed)*

REMARKS:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? *(Example: sole proprietor, partnership, or members of Board of Directors.)* ☐ Yes ☒ No

If yes, list names, addresses of individuals, and provider numbers:

Name | Address | Provider Number

IV. (a) Has there been a change in ownership or control within the last year? ☐ Yes ☒ No *If yes give* date:

(b) Do you anticipate any change of ownership or control within the year? ☐ Yes ☒ No *If yes* when?

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☒ No *If yes* when?

V. Is this facility operated by a management company or leased in whole or in part by another organization? ☐ Yes ☒ No *If yes give* date of change in operations:

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? ☐ Yes ☒ No

VII. (a) Is this facility chain affiliated? *If yes, list* name, address of corporation, and EIN: ☐ Yes ☒ No

Name | Address | EIN

(b) If the answer to Question VII.A. is No, was the facility ever affiliated with a chain? *If yes, list* name, address of corporation, and EIN: ☐ Yes ☒ No

Name | Address | EIN

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years? ☐ Yes ☒ No

If yes, give year of change: Current Beds: Prior Beds

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed)	Title
William C. Heymann, MD	President
Signature	**Date**
William C Heymann	2/21/05

NOT VALIDATED

IRS W-9 Form

Form **W-9** (Rev. January 2003) Department of the Treasury Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.

Name

Business name, if different from above

ACS Primary Care Physicians Southwest, PA

Check appropriate box: ☐ Individual/ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other ASSOCIATION ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

6750 W. Loop S., Ste 460, Bellaire, TX 77401

City, state, and ZIP code

Bellaire, TX 77401

Requester's name and address (optional)

List account number(s) here (optional)

Taxpayer Identification Number (TIN)

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

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

Social security number

or

Employer identification number 7 5 - 2 5 6 2 7 8 4

Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Signature of U.S. person Kristin C Harper Date 8/21/05

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Cat. No. 10231X

Form W-9 (Rev. 1-2003)

NOT VALIDATED

HHSC Medicaid Provider Agreement

Name of Provider JULIE GRAVES MOY, MD *Medicaid Provider ID Number _____

Doing Business As _____ Medicare Provider ID Number 8D0345

Physical Address

3801 LAMAR BLVD AND 3003 BEE CAVES ROAD

AUSTIN, TX 78756 AND 78746
Mailing Address

PO BOX 636018

CINCINNATI, OH 45263-6018

* *Please list additional Texas Provider Identifiers (TPIs) on the Addendum Statement for this Agreement. New applicants should leave this space blank.*

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

A copy of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. Provider has a duty to become familiar with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state and federal laws and amendments governing and

1.2 State and Federal regulatory requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), or Executive Order 12549. Provider has also not been excluded or debarred from participation in any other state or federal health care program. Provider must notify 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), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 C.F.R. Part 76, "Government-wide Debarment and Suspension (Non-procurement) and Government-wide Requirements

This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to HHSC or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 C.F.R. Part 76 by participants in lower tier covered transactions.

HHSC Medicaid Provider Agreement

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to the Texas Department of Health, Texas Health and Human Services Commission, Texas Department of Human Services, Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing 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, 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.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. § 431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. § 431.107 and copies of those records free of charge to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for five years from the date of service (six years for freestanding 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/or their agents access to its

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of the Inspector General, and internal and external auditors for the state/federal government and/or HHSC may conduct interviews of Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and their employees, witness, and clients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit and/or the Texas Health and Human Services Commission's Office of the Inspector General. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

HHSC Medicaid Provider Agreement

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 child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25% ownership interest is delinquent in any child support obligation. Provider must attach a list of the names, Social Security numbers, and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25% ownership interest in the Provider. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified grant, loan, or payment. (3) If 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% ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws 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 payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true and accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

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

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with 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. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a client for a covered service.

1.3.4 Federal 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 C.F.R. §447.20).

1.3.5 As a condition for eligibility for Medicaid benefits, a client assigns all rights to recover from any third party or any other source of payment to HHSC (42 C.F.R. §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (25 TAC Chapter 28), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 C.F.R. §447.15).

HHSC Medicaid Provider Agreement

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

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

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP 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.

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.

HHSC Medicaid Provider Agreement

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 children and pregnant women (CPW)
- 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 Public schools that are the sponsoring entity for a non-school SHARS provider are also required to reimburse HHSC, according to established HHSC procedures, the non-federal portion of expenditures made by HHSC. A non-public school SHARS provider must submit a letter from the sponsoring public school acknowledging this relationship and indicating that the public school understands that it will be billed for the state portion of the fee paid to the non-public SHARS provider.

