DCN: 200925100009330

Soren Vindekilde
Mailed 8/27/09

TEXAS MEDICAID PROVIDER ENROLLMENT APPLICATION

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP

A STATE MEDICAID CONTRACTOR

REV. XII

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 21.1 through 21.8 of the instructions.

Legend: * Medicare number required; O 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
- ☐ * Chiropractor
- ☐ * Community Mental Health Center
- ☐ * Comprehensive Health Center (CHC)
- ☐ * Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Consumer Directed Services Agency (CDSA)
- ☐ Dentist
- ☐♦ 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
- ☐ HCSSA
- ☐ Hearing Aid
- ☐ * Home Health
- ☐ *✚ Hospital — In-State
- ☐✚ Hospital Ambulatory Surgical Center (HASC)
- ☐✚ Hospital — Military
- ☐ *✚ Hospital — Out-of-State
- ☐♦ Hyperalimentation
- ☐ *✚ Independent Diagnostic Testing Facility
- ☐ *✚ Independent Lab
- ☐ Licensed Marriage and Family Therapist (LMFT)
- ☐ Licensed Professional Counselor (LPC)
- ☐✚ Maternity Service Clinic (MSC)
- ☐ MH Rehabilitation Services
- ☐O Occupational Therapist (OT)
- ☐ * *Optician*
- ☐ * Optometrist (OD)
- ☐ Personal Assistant Services
- ☐O Physical Therapist (PT)
- ☐ * Physician (MD, DO) *OB/GYN and Pediatricians not required to have a Medicare Number*
- ☐ * Physician Assistant
- ☐ * Physiological Lab
- ☐ * Podiatrist
- ☐ * Portable X-Ray
- ☐ * Psychologist
- ☐ * Radiation Treatment Center
- ☐ Radiological Lab
- ☐ *✚ Renal Dialysis Facility
- ☐ Respiratory Care Practitioner
- ☐ *✚ Rural Health Clinic – Hospital, Freestanding
- ☐ * Skilled Nursing Facility
- ☐O Social Worker (LCSW)
- ☐✚ SHARS — School, Co-op or School District
- ☐ SHARS — Non-School
- ☐ Service Responsibility Option (SRO)
- ☑✚ TB Clinic
- ☐♦ Vision Medical Supplier (VMS)
- ☐ Multi-Specialty Group

Case Management Services

- ☐✚ Early Childhood Intervention (ECI)
- ☐✚ MH Case Mgmt/MR Case Management
- ☐ MH Rehab
- ☐✚ Case Management for Children and Pregnant Women (CPW)
- ☐ Blind Children's Vocational Discovery & Development Program
- ☐ Women, Infants & Children (WIC) — Immunization Only

Comprehensive Care Services (CCP)

- ☐ Dietitian
- ☐ Licensed Vocational Nurse
- ☐ Occupational Therapist (OT)
- ☐ Pharmacy (please refer to the definition of Pharmacy in the Enrollment Requirements by Provider Type Section)
- ☐ Physical Therapist (PT)
- ☐ Registered Nurse
- ☐ Social Worker (LCSW)
- ☐ Speech Therapist (SLP)

Texas Health Steps (THSteps) Services (EPSDT)

☐ **I do not wish to participate as a provider for THSteps preventative medical check ups**

Texas Vaccines for Children Program

Do you currently receive free vaccines from the Texas Vaccines For Children Program?: ☐ Yes ☐ No *(if "no," please answer the next question.)*

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

☐ No ☐ Yes *(if "yes," complete pages 20.1 - 20.3 of this application to become a Texas Vaccines for Children provider)*

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Texas Medicaid Provider Enrollment Application

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

REQUESTING ENROLLMENT AS: ☑ Individual ☐ Group ☐ Facility ☐ Performing Provider

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* 1075541-01

***Please list ~~Group~~ NPI and Primary Taxonomy Code 1114144961 261QA0005X

***Group/Company, or Last Name	First	Initial	Title/Degree	Do you want to be a limited provider? (See page 4)
VindeKilde	Soren	J	MD	☐ Yes ☑ No

Provider business e-mail Soren.VindeKilde@cityofhouston.net

Business website address

***Telephone Number	Social Security Number (For Individual Enrollment Only)	Professional License Number Copy of License/Temporary License Required.	Professional License Issue Date MM/DD/YY	Professional License Expiration Date MM/DD/YY
713-928-9852	[redacted]	G2877	1982	11-30-09

Date of Birth MM/DD/YY	Medicare Intermediary	Medicare Number	Medicare Certification Date MM/DD/YY
[redacted]			

Employer's Tax ID No.	***Legal Name According to the IRS (Must match the legal name field on the W-9 & page 11.1)	***Primary Specialty
74-6001164	City of Houston	Sub-Specialty

***Physical Address — *Where healthcare services are rendered.*

Number	Street	Suite	City	State	ZIP
7037	Capitol		Houston	TX	77011

***Accepting New Clients? (yes or no)	***Counties Served	***Client Age Restrictions	*** Gender Limitations

Accounting/Billing Address — *Where provider information is to be sent.*

Number	Street	Suite	City	State	ZIP
P.O. Box 88361			Houston	Tx.	77288-8861

Physical Address Fax Number

Accounting/Billing Address Fax Number 713-798-0803

Group Medicare Number: **OR Group Texas Medicaid TPI:**

***Mandatory Field

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Facilities Only:

Is this a freestanding facility?	☐ Yes	☐ No
Is this a hospital-based facility?	☐ Yes	☐ No
Is this an ESRD facility?	☐ Yes	☐ No
If yes, what is your composite rate?		

Hearing Aid Providers Only:

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

School Health and Related Services (SHARS) Providers Only

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 enrolling as a **school district?**	☐ Yes	☐ No
If yes, give school six-digit T.E.A. number:		
	☐ Yes	☐ No
Are you enrolling as a **non-school SHARS provider?**		
If yes, please attach school affiliation letter		

Hospital Providers Only

Are you a hospital facility?	☐ Yes	☐ No
If yes, indicate the type of hospital facility.	☐ Children's ☐ Long Term ☐ Private Full Care ☐ Psychiatric ☐ State Owned	☐ Teaching Facility ☐ Short Term ☐ Private Outpatient ☐ Rehabilitation
If yes, what is your average daily room rate for private and semi-private?	Private	Semi-Private

Public/Non-Public Providers (required by all 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 or public entity?	☐ Private	☑ Public
If yes, are you required to certify expended funds?	☐ Yes	☑ No
Name and address of a person certifying expended funds:		

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Do not Complete for Individual enrollment

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

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

Name	Title	Social Security Number	Date of Birth MM/DD/YY	Drivers License Number	% Owned

SECTION C—GROUP PRACTICE *Required if enrolling as a GROUP PRACTICE*

Indicate the type of group enrollment you are requesting by checking one of the following:

- ☐ Adding additional performing provider(s) to an existing group *(Indicate Group TPI below)*
- ☐ Enrolling a new group with performing provider(s)

Group 9-digit Texas Medicaid TPI **OR** **Group Medicare Number *(if applicable)***

List All Providers That Will Be Performing Services as Part of This Group

Name	Date of Birth MM/DD/YY	Professional License Number	Professional License Issue Date MM/DD/YY	Social Security Number	Medicare Number	Title/ Degree

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

Texas Medicaid Provider Enrollment Application

SECTION D — *REQUIRED INFORMATION for Specific Provider Types*

All Licensed Providers	If enrolled with Medicare, you must attach a copy of a current Medicare Remittance Advice Notice (MRAN).
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/FQS/FQHL	You must attach a copy of your grant award.
Mammography Services Providers	You must attach a copy of your mammography systems certification 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 Children and Pregnant Women 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 affiliation letter from the school district. Requirements of a valid affiliation letter are found in the *Texas Medicaid Provider Procedures Manual*, School Health and Related Services (SHARS) section.
Out of State Providers	You must submit proof of meeting one of the following criteria prior to being able to enroll with the Texas Medicaid program: o Services are more readily available in the state where the client is temporarily located o The customary or general practice for clients in a particular locality is to use medical resources in the other state (this is limited to providers located in a state bordering Texas). The following are subject to a 90 day enrollment: o A medical emergency documented by the attending physician or other provider o The client's health is in danger if he or she is required to travel to Texas o All services provided to adopted children receiving adoption subsidies (these children are covered for all services, not just emergency). o Other out-of-state medical care may be considered when prior authorized. o Medicare primary, Medicaid secondary for coinsurance and/or deductible payments only Refer to the Texas Provider Procedures Manual at www.tmhp.com for further information regarding out of state enrollment.

HHSC Medicaid Provider Agreement

Name of Provider Sonan John Vindekoda TPI Number 1075541-01

Medicare Provider ID Number _____

Physical Address 7037 Capitol

Accounting/Billing Address (if applicable) City of Houston Health + Human Services
P.O. Box 88361, Houston, TX 77288-8861

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

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

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

1.2 State and Federal regulatory requirements.

1.2.1 By signing this agreement, Provider certifies that the provider and it's principals have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal contracting. Provider further certifies that the provider and its principals have also not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal healthcare program. Provider must notify the Health and Human Services Commission (HHSC) or its agent within 10 business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal contracts and grants.

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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 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Texas Attorney General's Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, at least 10 business days before making such changes. Provider also agrees to notify HHSC or its agent within 10 business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to HHSC complete information related to any such suspension or restriction.

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

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

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

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1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to grant Medicaid recipients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the Medicaid program for Medicaid recipients and discounted services to the general public must not be billed to Medicaid for a Medicaid recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

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

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in court-ordered child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25 percent is not eligible to receive the specified grant, loan, or payment. (3) If HHSC is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records..

1.3 Claims and encounter data.

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

1.3.2 Provider must submit encounter data required by HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with HHSC rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by HHSC for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that HHSC is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement

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

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

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

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

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, and receive electronic claim status inquiries, remittance and status (R&S) reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic R&S report. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to HHSC or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from HHSC, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

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

II. ADVANCE DIRECTIVES – HOSPITAL AND HOME HEALTH PROVIDERS

2.1 The client must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

2.1.1 the individual's right to self-determination in making health care decisions;

2.1.2 the individual's rights under the Natural Death Act (Health and Safety Code, Chapter 672) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;

2.1.3 the individual's rights under Health and Safety Code, Chapter 674, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

2.1.4 the individual's rights to execute a Durable Power of Attorney for Health Care under the Civil Practice and Remedies Code, Chapter 135, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

2.2 The Provider must have a policy regarding the implementation of the individual's rights and compliance with state and federal laws.

2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the client has or has not executed an advance directive.

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

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

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III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

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

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

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

IV. CLIENT RIGHTS

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

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

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

V. THIRD PARTY BILLING VENDOR PROVISIONS

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

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

- Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.
- Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.
- Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients.
- Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or it's contractor.

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- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program.
- Biller agrees to enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.
- Biller and Provider agree to notify the Medicaid program within 5 business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

VI. TERM AND TERMINATION

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

VII. ACKNOWLEDGEMENTS AND CERTIFICATIONS

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

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

MR12

Provider Signature A J Vindeheer Date 8-14-07

Soren John Vindeheer, MD
Printed Name

DCN: 200925100009330

Provider Information Form (PIF-1)

Each Provider must complete this Provider Information Form (PIF-1), before enrollment. A provider is any person or legal entity that meets the definition below.

Each Provider must also complete a Principal Information Form (PIF-2), for each person who is a Principal of the Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of the Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

The Provider or provider's duly authorized representative must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement.

"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a provider agreement or contract in force with a Medicaid operating agency, and who has a provider number issued by the Commission or their designee to:

(1) provide medical assistance, Medicaid, under contract or provider agreement with the Commission or its designee; or
(2) provide third party billing services under a contract or provider agreement with the Commission or its designee

A "Third-Party Biller" is a type of "Provider" under the above definition and is a person, business, or entity that submits claims on behalf of an enrolled health care provider, but is not the health care provider or an employee of the health care provider. For these purposes, an employee is a person for which the health care provider completes an IRS Form W-2 showing annual income paid to the employee.

Last, First, Middle Name OR Group/Company Name **Maiden Name**

Vindekilde, Soren John

List any other Alias, Name or Form of your name ever used **National Provider Identifier (NPI) (10 digit)**

1114144961

Primary Taxonomy Code (10 digit)

261QA0005X

Secondary Taxonomy Code (10 digit)

The provider may indicate up to 15 taxonomy codes; please attach additional pages if needed.

Non Texas Enrolled Taxonomy Codes

207V00000X

For additional names or addresses, please attach necessary pages.

Physical Address

Number	Street	Suite	City	State	ZIP
7037	Capital		Houston	TX	77011

Accounting/Billing Address

Number	Street	Suite	City	State	ZIP
P.O. Box 88361			Houston, TX	77288-8861	

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

☐ Third Party Biller ☐ Management Company ☑ Employer ☐ Self ☐ Other *(explain below)*

Explain if "Other" was selected.

