## DOCUMENT VERIFICATION SHEET

Provider #:
Initials:
Date:
Checklist for Groups of Physicians
Enrollment Application for groups of physicians
If other than groups of physicians:
Enrollment Application
Provider Agreement
Disclosure of Ownership Statement
If Corporation:
Board of Directors Resolution
Certificate of Incorporation or Authority
Letter of Good Standing if not exempt (501C)

NHIC

National Horitage Insurance Co. 7600 Stoa. Creek. Boulevard Suite 100E Austin. Texas 78757 (512; 455 5111 Austin. Texas 78757 (512; 455 5111

Dec. 6, 1985

City of Houston Health Dept.

1115 N. Mac Dregoi RM. 130

Houston Dr. 77030

Re: Family Planning Agency Group Number 2000 P 4386

Dear Agency Provider:

He have completed the enrollment of strong h. Vendoruse and have added him to your group of practicing physicians. His Medicaid and have added him to your group of practicing physicians. His Medicaid and is effective performing Identification number is Psus 18010 and is effective as coordinated with the date of his provider agreement. Please remember to use this number to identify the performing physician in block 24-F on your claim form. Thank you.

Sincerely,

Kimberly Walker
Kimberly Walker

Provider Enrollment

## FAMILY PLANNING SERVICE AGREEMENT BETWEEN

DEC 02 1985.

City of Houston Health & Human Services Department

## AND

2	
Soren John Vindekilde , M.D.	
City of Houston Health and Human Services Department	
hereinafter referred to as the Agency, and S John Vindekilde	
, M.D., a physician duly licensed to practice medicine by the State Board of Medical Examiners for the State of Texas, hereinafter referred to as the Doctor, hereby enter into the following agreement:	í

The parties hereto understand and agree that the Agency is to provide services under the provisions of the Title XIX Family Planning Program and that claims for such services provided are to be submitted by and paid to the Agency. As a staff physician of the Agency, the undersigned Doctor hereby agrees that:

- A. The Agency shall collect all claims under the Title XIX Family Planning Program for services provided by me to patients for the Agency.
- B. If in any case, a claim or claims are filed by me or payment received by me under the Title XIX Family Planning Program for services provided to patients for the Agency, I will promptly turn over all the proceeds from any such claim received to the Agency.

This agreement is to be considered an addendum to my staff service agreement with the Agency in exactly the same manner as had it constituted a part of our initial understanding.

Executed this	lst	day of	September	, 19_85
	Ci	ty of Hou <u>sto</u>		Human Services Department e of Agency
		BY	Margo	A. Sillines (180).
		Assi	stant Directo	or, Personal Health Services Title
		× <u> </u>	1 Solas	Cirlehoso, M.D.
		×	G287 Li	7 cense Number
		_	1-04	

Z 000 P 4386

Group Provider Number