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. TERM AND TERMINATION

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

Provider Signature Julie Graves MD Date 2/21/05

Julie Graves MD

Printed Name and Title of Person Signing for Provider

Certification

THIS FORM IS REQUIRED FOR ALL APPLICANTS

ATTACHMENT 1

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor; "contract" refers to both contract and subcontract.
By signing and submitting this certification the potential contractor accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or the HHSC may pursue available remedies, including suspension and/or debarment.
2. The potential contractor will provide immediate written notice to the person to whom this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
3. The words "covered contract," "debarred", "suspended," "ineligible," "participant," "person," "principal," "proposal," and "voluntarily excluded," as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.
4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract? ☐ Yes ☒ No

5. The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.
6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.
7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

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

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

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

Name of Potential Contractor	Vendor ID or Social Security Number	HHSC Contract Number (If applicable)
Julie Graves, Moy	75-2562784	N/A

Signature of Applicant/Provider	Date	Printed Name and Title of person signing form
Julie Graves Moy	2/2/05	Julie Graves Moy

NOT VALIDATED

DCN: 200505900010479

Provider Information Form

☒ 1.A. All Groups, Partnerships, IPAs, Individual Practitioners, and Non-corporate Entities, including Associations, must complete this form before enrollment in the Texas Medicaid Program.

☐ 1.B. If you, the provider, are part of a corporation and this form is for one of the following individuals, including, but not limited to: Directors of Clinics/Facilities, Directors of Management Companies, and for each corporation, the following individuals: owners, officers, directors, and shareholders with at least 25 percent share.

☐ 1.C. All other providers not covered by 1.A. or 1.B.

Name: Julie Graves Moy

Doing Business As (DBA) Name: N/A

Other Name:

For additional names or addresses, please attach necessary pages

Physical Address (No PO Box Addresses)

Number Street	Suite	City	State	ZIP
3801 LAMAR BLVD AND 3003 BEE CAVES ROAD		AUSTIN, TX	TX	78756 & 78746

Accounting Address (PO Box or Street Address)

Number Street	Suite	City	State	ZIP
PO BOX 636018		CINCINNATI	OH	45263-6018

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

☒ Billing Agent ☐ Management Company ☐ Employer ☐ Self ☐ Other (explain below)

Explain if "Other" was selected.

License Number and Issuer: G5110

License Issue Date: 8/27/83

License Expiration Date: 2/28/06

Social Security Number: [redacted]

Employer's Tax ID: 75-2562784

Specialty of Practice: EMERGENCY MEDICINE

Medicare Intermediary: Trailblazer Health Enterprises

Medicare Provider Number: 8D0345

Medicare Effective Date: 12/15/2004

Driver's License Number and Issuer: [redacted]

Driver's License Expiration Date: [redacted]

Date of Birth: 11/4/57

Gender: ☐ M ☒ F

Previous Physical Address (No PO Box Addresses)

Number Street	Suite	City	State	ZIP

Previous Accounting Box Address (PO Box or Street Address)

Number Street	Suite	City	State	ZIP

NOT VALIDATED

Provider Information Form

List all physical locations where Medicaid services are rendered using noted TPI(s).

Do you plan to use a billing agent to submit your Medicaid claims?

☒ Yes ☐ No *If yes, provide the following information about the billing agent.*

Billing Agent Name	Address
IMBS, Inc.	2620 RIDGEWOOD RD. STE 300
Tax ID Number	
65-0622847	AKRON OH. 44313
Contact Person Name	Telephone Number
KATHLEEN LISTON	330-865-6060

List all Texas Medicaid TPIs under which you have billed in the past 12 months *(attach additional sheets if necessary):*

UNKNOWN

List all contractual relationships with medical entities and the TPIs of those entities *(attach additional sheets if necessary):*

N/A

Have you ever been excluded, debarred, or sanctioned from any state or federal program?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):*

Is your license currently suspended or restricted?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occured, and any adverse action against your license (attach additional sheets if necessary):*

NOT VALIDATED

Provider Information Form

Have you ever been convicted of a crime (excluding minor traffic citations)? ☐ Yes ☒ No

a) Conviction or Convicted — a judgment of conviction or deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding;
b) A person has been found guilty by a federal, state, or local court;
c) A person has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
d) A person has entered a first offender or other program and judgment of conviction has been withheld.

If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):

Are you currently behind 30 days or more on your child support payments? ☐ Yes ☒ No

If yes, provide details (attach additional sheets if necessary):

Laboratory – CLIA (Clinical Laboratory Improvement Act)

CLIA Certification Number* and approved specialty services: *Please enclose a copy of your CLIA Certificate*

N/A

Mammography Facility Certification

Radiation Control Certification Number: *Please enclose a copy of your Certification*

N/A

NOT VALIDATED

DCN: 200505900010479

Provider Information Form

THIS SECTION MUST BE COMPLETED, SIGNED, AND NOTARIZED BY ALL PROVIDERS

I certify that the above constitutes true and correct information. I agree to inform HHSC or its designee, in writing, of any changes, or if additional information becomes available.

Julie Graves May — Julie Graves May

Signature of Provider — Printed or Typed Name of Provider

Subscribed and Sworn before me, Sheila Foster a Notary Public for the State of Texas, on the 24th day of February, 2005

Sheila M Foster — Texas

Signature of Notary Public — State of

Notary Seal or Stamp

SHEILA M. FOSTER
Notary Public, State of Texas
My Commission Expires
September 24, 2008

MESSAGE TO NOTARY:
PLEASE BE SURE TO COMPLETE ALL OF THE BLANKS IN THIS NOTARY

MR23

Reminder: This form must have original signatures and be notarized before returning to TMHP.

TEXAS STATE BOARD OF MEDICAL EXAMINERS

P.O. BOX 2018 • AUSTIN, TEXAS 78768-2018

PHYSICIAN PERMIT

LICENSE/PERMIT NUMBER

G5110

EXPIRATION DATE

02-28-2006

JULIE GRAVES MOY, MD
1820 W 11TH STREET
AUSTIN TX 78703-3915

THIS CERTIFIES THAT THE LICENSEE/PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR ANNUAL REGISTRATION FOR THE YEAR INDICATED ABOVE

PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS

HHSC Medicaid Provider Agreement

Name of Provider CARL PEVOTO, MD *Medicaid Provider ID Number _____

Doing Business As _____ Medicare Provider ID Number 8D0344

Physical Address

3801 LAMAR BLVD AND 3003 BEE CAVES ROAD

AUSTIN, TX 78756 AND 78746
Mailing Address

PO BOX 636018

CINCINNATI, OH 45263-6018

* *Please list additional Texas Provider Identifiers (TPIs) on the Addendum Statement for this Agreement. New applicants should leave this space blank.*

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

A copy of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. Provider has a duty to become familiar with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state and federal laws and amendments governing and

1.2 State and Federal regulatory requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a–7), or Executive Order 12549. Provider has also not been excluded or debarred from participation in any other state or federal health care program. Provider must notify 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), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 C.F.R. Part 76, "Government–wide Debarment and Suspension (Non–procurement) and Government–wide Requirements

This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion–Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to HHSC or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 C.F.R. Part 76 by participants in lower tier covered transactions.

HHSC Medicaid Provider Agreement

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to the Texas Department of Health, Texas Health and Human Services Commission, Texas Department of Human Services, Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing 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, 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.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. § 431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. § 431.107 and copies of those records free of charge to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for five years from the date of service (six years for freestanding 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/or their agents access to its

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of the Inspector General, and internal and external auditors for the state/federal government and/or HHSC may conduct interviews of Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and their employees, witness, and clients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit and/or the Texas Health and Human Services Commission's Office of the Inspector General. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

HHSC Medicaid Provider Agreement

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 child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25% ownership interest is delinquent in any child support obligation. Provider must attach a list of the names, Social Security numbers, and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25% ownership interest in the Provider. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified grant, loan, or payment. (3) If 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% ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws 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 payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true and accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

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

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with 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. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a client for a covered service.

1.3.4 Federal 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 C.F.R. §447.20).

1.3.5 As a condition for eligibility for Medicaid benefits, a client assigns all rights to recover from any third party or any other source of payment to HHSC (42 C.F.R. §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (25 TAC Chapter 28), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 C.F.R. §447.15).

HHSC Medicaid Provider Agreement

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

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

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP 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.

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.

HHSC Medicaid Provider Agreement

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 children and pregnant women (CPW)
- 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 Public schools that are the sponsoring entity for a non-school SHARS provider are also required to reimburse HHSC, according to established HHSC procedures, the non-federal portion of expenditures made by HHSC. A non-public school SHARS provider must submit a letter from the sponsoring public school acknowledging this relationship and indicating that the public school understands that it will be billed for the state portion of the fee paid to the non-public SHARS provider.

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. TERM AND TERMINATION

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

Provider Signature Carl Peuoto MD Date 10-22-04

Carl Peuoto

Printed Name and Title of Person Signing for Provider

Certification

THIS FORM IS REQUIRED FOR ALL APPLICANTS

ATTACHMENT 1

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor; "contract" refers to both contract and subcontract.
By signing and submitting this certification the potential contractor accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or the HHSC may pursue available remedies, including suspension and/or debarment.
2. The potential contractor will provide immediate written notice to the person to whom this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
3. The words "covered contract," "debarred", "suspended," "ineligible," "participant," "person," "principal," "proposal," and "voluntarily excluded," as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.
4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract? ☐ Yes ☒ No

5. The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.
6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.
7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

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

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

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

Name of Potential Contractor	Vendor ID or Social Security Number	HHSC Contract Number *(if applicable)*
Carl Pevoto	75-2562784	N/A

Signature of Applicant/Provider	Date	Printed Name and Title of person signing form
Carl Pevoto	2/22/05	Carl Pevoto

NOT VALIDATED

Provider Information Form

☒ 1.A. All Groups, Partnerships, IPAs, Individual Practitioners, and Non-corporate Entities, including Associations, must complete this form before enrollment in the Texas Medicaid Program.

☐ 1.B. If you, the provider, are part of a corporation and this form is for one of the following individuals, including, but not limited to: Directors of Clinics/Facilities, Directors of Management Companies, and for each corporation, the following individuals: owners, officers, directors, and shareholders with at least 25 percent share.

☐ 1.C. All other providers not covered by 1.A. or 1.B.

Name Carl Revuta MD

Doing Business As (DBA) Name N/A

Other Name

For additional names or addresses, please attach necessary pages

Physical Address (No PO Box Addresses)

Number Street	Suite	City	State	ZIP
3801 LAMAR BLVD AND 3003 BEE CAVES ROAD		AUSTIN, TX	TX	78756 & 78746

Accounting Address (PO Box or Street Address)

Number Street	Suite	City	State	ZIP
PO BOX 636018		CINCINNATI	OH.	45263-6018

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

☒ Billing Agent ☐ Management Company ☐ Employer ☐ Self ☐ Other (explain below)

Explain if "Other" was selected.

License Number and Issuer D1005

License Issue Date 8/18/63

License Expiration Date 2/28/07

Social Security Number [redacted]

Employer's Tax ID 75-2562784

Specialty of Practice EMERGENCY MEDICINE

Medicare Intermediary Trailblazer Health Enterprises

Medicare Provider Number 8D0344

Medicare Effective Date 12/15/2004

Driver's License Number and Issuer [redacted]

Driver's License Expiration Date [redacted]

Date of Birth 11/11/34

Gender ☒ M ☐ F

Previous Physical Address (No PO Box Addresses)

Number Street	Suite	City	State	ZIP

Previous Accounting Box Address (PO Box or Street Address)

Number Street	Suite	City	State	ZIP

NOT VALIDATED

Provider Information Form

List all physical locations where Medicaid services are rendered using noted TPI(s).

Do you plan to use a billing agent to submit your Medicaid claims?

☒ Yes ☐ No *If yes, provide the following information about the billing agent:*

Billing Agent Name	Address
IMBS, Inc.	2620 RIDGEWOOD RD. STE 300
Tax ID Number	
65-0622847	AKRON OH. 44313
Contact Person Name	Telephone Number
KATHLEEN LISTON	330-865-6060

List all Texas Medicaid TPIs under which you have billed in the past 12 months *(attach additional sheets if necessary):*

UNKNOWN

List all contractual relationships with medical entities and the TPIs of those entities *(attach additional sheets if necessary):*

N/A

Have you ever been excluded, debarred, or sanctioned from any state or federal program?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):*

Is your license currently suspended or restricted?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occured, and any adverse action against your license (attach additional sheets if necessary):*

NOT VALIDATED

Provider Information Form

Have you ever been convicted of a crime (excluding minor traffic citations)? ☐ Yes ☒ No

a) Conviction or Convicted — a judgment of conviction or deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding;
b) A person has been found guilty by a federal, state, or local court;
c) A person has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
d) A person has entered a first offender or other program and judgment of conviction has been withheld.

If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):

Are you currently behind 30 days or more on your child support payments? ☐ Yes ☒ No

If yes, provide details (attach additional sheets if necessary):

Laboratory – CLIA (Clinical Laboratory Improvement Act)

CLIA Certification Number* and approved specialty services: *Please enclose a copy of your CLIA Certificate*

N/A

Mammography Facility Certification

Radiation Control Certification Number: *Please enclose a copy of your Certification*

N/A

NOT VALIDATED

DCN: 200505900010479

Provider Information Form

THIS SECTION MUST BE COMPLETED, SIGNED, AND NOTARIZED BY ALL PROVIDERS

I certify that the above constitutes true and correct information. I agree to inform HHSC or its designee, in writing, of any changes, or if additional information becomes available.

Carl Pevoto

Signature of Provider

Carl Pevoto

Printed or Typed Name of Provider

Subscribed and Sworn before me, Sheila Foster a Notary Public for the State of Texas, on the 23rd day of February, 2005.

Sheila M Foster

Signature of Notary Public

Texas

State of

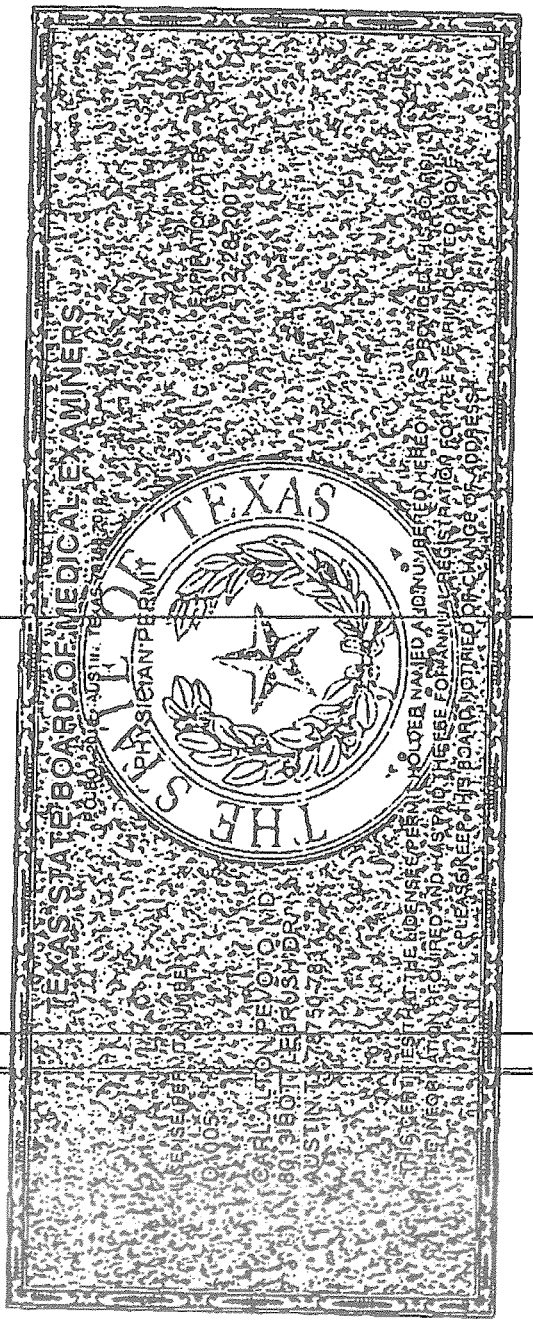
Notary Seal or Stamp

SHEILA M. FOSTER
Notary Public, State of Texas
My Commission Expires
September 24, 2008

MESSAGE TO NOTARY:
PLEASE BE SURE TO COMPLETE ALL OF THE BLANKS IN THIS NOTARY

MR23

Reminder: This form must have original signatures and be notarized before returning to TMHP.


THE STATE OF TEXAS
TEXAS STATE BOARD OF MEDICAL EXAMINERS
PHYSICIAN PERMIT

HHSC Medicaid Provider Agreement

Name of Provider H. BROOK RANDAL, MD *Medicaid Provider ID Number _____

Doing Business As _____ Medicare Provider ID Number 8D0346

Physical Address

3801 LAMAR BLVD AND 3003 BEE CAVES ROAD

AUSTIN, TX 78756 AND 78746
Mailing Address

PO BOX 636018

CINCINNATI, OH 45263-6018

* *Please list additional Texas Provider Identifiers (TPIs) on the Addendum Statement for this Agreement. New applicants should leave this space blank.*

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 **Agreement and documents constituting Agreement.**

A copy of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. Provider has a duty to become familiar with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state and federal laws and amendments governing and

1.2 **State and Federal regulatory requirements.**

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a–7), or Executive Order 12549. Provider has also not been excluded or debarred from participation in any other state or federal health care program. Provider must notify 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), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 C.F.R. Part 76, "Government–wide Debarment and Suspension (Non–procurement) and Government–wide Requirements

This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion–Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to HHSC or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 C.F.R. Part 76 by participants in lower tier covered transactions.

HHSC Medicaid Provider Agreement

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to the Texas Department of Health, Texas Health and Human Services Commission, Texas Department of Human Services, Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing 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, 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.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. § 431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. § 431.107 and copies of those records free of charge to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for five years from the date of service (six years for freestanding 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/or their agents access to its

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of the Inspector General, and internal and external auditors for the state/federal government and/or HHSC may conduct interviews of Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and their employees, witness, and clients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit and/or the Texas Health and Human Services Commission's Office of the Inspector General. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

HHSC Medicaid Provider Agreement

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 child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25% ownership interest is delinquent in any child support obligation. Provider must attach a list of the names, Social Security numbers, and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25% ownership interest in the Provider. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified grant, loan, or payment. (3) If 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% ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws 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 payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true and accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

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

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with 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. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a client for a covered service.

1.3.4 Federal 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 C.F.R. §447.20).

1.3.5 As a condition for eligibility for Medicaid benefits, a client assigns all rights to recover from any third party or any other source of payment to HHSC (42 C.F.R. §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (25 TAC Chapter 28), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 C.F.R. §447.15).

HHSC Medicaid Provider Agreement

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

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

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP 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.

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.

HHSC Medicaid Provider Agreement

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 children and pregnant women (CPW)
- 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 Public schools that are the sponsoring entity for a non-school SHARS provider are also required to reimburse HHSC, according to established HHSC procedures, the non-federal portion of expenditures made by HHSC. A non-public school SHARS provider must submit a letter from the sponsoring public school acknowledging this relationship and indicating that the public school understands that it will be billed for the state portion of the fee paid to the non-public SHARS provider.

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. TERM AND TERMINATION

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

Provider Signature H. Brook Randal Date 10/25/2005

H. Brook Randal

Printed Name and Title of Person Signing for Provider

Certification

THIS FORM IS REQUIRED FOR ALL APPLICANTS

ATTACHMENT 1

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor; "contract" refers to both contract and subcontract.
By signing and submitting this certification the potential contractor accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or the HHSC may pursue available remedies, including suspension and/or debarment.
2. The potential contractor will provide immediate written notice to the person to whom this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
3. The words "covered contract," "debarred", "suspended," "ineligible," "participant," "person," "principal," "proposal," and "voluntarily excluded," as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.
4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract? ☐ Yes ☒ No

5. The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.
6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.
7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

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

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

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

Name of Potential Contractor	Vendor ID or Social Security Number	HHSC Contract Number (If applicable)
H. Brook Randal	75-2562784	N/A

Signature of Applicant/Provider	Date	Printed Name and Title of person signing form
Brook Randal MD	10/24/03	Brook Randal, MD

NOT VALIDATED

Provider Information Form

☒ 1.A. All Groups, Partnerships, IPAs, Individual Practitioners, and Non-corporate Entities, including Associations, must complete this form before enrollment in the Texas Medicaid Program.

☐ 1.B. If you, the provider, are part of a corporation and this form is for one of the following individuals, including, but not limited to: Directors of Clinics/Facilities, Directors of Management Companies, and for each corporation, the following individuals: owners, officers, directors, and shareholders with at least 25 percent share.

☐ 1.C. All other providers not covered by 1.A. or 1.B.

Name: H Brook Randal

Other Name:

Doing Business As (DBA) Name: N/A

For additional names or addresses, please attach necessary pages

Physical Address (No PO Box Addresses) Number Street	Suite	City	State	ZIP
3801 LAMAR BLVD AND 3003 BEE CAVES ROAD		AUSTIN, TX	TX	78756 & 78746

Accounting Address (PO Box or Street Address) Number Street	Suite	City	State	ZIP
PO BOX 636018		CINCINNATI	OH	45263-6018

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

☒ Billing Agent ☐ Management Company ☐ Employer ☐ Self ☐ Other (explain below)

Explain if "Other" was selected.

License Number and Issuer: G3943

License Issue Date: 2/27/83

License Expiration Date: 5/31/05

Social Security Number: [redacted]

Employer's Tax ID: 75-2562784

Specialty of Practice: EMERGENCY MEDICINE

Medicare Intermediary: Trailblazer Health Enterprises

Medicare Provider Number: 8D0346

Medicare Effective Date: 12/15/2004

Driver's License Number and Issuer: [redacted]

Driver's License Expiration Date: [redacted]

Date of Birth: 2/15/51

Gender: ☐ M ☒ F

Previous Physical Address (No PO Box Addresses) Number Street	Suite	City	State	ZIP

Previous Accounting Box Address (PO Box or Street Address) Number Street	Suite	City	State	ZIP

NOT VALIDATED

Provider Information Form

List all physical locations where Medicaid services are rendered using noted TPI(s).

Do you plan to use a billing agent to submit your Medicaid claims?

☒ Yes ☐ No *If yes, provide the following information about the billing agent:*

Billing Agent Name	Address
IMBS, Inc.	2620 RIDGEWOOD RD. STE 300
Tax ID Number	
65-0622847	AKRON OH. 44313
Contact Person Name	Telephone Number
KATHLEEN LISTON	330-865-6060

List all Texas Medicaid TPIs under which you have billed in the past 12 months *(attach additional sheets if necessary):*

UNKNOWN

List all contractual relationships with medical entities and the TPIs of those entities *(attach additional sheets if necessary):*

N/A

Have you ever been excluded, debarred, or sanctioned from any state or federal program?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):*

Is your license currently suspended or restricted?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occured, and any adverse action against your license (attach additional sheets if necessary):*

NOT VALIDATED

Provider Information Form

Have you ever been convicted of a crime (excluding minor traffic citations)? ☐ Yes ☒ No

a) Conviction or Convicted — a judgment of conviction or deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding;
b) A person has been found guilty by a federal, state, or local court;
c) A person has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
d) A person has entered a first offender or other program and judgment of conviction has been withheld.

If yes, fully explain the details, including date, the state where the incident occurred, and any adverse action against your license (attach additional sheets if necessary):

Are you currently behind 30 days or more on your child support payments? ☐ Yes ☒ No

If yes, provide details (attach additional sheets if necessary):

Laboratory – CLIA (Clinical Laboratory Improvement Act)

CLIA Certification Number* and approved specialty services: *Please enclose a copy of your CLIA Certificate*

N/A

Mammography Facility Certification

Radiation Control Certification Number: *Please enclose a copy of your Certification*

N/A

NOT VALIDATED

Provider Information Form

THIS SECTION MUST BE COMPLETED, SIGNED, AND NOTARIZED BY ALL PROVIDERS

I certify that the above constitutes true and correct information. I agree to inform HHSC or its designee, in writing, of any changes, or if additional information becomes available.

Brook Randall MD
Signature of Provider

Brook Randall, MD
Printed or Typed Name of Provider

Subscribed and Sworn before me, Sheila Foster a Notary Public for the State of Texas, on the 24th day of February, 2005

Sheila M Foster
Signature of Notary Public

Texas
State of

Notary Seal or Stamp

SHEILA M. FOSTER
Notary Public, State of Texas
My Commission Expires
September 24, 2008

MESSAGE TO NOTARY:
PLEASE BE SURE TO COMPLETE ALL OF THE BLANKS IN THIS NOTARY

MR23

Reminder: This form must have original signatures and be notarized before returning to TMHP.

RECEIVED APR 29 2004

TEXAS STATE BOARD OF MEDICAL EXAMINERS

P.O. BOX 2018 • AUSTIN, TEXAS 78768-2018

PHYSICIAN PERMIT

LICENSE/PERMIT NUMBER
G3943

EXPIRATION DATE
05-31-2005

H BROOK RANDAL, MD
510 PARK BLVD.
AUSTIN TX 78751-4313

THIS CERTIFIES THAT THE LICENSEE/PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR ANNUAL REGISTRATION FOR THE YEAR INDICATED ABOVE.

PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS.