August 6, 2001

N.H.I.C.
Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795

To Whom It May Concern:

Please make the following changes to my provider # 1387606403. These changes will be effective 8/24/01.

Tax ID #:

Accounting Address: "Pay to"
P.O. Box 687
Keene, TX 76059

Respectfully,

Physician

Provider Information Change Form

Complete this form to update your provider files. Fax the completed form or mail to the appropriate entity. PLEASE PRINT OR TYPE THE INFORMATION SUBMITTED ON THIS FORM.

Date: 8/27/01 Nine-digit Medicaid provider number: 138716b403

If you have more than one Medicaid number that will also be using this same information, list the other provider numbers: _____

Physical Address (Cannot be a PO Box)	Accounting/Mailing Address (W-9 Form Required)	Secondary Address (Plan Use Only)
_____	PO Box 1087	_____
_____	Keene, TX 76059	_____
_____	_____	_____
_____	(800) 962-3303	_____
Telephone	Telephone	Telephone
_____	N/A	_____
Fax	Fax	Fax

Type of Change: (please check the appropriate box below)

- ☐ Change of Physical Address, phone and/or fax number
- ☒ Change of Billing/Mailing Address, phone and/or fax number
- ☐ Change/Add Secondary Address, phone and/or fax number
- ☐ Change of Provider Status (i.e., termination from plan, moved out of area, specialist, etc.). Please Explain
- ☒ Other (i.e., panel closing, capacity changes, age acceptance, etc.)

Explanation Required:

Change of Billing Agency
Medical Consultants, Inc.
dba Emergency Physicians Billing Services (EPBS) 3303 S. Meridian Okla. City, OK 73119

Tax Information: IRS ID Number (attach W-9) _____ Effective Date 8/25/01

List the exact name reported to the IRS for the above Tax ID number:

Must be signed and dated or changes cannot be completed:

Provider Signature: X _____ Date: 8/20/01

E-mail Address: N/A

Send your completed change form to:

NHIC
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720-0795
FAX: 512-514-4214

If Managed Care, please send this form via mail or fax to NHIC c/o your respective plan.

Medical Consultants, Inc.. Master Billing Services Agreement
CLIENT: Huguley Emergency Physicians, LLP
Effective Date of Agreement: August 1, 2001

PROVIDER BILLING SERVICE AGREEMENT
(Non-Reassignment)

THIS PROVIDER BILLING AGREEMENT ("Agreement") is hereby executed by and between Medical Consultants, Inc d.b.a. Emergency Physicians Billing Services ("EPBS") and Philip C. Abel, MD **("Provider").**

1. **Certification:** Provider hereby certifies that he/she is a licensed provider of professional medical services and retains appropriate credentials.

2. **Authorization:** Provider hereby authorizes EPBS to act as Provider's exclusive billing service and related business address for professional fees for the location referenced herein, including executing claims for payment on Provider's behalf when required. Additionally, EPBS is authorized to receive copies of all of Provider's patient charts for the location referenced herein.

3. **Provider Responsibilities:** Provider shall:
   3.1. Sign charts of all patients who have received professional services from Provider.
   3.2. Be solely responsible for the accuracy of all patient information, examinations, and procedures recorded by provider on the patient chart.
   3.3. Document accurately and completely the medical services for which reimbursement is sought.
   3.4. Follow proper documentation and medical necessity requirements for federal and state programs.
   3.5. Refrain from submitting false or inaccurate information, documentation or records to EPBS.
   3.6. Notify EPBS in writing within 30 days of determining credible evidence of misconduct on the part of EPBS.

4. **EPBS Responsibilities:** EPBS shall:
   4.1. Submit third party payer claims
   4.2. Mail statements to patients
   4.3. Process payments for professional services
   4.4. Arrange that all government payments, including Medicare, Medicaid and/or CHAMPUS shall be deposited to a lockbox bank account wholly owned and controlled by Provider, as required by the payor. EPBS has no control of, or signature privileges for this account. All billing fees related to Medicare, Medicaid and/or CHAMPUS billing services are paid from these payments. Nothing in this Agreement shall prohibit the Provider from modifying or revoking payment disposition instructions at any time.
   4.5. Arrange that non-government payments for professional fees billed under this agreement and made payable to Provider shall be deposited to a Huguley Emergency Physicians, LLP lockbox bank account. All billing fees related to these services are paid from these payments.
   4.6. Provide access to all Medicare billing and remittance information and act only on behalf of the Provider.
   4.7. Comply with the requirements of law and with all applicable ordinances, statutes, regulations, directives, orders and other lawful enactments or pronouncements of any federal, state or other lawful authority.

5. **Effective Date:** The date of this Agreement is effective for Dates of Service beginning 8/25/01.

6. **Term:** This Agreement shall remain in effect for a term of one (1) year ("Initial Term") and shall automatically renew for additional successive terms of one (1) year each ("Renewal Term") unless one party notifies the other party in writing of its intent to terminate the Agreement. The termination of this Agreement shall not affect the payment obligations of the Provider/Client with respect to the services provided by EPBS prior to the effective date of termination.

Provider (Print): Philip C. Abel MD

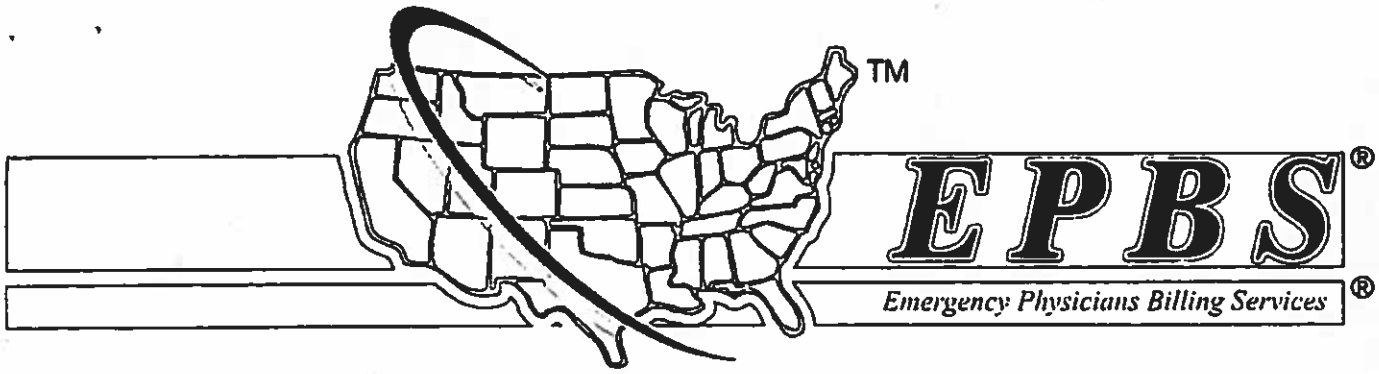
Address: 4380 Red Bird Lane, Burleson, Tx 76028

Phone: 817-568-9091 **SS #:**

Hospital Location: HUGULEY MEMORIAL MEDICAL CENTER

Signature: X _____ **Date:** 3/20/01
Provider Authorization

Signature: _____ **Date:** 8/23/01
Medical Consultants, Inc. (EPBS) Authorization



September 10, 2001

N.H.I.C.
Attn: Provider Enrollment
11044 Research Blvd., Bldg. C
Austin, TX 78759-5239

To Whom It May Concern:

Enclosed you will find the following for Philip C. Abel, M.D.:

- Completed Electronic Funds Transfer (EFT) Form
- Confirmation of individual bank account
- Provider Billing Service Agreement authorizing EPBS to act as the exclusive billing service

Please make the necessary provisions for electronic funds transfers to begin immediately for this provider.

If you have any questions, please call.

Respectfully,

Angela Gray

Angela Gray
Client Services

Enclosures

Received
SEP 13 2001
Provider Enrollment

P.O. Box 96408 • Oklahoma City, Oklahoma 73143
3303 South Meridian • Oklahoma City, Oklahoma 73119
(800) 962.3303 • Local (405) 682.3303 • Fax (405) 682.1586 • www.epbs.com

First State Bank

August 23, 2001

To Whom It May Concern:

This letter is to confirm that a checking accoun[illegible]s been opened in the name of Phillip C. Abel, M.D., P.A..

Thank you,

Stefanie McBroom
New Accounts Supervisor

P.O. Box 676 • Keene, Texas 76059 • (817) 645-8861 • Fax (817) 556-0335
1403 W. Henderson • Cleburne, Texas 76031 • (817) 641-1500 • Fax (817) 202-4210
P.O. Box 965 • Joshua, Texas 76058 • (817) 558-2700 • Fax (817) 556-3775
www.keenebank.com
Member FDIC

PointOne Physician Services

fostering medical partnerships

Fax Transmittal Form

To Jim Patterson Organization Name/Dept: DHC CC: Phone number: Fax number: 512-514-4214	**From** Barbara George Credentialing Representative Phone: 817-551-2721 or 568-5369 Fax: 817-568-5545 Email: BGeorge@AHSS.ORG
☒ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply	Date sent: 08-28-00 Time sent: Number of pages including cover page:

Message:

Jim, attached is Dr. Abel's Disclosure of Ownership and a W-9.

Please – can you e-mail me his number & effective date today?

TY
Barbara

11907 Med Park Drive P.O. Box 607 Burleson, TX 76097 Voice: 817-551-2721 Fax: 817-568-5545 email: pointonephysician@mindspring.com

Disclosure Of Ownership And Control Interest Statement

I. Identifying Information

(a) Name of Entity	D/B/A	Telephone No.		
Philip C. Abel, M.D. P.A.		(817) 551-2721		
Street Address		**City, County**	**State**	**Zip Code**
P.O. Box 99333		Ft. Worth Tarrant	Texas	76199-0333

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

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 11-2. Identify each item number to be continued.

(a). Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 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 or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest attached page 10.) List any additional names and addresses under "Remarks" on Page 11-2. 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
	NONE	

(b) **Type of Entity: (ONLY ONE ENTITY MUST BE CIRCLED)**

☒ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated ☐ Associations ☒ Other P.A.

Please Note:
When Claiming "Corporation" Providers Must Complete And Return The Following Forms:

- Corporate Board Of Directors Resolution Form (Attached, Pg. 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 Requester. Callers Must Have The Taxpayer's Name, Taxpayer Identification Number, And Charter Number Available At The Time Of The Request.
If Corporation Has A 501c Internal Revenue Exemption, Letter Of Good Standing Is Not Required. Please Indicate This By Signing Below:

Philip C. Abel, M.D., P.A.
Corporate Name

Signature

Philip C. Abel, M.D.
Name (Written/Typed)

08-25-2000
Date

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations in remarks.
REMARKS:

N/A

Check appropriate box for each of the following questions

(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.) If yes, list names, addresses of individuals, and provider numbers. ☐ Yes ☒ No

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 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 EIN #

Address

(b) If the answer to Question VII.a. is "No", was the facility ever affiliated with a chain? ☐ Yes ☒ No
(If YES, list Name, Address of Corporation and EIN)
Name EIN #

Address

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 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 Th Secretary, As Appropriate.

Name of Authorized Representative (Typed)	Title
Philip C. Abel, M.D.	M.D.

Signature 

Date 08-25-2000