DCN: 200925100009330

Provider Information Form (PIF-1)

Professional Licensing board, Professional License Number, and State

G2877

Professional License Initial Issue Date MM/DD/YY

1982

Professional License Current Expiration Date MM/DD/YY

11-30-2009

Social Security Number

[redacted]

Employer's Tax ID

74-6001164

Specialty of Practice (Example: Pediatrics, General Practice, etc.)

Ob/Gyn

Medicare Intermediary

Medicare Provider Number

Medicare Effective Date MM/DD/YY

Driver's License Number

[redacted]

State Issuer

[redacted]

Driver's License Expiration Date MM/DD/YY

[redacted]

Date of Birth MM/DD/YY

[redacted]

Gender

☒ M ☐ F

CLIA Number (attach a copy of the CLIA certification)

45D0660081

CLIA Address (list the address listed on the CLIA Certificate)

Number	Street	Suite	City	State	ZIP
1115	South Breaswood		Houston,	TX.	77030-1715

Previous Physical Address

Number	Street	Suite	City	State	ZIP

Previous Accounting/Billing Address

Number	Street	Suite	City	State	ZIP

Do you plan to use a Third Party Biller to submit your Medicaid claims?

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

Billing Agent Name

Address

Tax ID Number

Contact Person Name

Telephone Number

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/Atypical Provider Identifier (API) or TPI of each Provider or entity *(attach additional sheets if necessary)*:

N/A

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.

Have you ever been sanctioned (as defined above) in any state or federal program?

☐ Yes ☒ No *If yes, fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected (attach additional sheets if necessary):*

Provider Information Form (PIF-1)

Provider Information Form (PIF-1)

Is your professional license or certification currently revoked, suspended or otherwise restricted? ☐ Yes ☒ No

Have you ever had your professional license or certification revoked, suspended, or otherwise restricted? ☐ Yes ☐ No

Are you currently or have you ever been subject to a licensing or certification board order? ☐ Yes ☒ No

Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? ☐ Yes ☒ No

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described below, and which includes deferred adjudications and all other types of pretrial diversion programs. (You may be subject to a criminal history check.)

Convicted means that:

(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

(1) There is a post-trial motion or an appeal pending, or

(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

☐ Yes ☒ No *If yes, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of (attach additional sheets if necessary):*

Are you currently behind 30 days or more on court ordered child support payments?

☐ Yes ☒ No *If yes, provide details (attach additional sheets if necessary):*

Are you a citizen of the United States?

☒ Yes ☐ No

If no, of what Country are you a citizen?

If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.

DCN: 200925100009330

TEXAS MEDICAL BOARD

IDENTIFICATION CARD

LICENSE/PERMIT NUMBER	EXPIRATION DATE
G2877	11-30-2009

SOREN JOHN VINDEKILDE, MD
3014 APPLE VALLEY LANE
SOREN JOHN VINDEKILDE, MD
3014 APPLE VALLEY LANE
MISSOURI CITY TX 77459-3117

PHYSICIAN PERMIT

DCN: 200925100009330

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: City of Houston

Business name, if different from above:

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

Address (number, street, and apt. or suite no.): P.O. Box 1562

City, state, and ZIP code: Houston, TX 77251

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: 74-6001164

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: [signature] Date: 11/15/04

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

DCN: 200925100009330

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS
BUREAU OF LAB SVC HOUSTON DEPT OF HLTH
& HUMAN SVCS
1115 SOUTH BRAESWOOD
HOUSTON, TX 77030-1715

CLIA ID NUMBER
45D0660081

EFFECTIVE DATE
08/11/2006

EXPIRATION DATE
08/10/2008

LABORATORY DIRECTOR
DAVID L MASERANG, PHD

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

193 cms2_012-07

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective dates

LAB CERTIFICATION (CODE)	EFFECTIVE DATE	LAB CERTIFICATION (CODE)	EFFECTIVE DATE
BACTERIOLOGY (110)	08/11/1994		
MYCOBACTERIOLOGY (115)	08/11/1994		
MYCOLOGY (120)	08/11/1994		
PARASITOLOGY (130)	08/11/1994		
VIROLOGY (140)	08/11/1994		
SYPHILIS SEROLOGY (210)	08/11/1994		
GENERAL IMMUNOLOGY (220)	08/11/1994		
ROUTINE CHEMISTRY (310)	08/11/1994		
TOXICOLOGY (340)	08/11/1994		
HEMATOLOGY (400)	08/11/1994		
ABO & RH GROUP (510)	08/11/1994		
ANTIBODY NON-TRANSFUSION (530)	08/11/1994		
ANTIBODY IDENTIFICATION (540)	08/11/1994		

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE