Physician Optimal Network Incorporated

January 2026

Dear PONI Member:

Happy New Year! Thank you for your continued participation with PONI, the largest association of independent physicians in Parker, Johnson and Hood counties. In 2026 you will see PONI continue to grow our membership outside of North Texas, adding new Agreements and Value Based Contracting opportunities for all our Members.

- ✓ "One-Stop Shop" Credentialing, Enrollment and Contracting Services
  - Health Plan Credentialing and Enrollment
  - Medicare, Medicaid Enrollment and Re-attestation
  - Individual Health Plan Contracting and Credentialing Enrollment for Plans not available through your PONI association (including Baylor Scott & White Health Plan, BCBS, UnitedHealthcare, and others).
- ✓ *PONI offers access to over 65 managed care product agreements* through our Messenger Model "opt-in" process, and our agreement with Catalyst allows PONI to support direct contracting and credentialing with any Health Plan not available through your PONI Membership.
- ✓ If you need a contract not already available through PONI, our staff is available to assist you with individual payor contracting needs. Just give us a call or email provider relations to let us know what contracts you need.
- ✓ Medicare, Medicaid, and Direct Contracting Services are also available by request for an affordable flat rate fee.
- ✓ PONI has also partnered with independent insurance agents to offer high coverage, low-cost access to health insurance through https://lifexresearch.com/. For employers with 2-50 employees, as well as for individuals seeking coverage, LifeX Research provides an excellent option. For details and a quote, contact PONI Provider Relations for more information.
- ✓ We launched the revised PONI website in 2025, with updated capabilities for online payment of PONI fees, access to the PONI provider directory, and a calendar of upcoming PONI events to support providers and their office managers. Be sure to check https://poninetwork.com when you need information about your Plan Participation or to locate other PONI Member for Patient Referrals.

Thank you for your dedication to providing care for the members of our community. We look forward to a successful and prosperous year in 2026!

Sincerely,

Susie White
President

Physician Optimal Network, Inc.
%Cypress Healthcare Consultants
500 N Central Expressway, #500
Plano, Texas 75074
(972) 424-1360

Physician Optimal Network Incorporated

500 N Central Expressway, Suite 500
Plano, Texas 75074

PONI RATE CARD

Calendar Year 2026

Menu of Available Services and Fees

SERVICES AND FEES	PONI
Annual Membership Dues	$1050.00 for MD, DO, DC, DPM, OD $ 850.00 for non-physician providers
Non Refundable Initial Credentialing Application Fee	$725.00 for MD, DO, DC, DPM, OD $565.00 for non-physician providers
Non Refundable Recredentialing Fee (Triennial) – all Provider types	$550.00
Expedited Credentialing Fee (in addition to base credentialing fee)*	$225.00
Expedited Recredentialing Fee (in addition to base recredentialing fee)**	$225.00
Credentialing Reactivation Fee	$225.00
Medicare Enrollment	$535.00
Group Medicare Enrollment	$535.00
Medicaid Enrollment	$535.00
Group Medicaid Enrollment	$535.00
Bundled (CMS/Medicaid)Enrollment	$795.00
Group Bundled (CMS/Medicaid)Enrollment	$795.00
Single Health Plan Contracting (for contracts not available thru PONI) Contract Negotiation/Procurement	$795.00 (includes individual credentialing for one (1) provider) Additional providers may be added to the Agreement and credentialed individually for $380 per provider.

*Upon Provider's Request.

**Expedited Recredentialing Fee will be charged in the event provider's documentation for recredentialing is received by the Credentialing staff with fewer than twenty (20) business days to process prior to the deadline for submission to Committee. Failure to be recredentialed according to the Health Plan schedule will result in termination from Health Plan(s).

Application to and Membership in PONI does <u>not</u> guarantee participation in Managed Care Networks, which apply varying rules of eligibility based on the product/network type (Commercial, Medicare, Medicaid, Worker's Compensation, etc.)

Physician Optimal Network Incorporated

500 N Central Expressway, Suite 500
Plano, Texas 75074

PONI FEES AND INVOICING
Payment Schedule for 2026

Annual Membership Dues

PONI continues to focus on minimizing the cost of services. The amortized cost of membership for Physician Members is $87.50 per month, and $70.83 per month for mid-level providers. When fees are paid annually (according to the schedule below), fees are discounted an additional 10%.

- ✓ *Late payment (defined as payment outside of the thirty-one (31) day invoice/payment date), will be assessed a 5% late fee.*
- ✓ Payment past due by sixty-one (61) days or more may result in termination from PONI network and all contracted Health Plans and Networks. Past due by ninety (90) days will result in termination from PONI and all contracted Health Plans and Networks. Multiple warnings are provided in advance of termination to ensure Members have notice of removal.
- ✓ When a Provider is terminated from PONI, he/she is terminated from *all health plans accessed through PONI.*

Member Dues and Payment Schedule	**Amount**	**Due By or Before**
Annual Dues for Physician Members (annual)	$ 945.00*	02/06/2026
Annual Dues for Physician Members (semi-annual)	$ 525.00	02/06/2026
	$ 525.00	08/07/2026
Annual Dues for Non-Physician Members (annual)	$ 765.00*	02/06/2026
Annual Dues for Non-Physician Members (semi-annual)	$ 425.00	02/06/2026
	$ 425.00	08/07/2026

*Reflects 10% discount for payment of annual dues, by due date.

Credentialing and Other Fees

Non Refundable Initial Credentialing Physician	$ 725.00	At time of service
• Non-Physician	$ 565.00	At time of service
Non Refundable Recredentialing Fees (triennially)	$ 550.00	At time of service
Expedited Credentialing Request by Provider	$ 225.00	At time of service
***Re-activation** of a Closed Credentialing File (Per Provider)	$ 225.00	At time of service

1. A maximum of three (3) follow-up attempts will be made to collect missing information (including payment) from the Applicant Provider.
2. If an Application remains incomplete following the 3rd attempt, the file will be CLOSED, and the incomplete packet returned to the Applicant. A re-activation fee will be required to re-open the file.
3. *Applications **cannot** be processed without payment, or if they are incomplete in any element.*

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Physician Optimal Network Incorporated

Payment Form – ACH, Credit Card, Check - Physician Optimal Network, Inc. (PONI)

500 N Central Expressway, Suite 500
Plano, Texas 75074
P: (469) 661-0771 F: (469) 757-8883

INVOICE #: _____

Pay By (Check One): ☐ **CHECK** ☐ **ACH** ☐ **CREDIT CARD**

Paying by Check:

Date:_____ Check number:_____

Please Make Checks Payable to: Physician Optimal Network, Inc.

Paying by ACH or Credit Card (Visa, MC, Discover, Am Ex):

I,_____, authorize Physician Optimal Network, Inc. (PONI) to
(Name Must be Printed Here)
charge the following total amount to the credit card / bank account listed further below:

$_____ Description:_____

Please include the total dollar amount authorized and describe what you are submitting payment for.

Confirm Frequency: ONE TIME Payment: ☐ RECURRING Payment/"Auto-Pay": ☐
(Recurring payment frequencies:
***PONI membership dues** – 2 times a year, every 6 months (Jan-June & July-Dec), or if annual, then 1 time a year.*
***Recredentialing fees** – 1 time every 3 years when providers are due for PONI recredentialing.)*

ACH Information:
Account Type: Checking: ☐ Savings: ☐

Bank Name: _____ Name on Account: _____

Account #: _____ Routing #: _____

Credit Card Information:
Type of Card (Visa, MC, Discover, Am Ex):_____ Card Number: _____

Name on Card:_____ Exp Date:_____ 3-Digit Code (CVV): _____
PRINT NAME (4-Digit for Am Ex)

Billing Address:_____ Zip Code: _____

By my signature hereto, I affirm my understanding and agreement I will be charged upon receipt of signed credit card/ACH agreement, and this authorization will remain in effect until I cancel it in writing. I agree to notify PONI in writing of any change in my account information or termination of this authorization at least 15 days prior to the next billing date, if applicable. I agree not to dispute this billing with my bank so long as the transaction corresponds to the terms indicated in this authorization form.

Email Address:_____ Phone:_____

Signature:_____ Date:_____

Physician Optimal Network Incorporated

500 N Central Expressway, Suite 500
Plano, Texas 75074
https://poninetwork.com



Direct Health Plan Contracting and Credentialing Services

PONI is pleased to offer a new service for Direct Health Plan Contracting and Credentialing. This service is available to PONI Members as well as to Providers in the community that are not Members of PONI.

- Requesting our assistance with director contracting and credentialing is very simple, requiring only the completion of this Service Request Form and payment of a project deposit.

Group Name (if applicable)	Provider Name(s)	Specialty(ies)	Individual and/or Group TIN	Name(s) of Health Plan to Contract

Professional Fees:

Contract Procurement + Individual Credentialing for one (1) Provider $795.00
Credentialing for additional (beyond the included 1 Provider) $380.00 each

Totals for this Request:

Number of Health Plan or Health Network Agreements Requested: _____
Number of Providers to Include in Contracting/Credentialing: _____

Project Fees: $_____ Deposit $_____

Approved by: _____ _____
Client Signature PONI Management
Project Start Date: _____

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500 N Central Expressway, Suite 500
Plano, Texas 75074
https://poni.network.com



Medicare and/or Medicaid Enrollment Services

PONI is pleased to offer a new service for Medicare and/or Medicaid Enrollment Services. This service is available to PONI Members as well as to Providers in the community that are not Members of PONI.

- Requesting our assistance with Medicare and Medicaid Enrollment is very simple, requiring only the completion of this Service Request Form and payment of a project deposit.

Group Name (if applicable)	Provider Name(s)	Specialty(ies)	Individual and/or Group TIN	Service Requested (Medicare, Medicaid, Group or Individual, or both Medicare/Medicaid)

Professional Fees:

Medicare or Medicaid Enrollment for one (1) Provider	$535.00
Medicare or Medicaid Enrollment for Group	$535.00
Bundled Medicare/Medicaid Enrollment for Individual or Group	$795.00 each

Totals for this Request:

Number of Providers to Include for Enrollment: _____

Type Enrollment:

_____Medicare _____Medicaid _____Bundled

Project Fees: $_____ Deposit $_____

_____ Individual Physician(s) _____Group

Approved by: _____ _____

Client Signature PONI Management

Project Start Date: _____

Physician Optimal Network Incorporated

CREDENTIALING CRITERIA CHECKLIST

Please use this checklist to ensure that you have completed and submitted all required information needed to process your membership in Physician Optimal Network, Inc.

INITIAL AND RECREDENTIALING SERVICES REQUIRE PAYMENT PRIOR TO PROCESSING – Submit Payment at the Time Application is submitted.

PLEASE COMPLETE THE CREDENTIALING APPLICATION IN ITS ENTIRETY
INCOMPLETE APPLICANTS WILL NOT BE PROCESSED – NO EXCEPTIONS

Provider Name:_____ NPI:_____

Group Name:_____ TIN:_____

Contact Name:_____ Phone:_____

Contact Email:_____ Website:_____

ALL DOCUMENTATION MUST BE CURRENT !!

Application & Intake Packet

ALL pages of TSCA & Packet MUST BE RETURNED
Any "non applicable" pages in packet or sections of TSCA must be marked "N/A".

- O **Texas Standard Credentialing Application**
  - O All expirations dates must be current
  - O Practice locations pages are required for EACH location
  - O Release pages 11 & 12 must be dated w/in 30 days of packet submission
- O **PONI New Provider Intake Letter**
  - O Supplemental Cred Info Form completed for EACH practice location
  - O Disclosure of Ownership & Control Interest Statement
  - O Various Payer Participation Forms
  - O Supervising Physician Attestation *(if applicable)*
  - O 1500 HCFA Form completed for EACH practice location
  - O W9 for current year
- O **Provider Agreement** *(if applicable)*

Supporting Documentation

Verification/look up screen prints will not be accepted, must provide copy of certification when required *(marked with *).*

- O **Resume / CV** *(Initial applicants only)*
- O **Current Texas License Certificate**
- O **Current Texas DEA*** *(if applicable)*
- O **Current Board Certification** *(if applicable)*
- O **Current CLIA / XRAY Certificates*** *(If applicable)*
- O **Current Malpractice Certificate*** *(min 200K/600K)*
- O **Education Diploma(s)** *(Initial applicants only)*

Please reach out to PONIcred@cypresshcc.com if you have any questions or concerns.
Thank you!

Physician Optimal Network Incorporated

Administrative Offices:
500 N. Central Expressway, Suite 500
Plano, Texas 75074

HOW TO APPLY FOR PONI MEMBERSHIP

Thank you for your interest in joining PONI, a multi-specialty physician association (IPA). We look forward to receiving your application and preparing the necessary documents for your review by our Medical Advisory Committee. Once your application is verified as complete, our team will conduct the credentialing verification process in accordance with NCQA and Health Plan guidelines.

- We have included a Credentialing Application Checklist for your convenience. Please review the list carefully and be sure to submit a ***complete Application packet.***
- A complete Application packet requires you to include all requested credentialing documentation, a complete TSCA, and full payment of all fees due.
- PONI Credentialing will not process an incomplete Application!
- Staff will provide the Applicant with a maximum of three (3) notices of missing information.
- If an Applicant has not submitted all required documents after 3 notices of missing items, the file will be closed.
- Please note: Reactivating a Credentialing File will require payment of a $200 Re-Activation Fee, as well as a second Credentialing Application Fee, which is non-refundable.

Once complete and ready for submission, send your application by email to:
PONIcred@cypresshcc.com

If you need to submit your packet via U.S. mail for any reason, please use the mailing address shown below:
Catalyst Consultants
ATTN: PONI Credentialing
4810B Spicewood Springs Rd.
Austin, Texas 78759

Credentialing Review and Approval

The Medical Advisory Committee meets on the third (3rd) Tuesday of each calendar month of the year. In order to be considered in a given month, your application and all credentialing verification work must be completed by the second (2nd) Tuesday of that month.

Approved Providers will receive notification from PONI staff to confirm their participation in the IPA, and a welcome letter no later than ten (10) business days following their approval for participation.

EXAMPLE:
Applicants approved on Tuesday, September 19, 2023

- Welcome Letter sent no later than Tuesday, October 3, 2023
- Applicants approved on September 19, 2023, will be included in the Monthly Payor Update Report for the month of September.

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Submission of Provider Group Applications

In the event multiple Applicants are submitted as part of a Provider Group, the Group will be provided a Plan Participation Ballot that must be completed by and for each Provider Member of the Group.

We realize not all Members of a Group Practice will participate in the same Health Plans and Networks; therefore, each Provider Member of the Group must provide a signed Ballot indicating which of the available Plans and Networks he/she wishes to join as a Provider.

- In the event of uniformity of Group Participation in all available Plans/Networks, a Group may complete a submit a Combined Provider Ballot, which must be signed and dated by an individual authorized to sign on behalf of all Providers in the Group.
- If there is any deviation from uniformity of Ballot selections within a Group, the Group must submit completed and signed Ballots for each Provider in the Group.

What if you join a Group already participating with PONI?

As part of your Application Packet, the Provider will receive a Combined Messenger Notice to complete, sign and return.

- The Combined Messenger Notice will detail for the new Member exactly which Health Plans and Networks are available, and the Provider will be allowed to indicate by "Opt-In" or "Opt-Out" which Plans/Networks he/she wishes to participate with.
- Upon approval by the Medical Advisory Committee, the new Provider will be submitted for participation in the elected Plans/Networks at the end of the month during which their credentialing application was approved.

EFFECTIVE DATES

Following a Provider's approval for participation in PONI and submission to Health Plans/Networks, PONI will send a "Plan Participation Report" to the new Provider. The Plan Participation Report will reflect the Effective Dates for that Provider's participation in the various Plans/Networks. Where possible, the Effective Dates are populated in this report based on policies of the Plans/Networks. In some cases, the Plans/Networks do not confirm Effective Dates for 60-90 days, but staff will confirm known Effective Dates as part of the Provider's Welcome Letter/Packet.

Questions about Credentialing?

If you have questions related to any Credentialing issue or need to submit Credentialing documents to complete your file, please email PONIcred@cypresshcc.com.

Non-Credentialing Questions?

For ANY questions that are not specifically related to Credentialing/Recredentialing, email us at PONI_provrelations@cypresshcc.com. Provider Relations staff will help with questions about invoicing, services available, contracting questions, quality metrics and bonus eligibility or Plan/Network reimbursement terms.

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Administrative Offices:
500 N. Central Expressway, Suite 500
Plano, Texas 75074

PROVIDER RIGHTS:

At any time throughout the PONI credentialing process you may request that status of your application at PONIcred@cypresshcc.com. A credentialing team member will respond in writing or by phone within thirty (30) days of the request.

You will also be given the opportunity to correct any errors, to challenge or explain a variance in any conflicting information obtained from primary sources to what is reported on your application, review information we obtain from outside sources, upon request (this excludes peer review protected information, in compliance with federal or state law, recommendations and references, if applicable) in your credentialing application.

If a discrepancy is identified, you will be notified in writing via email, fax or certified mail within thirty (30) days after detection or Credentials Committee meeting if your file was reviewed by the Credentials Committee. You will have thirty (30) days from the date of the request to clarify or correct any such discrepancies.

Clarification or correction must be submitted in the form of a letter addressed to the Credentials Committee Chairperson and submitted to the credentialing team member requesting the information or the credentialing email address PONIcred@cypresshcc.com which is monitored throughout the business day.

All information provided in this packet is confidential and privileged; you may not disclose this information to any other party without prior written consent from PONI.

PONI

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Contracted Payer	Accept	Reject
Aetna Health Plans		
PPO	☐	☐
HMO	☐	☐
MA PPO*	☐	☐
MA HMO*	☐	☐
Aetna Better Health		
CHIP**	☐	☐
Medicaid**	☐	☐
Cook Children's Health Plan		
CHIP**	☐	☐
STAR Kids**	☐	☐
STAR*	☐	☐
Coventry/FirstHealth		
PPO	☐	☐
Workers Comp	☐	☐
Corvel		
Workers Comp	☐	☐
Curative		
PPO	☐	☐
PPO+	☐	☐
EPO	☐	☐
Galaxy Health Network		
PPO	☐	☐
Workers Comp	☐	☐
Genuine Health ACO		
Reach *(PCPs Only)*	☐	☐
Healthcare Highways		
PPO	☐	☐
HealthSpring *(Formerly Cigna)*		
MA PPO*	☐	☐
MA HMO*	☐	☐
Health Smart		
PPO	☐	☐
Workers Comp	☐	☐
Humana Choice Care		
MA PPO**	☐	☐
MA FFS**	☐	☐

Contracted Payer	Accept	Reject
Independent Medical Systems		
PPO	☐	☐
Imperial Insurance Co. of Texas		
Marketplace	☐	☐
Molina		
CHIP**	☐	☐
STAR**	☐	☐
STAR Plus**	☐	☐
MMP*	☐	☐
Perinate**	☐	☐
Medicare*	☐	☐
Marketplace	☐	☐
Multiplan		
PPO	☐	☐
Medicare*	☐	☐
Workers Comp	☐	☐
NOMI Health		
PPO	☐	☐
Open Networks		
PPO	☐	☐
Oscar *(Pending)*		
PPO/EPO/POS	☐	☐
HMO	☐	☐
PHCS		
PPO	☐	☐
Prime Health		
Workers Comp	☐	☐
Providers Network of America		
PPO	☐	☐
Provider Partners Health Plan		
Medicare Advantage*	☐	☐
Provider Select		
PPO	☐	☐

Contracted Payer	Accept	Reject
Superior *** *(excludes optometrists)*		
STAR**	☐	☐
STAR Kids**	☐	☐
STAR Plus**	☐	☐
Foster Care**	☐	☐
CHIP**	☐	☐
Perinate**	☐	☐
(Wellcare by Allwell) Medicare*	☐	☐
MMP**	☐	☐
Ambetter	☐	☐
Three Rivers Provider Network		
PPO	☐	☐
TriWest *(cred submitted. Health plan contracts will be issued directly based on need.)*		
Veterans Affairs	☐	☐
Texas Children's Health Plan		
STAR*	☐	☐
STAR Kids**	☐	☐
CHIP**	☐	☐
CHIP Perinate**	☐	☐
United Health Care		
CREDENTIALING ONLY	☐	☐

Contracted Payer	Accept	Reject
Unity Preferred Network		
PPO	☐	☐
Workers Comp	☐	☐
USA		
PPO	☐	☐
Workers Comp	☐	☐
Velocity		
PPO	☐	☐
Wellpoint ***		
Amerivantage MA*	☐	☐
CHIP**	☐	☐
Perinate**	☐	☐
STAR Kids**	☐	☐
STAR*	☐	☐

** Requires Medicare PTAN*

*** Requires Medicaid TPI*

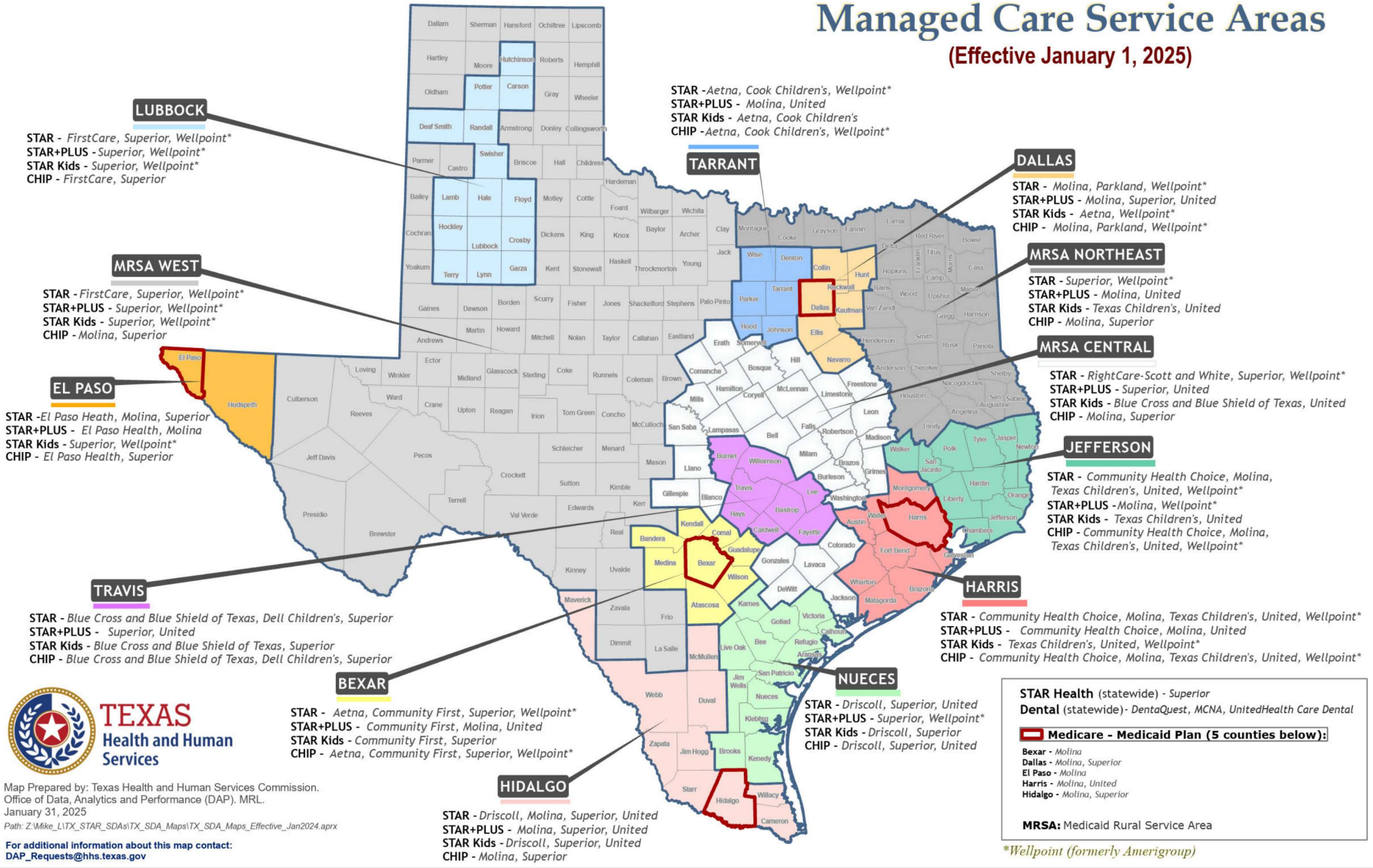
****** Refer to the Managed Care Services Map** - No members should seek medical attention under plans/products not listed for the region.*

Group Name _____ Date _____

Provider Name _____ TIN _____

Managed Care Service Areas

(Effective January 1, 2025)



STAR Health (statewide) - *Superior*
Dental (statewide) - *DentaQuest, MCNA, UnitedHealth Care Dental*

Medicare - Medicaid Plan (5 counties below):

Bexar - *Molina*
Dallas - *Molina, Superior*
El Paso - *Molina*
Harris - *Molina, United*
Hidalgo - *Molina, Superior*

MRSA: Medicaid Rural Service Area

**Wellpoint (formerly Amerigroup)*

TEXAS Health and Human Services

Map Prepared by: Texas Health and Human Services Commission.
Office of Data, Analytics and Performance (DAP). MRL.
January 31, 2025
Path: Z:\Mike_L\TX_STAR_SDAs\TX_SDA_Maps\TX_SDA_Maps_Effective_Jan2024.aprx

For additional information about this map contact:
DAP_Requests@hhs.texas.gov

Physician Optimal Network Incorporated

Supplemental Credentialing Information Form

This form includes all the information we report to payers. Please provide all the information requested below. Complete and submit a separate from for each practice location and/or TIN. Also, complete and submit an IRS form W-9 for each TIN.

Provider Name	Degree	Individual NPI	Individual Medicare Number	Individual Medicaid Number

Provider Designation PCP/SPC	Panels Open/Closed*	Panel Limits	Age Restrictions

Race (Optional)	Ethnicity (Optional)	Primary Language (Optional)	Secondary Language (Optional)

This Organization is non-discriminatory and will not discriminate or base any credentialing decisions on Race, Ethnicity, or Language.

Is this provider hospital-based? ☐ Yes ☐ No

Additional Information- * If panels are closed, specify which payers/networks here

Practice Location- This is where you see patients. Please report additional practice locations on a separate form. Primary Location? ☐

Should this location be printed in the directory for this provider? ☐ Yes ☐ No

Legal Business Name	Location Name/DBA	TIN

Location NPI	Location Medicare ID	Location Medicaid ID	Group Taxonomy

Street Address	City	State	Zip+4

Phone	Fax	Contact Name	Email

Correspondence Location- This is where your practice receives general correspondence. Check here ☐ if same as the primary practice address.

Street Address	City	State	Zip+4

Phone	Fax	Contact Name	Email

Credentialing Location- This is where your practice receives credentialing correspondence. Check here ☐ if same as the primary practice address.

Street Address	City	State	Zip+4

Phone	Fax	Contact Name	Email

Pay-to Address- This is where your practice receives reimbursement payments. Check here ☐ if same as the primary practice address.

Street Address	City	State	Zip+4

Phone	Fax	Contact Name	Email

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Group Name:_____ TIN:_____

Group Medicaid #_____ Group Medicare #_____

Provider Name	Individual Medicaid #	Individual Medicare #	TX Health Steps #	Worker's Comp Yes/No

I understand and acknowledge that Cypress Healthcare Consultants cannot submit my information to any Medicare or Medicaid plan until I have provided my active documentation of assigned numbers.

_____
Printed Name

_____
Signature

_____
Date

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted to Alliance Health Providers of Brazos Valley ("AHPBV") within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

Practice Information

Check one that describes you: ☐ Individual Practitioner ☐ Group Practice ☐ Disclosing Entity	
Name of Individual Practitioner, Group Practice, or Disclosing Entity ("Provider")	
DBA Name:	
Address:	
TIN or SSN:	NPI:

Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the Provider (e.g. an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the Definition of "person with ownership or control interest" in the Instructions), list the name, address, date of birth (DOB) and Social Security Number (SSN) for each such individual.

For entities with an ownership or control interest in the Provider, list the name, Tax Identification Number (TIN), and each address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if an individual) TIN (if an entity)

Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the Provider has an ownership or control interest of 5% or more? ☐ Yes ☐ No

If yes, list the name, address, DOB and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if listing an individual) TIN (if listing an entity)

Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other? ☐ Yes ☐ No If yes, list the individuals who are related to each other, and the type of relationship (spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

Names	Type of relationship

Section IV: Convictions

Has any person who has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN

Section V: Business Transactions

Has the Provider had any financial transactions with any subcontractors totaling more than $25,000 with any subcontractors during the previous 12 months? ☐Yes ☐No

Has the Provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous 5 years? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the previous twelve-month period, and any significant business transactions between the Provider and any wholly owned supplier or between the Provider and any subcontractor during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI: Managing Employees

Does the Provider have any managing employees? ☐ Yes ☐No

If yes, list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and percent of interest. (42 CFR 455.104) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN	% Interest

If "Group Practice" or "Disclosing Entity" is checked in the Practice Information section above, the undersigned hereby represents that he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate, and on behalf of each physician and practitioner listed on Exhibit A attached to this Statement, and the undersigned represents that he, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed physician and practitioner.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading, inaccurate, or incomplete data may result in a denial of participation for the affected providers.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

PONI
Physician Optimal Network Incorporated

Administrative Office:
500 N Central Expressway, Suite 500
Plano, Texas 75074

SUPERIOR SUPPLEMENTAL INFORMATION FORM

Practitioner Name_____ Specialty _____

TIN_____ NPI _____ Contact _____

Phone_____ Email _____

This form includes information required by Superior Health Plan. Please provide all the information requested.

CIRCLE As Appropriate to Answer Questions

Do you provide telehealth services? Yes No
Details and Hours, if yes: _____

Do you have experience treating IDD patients? Yes No

Are you a minority business owner? Yes No

Are you a Pediatric Extended Care Center? (PPECC) Yes No

Has provider completed cultural competence training? If yes, indicate details. Yes No

Details: _____

Do you offer non-english languages and/or ASL? If yes, please indicate details. Yes No

Details: _____

Do you supply translation services for written materials? Yes No

Is your office on an accessible public transportation route? Yes No

Do you have specialized training and experience treating the following:

Physical Disabilities Yes No
Chronic Illness Yes No
HIV/AIDS Yes No
Serious Mental Illness Yes No
Substance Abuse Yes No
Homelessness Yes No
Deafness or hard-of-hearing Yes No
Co-occuring disorders Yes No

If the answer is Yes, please indicate details: _____
_____
_____

PONI
Physician Optimal Network Incorporated

Administrative Office:
500 N Central Expressway, Suite 500
Plano, Texas 75074

SUPERIOR SUPPLEMENTAL INFORMATION FORM, page 2

FOR FOSTER CARE PROVIDERS ONLY

Do you have experience treating any of the following:

Children with sexual abuse?	Yes No
Children with physical abuse?	Yes No
Children with developmental disabilities?	Yes No
Patients with Special Health Care Needs (MSHCN)?	Yes No
Children with post-traumatic stress disorder (PTSD)?	Yes No
Evidence-based practices (EBPs) modalities or promising practice such as TIC?	Yes No

If the answer is Yes, please indicate details: _____

_____

_____

Indicate what accessible types of options you have for persons with physical disabilities:

Parking Spaces	Yes No
Curb Ramps	Yes No
Loading Zones at building entrance	Yes No
Doorways wide enough for wheelchair passage	Yes No
Accessible restrooms with grabbers	Yes No
ASL signage and raised text characters at office and elevator	Yes No
Medical equipment accessible to persons using mobility aids	Yes No
Exam rooms accessible to persons using mobility aids	Yes No

Other: _____

_____

_____

If you have any other specialized training or wish to provide additional details, please utilize the space provided below: _____

_____

_____

_____

Thank you for providing these additional required details for Superior Health Plan of Texas.

BlueCross BlueShield of Texas

TRIWEST COMMUNITY CARE NETWORK (CCN) PARTICIPATION REQUEST

Please complete all applicable data fields and returned completed form to attention Network Management:
Fax 972-238-7252 OR E-mail: VA_TriWest@bcbcstx.com

1. BCBSTX Provider Record ID:	2. Provider Name/Title:
3. Tax ID:	4. Individual-Type 1 NPI:
5. Date of Birth (DOB):	6. CAQH ID: ***(If registered with CAQH)***
7. Primary Specialty:	Secondary Specialty:
8. **Provider Type**: ***(You may only select one type)*** *MD/DO:* Select PCP and/or SCP *Non MD/DO:* Select Healthcare Professional Provider or Behavioral Health Provider	☐ Primary Care Physician (PCP) ☐ Hospital Based Provider ☐ Specialty Care Physician (SCP) ☐ Healthcare Professional Provider ☐ Behavioral Health Provider
9. If Mid-Level Practitioner (APN/PA), will you be providing Primary Care Services? ☐ Yes ☐ No	
10. If Mid-Level Practitioner (APN/PA), list the BCBS TriWest CCN in-network supervising physician name and Type 1 NPI Supervising Physician Name: _____TYPE 1 NPI:_____	
11. Practice Address, City, State, Zip *Note*: This address will be listed in directory and should reflect as such on CAQH application:	
12. Practice Appointment Phone #:	13. Referral Fax #:
14. Practice Email:	
15. Billing Address: ***(Where your checks/EOBS are sent)***	
16. Group Name:	
17. Group-Type 2 NPI:	
18. TAX ID:	
19. Hospital Affiliations: List all hospitals to which you refer or admit patients.	a. b. c.
20. **Individual provider agreements** require the provider's signature or the signature of the provider's designee with written authorization from the provider. **Group agreements** require the signature of an authorized representative of the group who is the CEO, President, Executive Director, Managing Director, or Administrator. Otherwise a written authorization from such an officer designating the representative who is authorized to sign is required. Name/Title of Signature Authority:	
21. Provider or Authorized Representative Signature/Date:	
22. Credentialing Contact Phone# and Email Address (where agreements, follow-up information, and additional documentation request from Network Management will be sent):	

POLITICAL SUBDIVISION WORKERS' COMPENSATION ("THE ALLIANCE")

TREATING DOCTOR AGREEMENT

A Treating Doctor is a Contract Provider: 1) whose specialty has been designated by The Alliance as a specialty that may serve as a Treating Doctor; 2) who has signed a Treating Doctor Agreement to provide treating doctor functions; and 3) who has been designated as the Treating Doctor for the Injured Employee.

(a) Contract Provider agrees to serve as a Treating Doctor and to accept the responsibility to coordinate all of the Injured Employee's health care needs for the Injured Employee's compensable injury. The following additional provisions are applicable to Treating Doctors.

(b) A Treating Doctor shall provide health care to the Injured Employee for the Injured Employee' compensable injury and shall make referrals to other Contract Providers, or request referrals to non-Contract Providers if medically necessary services are not available from a Contract Provider.

(c) Referrals to non-Contract Providers must be approved by the Pool of which the Injured Employer's Employee is a member (Responsible Pool). The Responsible Pool shall approve a referral to a non-Contract Provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the Injured Employee require expedited approval.

(d) A Treating Doctor shall cooperate in the medical case management process as required by The Alliance, including participation in return-to-work planning.

(e) Notwithstanding section 504.053 of the Labor Code, a Treating Doctor is responsible for the efficient management of medical care as required by section 408.025(c) of the Labor Code and Texas Department of Insurance rules.

(f) Notwithstanding section 504.053 of the Labor Code, a Treating Doctor shall comply with the requirements established by commissioner rule under Subsections 408.023(1) and (m) (relating to duties of treating doctors) including 28 Tex. Admin. Code §180.22 (relating to Health Care Provider Roles and Responsibilities).

PARTICIPATING PROVIDER

Authorized Signature Date

Print Name

Practice Name TIN

Physician Optimal Network Incorporated

Texas Worker's Compensation Required Information Form

This form must be completed and returned. Submit this form with your *current* Texas standardized credentialing application, including documents listed on the enclosed check list, to the address listed on the cover letter.

☐ **I am currently accepting workers' compensation patients or plan to accept workers' compensation patients.** I plan to continue to accept workers' compensation patients as a member of a certified workers' compensation network (CWCN). I understand that consistent with Texas law, a current list of clients accessing my contract is available through worker's compensation payor websites. If you check this box, please complete, sign and return this form with your credentialing application to acknowledge that you are agreeing to participate in a CWCN.

☐ **I do not currently accept workers' compensation patients** or I plan to discontinue my workers' compensation practice as of this date_____. If you check this box, you do not need to complete questions 1-6, but please do sign and return this form.

1. My practice, for workers' compensation patients:

   a. Can best be described as *(check one box that best applies)*:

   ☐ Initial injury care forworkers

   ☐ Initial visit for area of specialty care only (describe specialty):

   ☐ Specialty and/or referral care only (describe specialty):

   b. Is currently accepting legacy claims *(existing workers' comp claims that may be transitioned in to the network)* ..... ☐ *Yes* ☐ *No*

   c. Accommodates urgent walk-ins and or appointments within 48 hour ..... ☐ *Yes* ☐ *No*

   d. Has a physician on duty during all normal business hours ..... ☐ *Yes* ☐ *No*

   e. Has the following services directly available in my office or immediately available on site *(circle all that apply)*: Lab Tests Lab Drawing only Drug Screen Routine Radiology Minor Surgery

2. My office staff is trained in the identification and care of occupational illness and injury ..... ☐ *Yes* ☐ *No*

3. My office staff will promptly provide information, consistent with state requirements, to workers' compensation representatives regarding a claimant's condition and care ..... ☐ *Yes* ☐ *No*

4. My office staff maintains an active return to work philosophy including cooperation on light or modified duty assessment ..... ☐ *Yes* ☐ *No*

5. Did you submit a disclosure of financial interests in other health care providers to the state (if applicable ☐ *Yes* ☐ *No* ☐ *NA*

6. Please certify as to completion of required training to perform *Maximum Medical Improvement and Evaluation of Permanent Impairment*? ..... ☐ *Yes* ☐ *No* ☐ *NA*

Provider Name	*NPI*
Printed Name of Person Completing Form	*Contact Phone Number*
Signature of Person Completing Form	*Date*

Physician Optimal Network Incorporated

Supervising Physician Attestation

Advanced Practice Providers are not required by PONI Policy to have hospital privileges but must be supervised by a PONI - credentialed physician. Be advised some MCOs may require the supervising physician to be in clinic with the APP. APPs may have an alternate or multiple Supervisors on record.

Section 1 – Supervising Physician

In my current position with a Supervising Physician, I have reviewed, understand, agreed upon and signed along with my Supervising Physician, protocols or other written authorization which defines my professional duties, protocols and scope of duties as an Advanced Practice Provider in a manner that promotes professional judgment commensurate with my education, certification, and experience. A copy of the protocols/duties/scope of practice is maintained onsite at my primary practice location.

Supervisor Name * _____ Degree _____

Supervisor's Medical License Number _____ State _____

Alternate Supervisor Name * _____ Degree _____

Alternate's Medical License Number _____ State _____

Section 2 – DEA Credentials

[ ] Applicant does have a current, valid DEA credential ("Credentials") within the State of Texas.

[ ] Applicant does not have current, valid Credentials within the State of Texas because I have moved from out-of-state, or because I am starting a new practice, or because I will not be prescribing medications. The Supervising Physician listed below will write all prescriptions on my behalf until such time that I obtain and provide current and valid Credentials to PONI. I acknowledge it is my responsibility to immediately notify PONI upon my receipt of the Credentials.

Section 3 – Attestation By Applicant

I certify the information provided herein is true, correct, and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission concerning my collaborating/supervising physician and the established protocols/duties/ scope of practice may constitute grounds for withdrawal of my application for consideration.

Applicant Signature _____ Date _____

Applicant's Name _____ Specialty _____

Section 4 – Supervising Physician Certification

I consent to serving as the Supervising Physician for the Applicant named above.

Supervising Physician Name and Degree* _____

Physician Signature _____ Date _____ DEA Number _____

** Supervisors MUST be physicians licensed in the same state of the Advanced Practice Providers practice and MUST participate in the same network(s) as the applicant. Information provided here may be subject to verification.*

This form is a sample of Form CMS-1500 (02/12) and is used to report information to payors that is necessary to process reimbursement properly. Please provide a completed and redacted sample Form CMS-1500 (02/12) form currently used in your practice, or, complete this sample form typing or neatly printing all of the following information:

- 24j - Your individual NPI
- 25 - Your tax identification number (SSN or EIN) used when billing payors (this MUST match your attached IRS Form W9)
- 31 - The practitioner's full name and degree or credentials such as M.D., D.O., CRNA, or P.A.
- 32 - The complete practice location information including NPI and taxonomy code
- 33 - Complete billing information including NPI (individual NPI if you are not part of a group practice; otherwise use your group NPI)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II 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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

PROVIDER PARTICIPATION AGREEMENT

This agreement is subject to binding arbitration.

This Provider Participation Agreement ("Agreement") is made and entered into as of the Effective Date set forth on the signature page of this Agreement between Physician Optimal Network, Inc. ("Network"), and _____ ("Provider").
(TYPE or PRINT NAME of PROVIDER)

RECITALS

WHEREAS, Network is a provider network that has contracts with Physicians and other healthcare providers; and

WHEREAS, Network may from time to time enter into contractual arrangements with certain insurers, HMOs, and other Payors for the purpose of providing or arranging for the delivery of Health Care Services to Covered Persons of such Payors by Participating Providers; and

WHEREAS, Provider desires to participate as a Participating Provider in Network to provide Health Care Services coordinated and arranged by Network pursuant to this Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual covenants contained herein, the receipt and adequacy of which are acknowledged, it is agreed as follows:

I. DEFINITIONS

1.1. Clean Claim means a request for payment for Covered Services submitted by a Participating Provider or his or her designee on a HCFA 1500 form (or successor form), or the electronic equivalent of this form when billing claims electronically, that contains all of the elements as required pursuant to the Texas Department of Insurance regulations.

1.2. Compensation Schedule means the schedule of payments to a Participating Provider for Covered Services.

1.3. Complementary Care Professional means a non-Physician practitioner licensed under a recognized state licensing authority including, but not limited to, chiropractors who may be contracted by Network to provide Covered Services as required by a Payor or Health Benefit Plan.

1.4. Confidential Information means all materials, information and ideas of Network, without limitation, operation methods and information, accounting and financial information, marketing and pricing information methods and materials, internal publications and memoranda, and other matters, which have been developed by the Network and includes all information relating to the present or planned business of Network that has not been released publicly by authorized representatives of Network. Such confidential information may include, for example, contractual terms, trade secrets and inventions, marketing and sales programs, business plans, customer lists, customer referral sources, financial arrangements, financial data, pricing information, programs, data and other information pertaining to Network's past, current and planned business activity.

1.5. Covered Person(s) means any person who is eligible to receive Covered Services paid for by a Payor or whom a Payor is legally obligated to indemnify for the cost of Covered Services.

1.6. Covered Services means those healthcare services and supplies which are authorized for payment under the Health Benefit Plan sponsored by a Payor.

1.7. Credentialing Standards means the minimum professional standards established by Network or Payor for credentialing and recredentialing of Participating Providers.

1.8. Health Benefit Plan means a Payor's medical benefits and hospitalization plan, workers compensation or auto liability plan or a governmental plan whereby Payor agrees to make payments

to Participating Providers for Covered Services as defined in such Health Benefit Plan, and whereby the Payor offers incentives for Covered Persons to use Participating Providers, if applicable.

1.9. Identification System means the system of Payor to verify the eligibility of a Covered Person to receive Covered Services under this Agreement.

1.10. Non-Covered Services means those healthcare services which are not benefits under a Health Benefit Plan.

1.11. Participating Provider means Physicians, Providers and Complementary Care Professionals who have entered into written agreements with Network.

1.12. Payor means an insurance company, government program, managed care plan, third party administrator, union, employer or employee group which is responsible for the payment of Covered Services under this Agreement.

1.13. Payor Agreement means the separate agreement between Network and a Payor defining the terms and conditions under which Participating Providers are paid for Covered Services to Covered Persons.

1.14. Physician means an individual duly licensed to practice in the State(s) who maintains privileges on the medical staff of a hospital if applicable to Physician's specialty and who is an employee or owner of Provider.

1.15. Provider means the above named entity that is a party to this Agreement, and which consists of Providers listed on Attachment C hereto to include changes as mutually agreed to between the parties from time to time after the Effective Date of this Agreement.

1.16. Utilization Management Program means a program established by a Payor which is designed to oversee and manage the utilization of Covered Services based on appropriate medical necessity criteria.

II. DUTIES OF NETWORK

2.1. Representations and Warranties. Network represents to Provider that:

A. It is a duly organized corporation in good standing under the laws of the State in which it is organized or operates, and is authorized to enter into this Agreement;

B. It shall maintain in effect during the term of this Agreement such policies of Directors and Officers insurance coverage to insure against liability for damages, directly or indirectly, related to the activities of Network and its officers; and

C. It shall use best efforts to enter into Payor Agreements with Payors to market the services of Participating Providers.

2.2. Marketing Materials. Network will use its best efforts to arrange for Payors to list Provider and other Participating Providers in provider directories and other marketing and informational materials as developed and distributed by Payor.

2.3. Patient-Physician Relationship. Neither Network nor Payor shall, in any manner, prohibit, attempt to prohibit, or discourage Physician from (i) discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding that patient's healthcare, including but not limited to the patient's medical condition or treatment options; or (ii) discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the provisions, terms, requirements, or services of the Health Benefit Plan as they relate to the medical needs of the patient.

2.4. Credentialing and Recredentialing. Network shall be responsible for obtaining credentialing and recredentialing information from Participating Providers and may delegate the verification of such information to a credentialing verification organization. Network shall provide to Provider, upon request, its Credentialing Standards for participation in Network. Network shall maintain all credentialing and recredentialing information in confidence and consistent with applicable state and federal law. Provider agrees to furnish all information and documentation as required by the Credentialing Standards. Provider understands and agrees that failure to cooperate with credentialing procedures or furnishing inaccurate information will be sufficient grounds for denial or termination of participation.

2.5. Eligibility and Benefit Verification. Network's duties are limited to those specifically set forth herein. Network does not determine eligibility or benefits for Covered Persons under Health Benefit Plans. Network is not liable for reimbursement of Provider for services rendered pursuant to this Agreement, and does not exercise any control with respect to Payors' Health Benefit Plan assets, policies, practices, procedures, or payment of claims.

III. OBLIGATIONS OF PROVIDER

3.1. Services and Responsibilities. Provider agrees to provide Covered Services in accordance with the terms of this Agreement and any Payor Agreement to Covered Persons of Health Benefit Plans.

3.2. Representations and Warranties. Provider represents to Network that:

A. Provider is and, at all times during this Agreement, shall be eligible to participate as a Participating Provider consistent with the Credentialing Standards; and

B. Provider currently maintains professional and general liability insurance coverage in an amount satisfactory to Network and that Provider will continue to maintain such coverage for the duration of this Agreement as follows:

1) Professional liability insurance in minimum amounts as determined by Network to insure Provider's employees or independent contractors from and against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the provision of any service by Provider under this Agreement and the use of any property and facilities of Provider. In the event that such coverage is "claims made" coverage, such coverage shall be maintained by the way of "tail" coverage, for at least five (5) years following termination of this Agreement.

2) A policy or program of comprehensive general liability insurance with minimum limits as determined by Network.

3) Provider shall notify Network of any claims made or actions filed by Covered Persons or Payors arising out of, or relating to, services provided by Provider to a Covered Person, within seven (7) days of Provider's receipt of notification or becoming aware of such claim or action.

3.3. Compliance with Credentialing Standards. Provider shall comply, at all times during the term of this Agreement, with all applicable federal, state or municipal statutes or ordinances, including all applicable rules and regulations of the State Board of Medical Examiners and the ethical standards of the American and the applicable state Medical Association. If at any time during the term of this Agreement a Physician shall have his or her license to practice medicine suspended, conditioned or revoked, Physician shall immediately cease to provide Covered Services pursuant to this Agreement. Provider agrees to immediately notify Network if a Physician's medical staff membership or privileges are suspended, limited or revoked at any hospital, if a hospital initiates any adverse peer review action against Physician, or if Physician voluntarily or involuntarily relinquishes his/her U.S. Drug Enforcement Administration (DEA) or state certification. Provider agrees to notify Network within seven (7) days of the occurrence of any disciplinary proceedings

against Physician of sufficient gravity to be reported to or initiated by the applicable state Board of Medical Examiners or other similar body or any action which may be brought against Physician by any medical society or hospital, any action taken against Physician by any governmental agency, or any material adverse change to Provider's ability to provide Covered Services per this Agreement. Such notice shall include copies of any complaints, petitions, lawsuits or other documents filed or prepared in connection with such proceeding.

3.4. Compliance with State and Federal Statutes. Provider shall cooperate with Network so that Network may meet any requirements imposed on Network by state and federal law, and all regulations issued pursuant thereto. Provider shall agree to provide such records and information to Health Benefit Plans, and to applicable state and federal regulatory agencies for compliance, as may be required. Such obligations shall survive the expiration or termination of this Agreement. Provider shall permit Health Benefit Plans at all reasonable times to have access upon request to books, records and other papers relating to Covered Services and access to the amounts of any payments received from Covered Person or from others on Covered Person's behalf. Provider shall retain such books and records for a term of at least ten (10) years (or such longer period as may be required by law) from and after the termination of this Agreement. Provider shall make such records available to other Participating Providers, subject to applicable confidentiality and privacy requirements, when such records are necessary for treating a Covered Person. Provider shall, in conformance with applicable law and this Agreement, permit access to and inspection by Health Benefit Plans, the United States Department of Health and Human Services, the Comptroller General of the United States, and any other federal or state regulatory agency having jurisdiction over the delivery of healthcare services at all reasonable times and upon demand, of all of those facilities, books and records maintained or utilized by Provider in the performance of Covered Services pursuant to this Agreement. Provider agrees to comply with the specific terms and provisions required by the Center for Medicare and Medicaid Services ("CMS") for participation in Medicare Advantage plans as per Attachment D hereto to include any revisions thereto as required by CMS without further notice to Provider. Services to Covered Persons. Provider may arrange with one or more similarly licensed and qualified Participating Providers to provide services to Covered Persons during Provider's temporary unavailability. In all events, all such substitutes must be Participating Providers or must satisfy the same requirements as are imposed on Provider. Further, Provider agrees to use best efforts not to utilize the services of a non- Participating Provider to provide Covered Services pursuant to this Agreement unless such non- Participating Provider is fully qualified to perform the Covered Services and agrees to the following:

A. Accept peer review, utilization and quality management/ improvement procedures of Payors;

B. Not bill Covered Persons for Covered Services and to look solely to Participating Provider for payment;

C. Maintain professional liability coverage in amounts no less than those required of Participating Providers; and

D. Fully comply with the terms of this Agreement in providing services to Covered Persons as if the non-Participating Provider were a party to it.

3.5. Medical Records. The following obligations shall survive any subsequent termination or expiration of this Agreement:

A. Provider shall maintain appropriate medical records, charts, and diagnostic test results for each Covered Person as is usual and customary in the industry, and under applicable license, certification and accrediting standards.

B. Provider shall maintain all information contained in the medical records of Covered Persons under strictest confidence and in compliance with federal and state laws related to privacy and security of identifiable patient information. Provider shall refrain from disclosing such

information, except with the consent of the Covered Person or as otherwise permitted under applicable federal and state privacy and security laws.

C. To the extent permitted by law, Provider shall cooperate and communicate freely with other persons providing Covered Services to a Covered Person. Provider consents, to the extent permitted by law and as otherwise provided in this Agreement, to release such records as are deemed necessary or appropriate by the Covered Person or a Payor.

D. Provider agrees, upon request of the Covered Person, and subject to applicable disclosure and confidentiality laws, to transfer the medical records of Covered Person to another Participating Provider.

3.6. Utilization Management Program. Provider agrees to cooperate with the Utilization Management Program of each Health Benefit Plan. Network will use best efforts to request Payors to provide material changes to the Utilization Management Program to Provider in writing at least thirty (30) days prior to any material change. Provider agrees that Health Benefit Plans shall have the right to oversee and review the care administered to Beneficiaries. Provider agrees to the appropriate utilization of such managed care methods and practices as are consistent with sound healthcare practice and in accordance with accepted community standards of quality care.

3.7. Grievance Program. Provider shall cooperate with Network and fully participate in the development and implementation of a grievance and complaint program designed to process and consider questions, complaints, and other matters, as appropriate, from Beneficiaries.

3.8. Hold Harmless/Compliance with Health Maintenance Organization Regulations. If applicable to a Payor Agreement, Provider agrees to be bound by all applicable laws and regulations including, but not limited to, the Health Maintenance Organization Act of 1973 (42 U.S.C. Sec. 300e, et. seq.) and applicable regulations thereunder, the Employee Retirement Income Security Act (29 U.S.C. Sec. 1001, et. seq.) and applicable regulations thereunder, and Titles XVIII and XIX of the Social Security Act and applicable regulations thereunder, as amended from time to time. Provider agrees that in no event, including, but not limited to nonpayment or insolvency of Payor shall Provider bill, charge, seek compensation or reimbursement from or have recourse against Covered Person(s) for Covered Services. This provision shall survive termination of this Agreement and shall be construed in favor of Covered Person(s).

3.9. Reporting Changes of Provider Information. Provider will use best efforts to notify Network in writing, at least thirty (30) calendar days prior to any change in Provider's business address, business telephone number, office hours, tax identification number, insurance carrier or coverage or Physician's DEA registration number as applicable. Provider shall notify Network in advance of the effective date of any change in ownership or control.

3.10. Nondisclosure. Provider shall not disclose the terms of this Agreement or the Payor Agreement, including but not limited to the compensation arrangement, methodologies or other price-sensitive terms, without the prior written consent of Network. Such information shall be included as Confidential Information as defined by this Agreement. Notwithstanding anything contained herein to the contrary, nothing in this Section shall be construed to conflict with state or federal laws related to patient protection and communication of medical information by Provider. As such, Provider acknowledges that:

A. Any information related to this Agreement shall not be disclosed to an individual or entity other than Network or its designee, and shall be utilized for the sole and exclusive purposes of fulfilling the obligations specified in this Agreement. Provider shall at no time reveal to any person or entity any Confidential Information furnished by Network or Payor to Provider or otherwise coming into Provider's possession as a result of Provider's relationship with Network or Payor.

B. Money damages would not be a sufficient remedy for any breach of this section and Network shall be entitled, in addition to any other relief available in law or equity, to obtain equitable relief, including injunction and specific performance, to enforce this covenant, without the necessity of proving irreparable damage and without the posting of a bond, cash or otherwise.

C. The foregoing paragraphs of this Section of this Agreement shall survive the expiration or termination of this Agreement.

3.11. Disciplinary Action. Provider agrees to notify Network within five (5) calendar days of the occurrence of any disciplinary proceedings initiated by a State Board of Medical Examiners in any state in which Physician is licensed or any action that may be brought against Physician by any professional society or facility acting through its professional staff, directors, trustees or otherwise, or any action taken against Physician by any governmental agency, including, but not limited to, the following:

A. Any action taken to restrict, suspend or revoke Physician's license(s);

B. Any suit or arbitration action for malpractice against Physician;

C. Any felony information or indictment naming Physician;

D. Any disciplinary proceeding or action involving Physician before any administrative agency;

E. Any cancellation or material modification of Provider's professional liability insurance;

F. Any loss of medical staff privileges by Physician; or

G. Any other material adverse change to Provider's or Physician's ability to provide Covered Services under this Agreement.

Such notice shall include copies of any complaints, petitions, lawsuits or other documents filed or prepared in connection with such proceeding.

3.12. Referrals. Consistent with sound medical practice and in accordance with accepted community professional standards for providing medical care, Provider agrees to make referrals of Covered Persons to Participating Providers in the Payor's Health Benefit Plan. Provider should refer a Covered Person to a healthcare provider who is a non-Participating Provider only if the Covered Person requires medical services not available through a Participating Provider. Provider agrees to use best efforts to notify Covered Person in advance that a different payment or benefit schedule may apply as per the Health Benefit Plan.

3.13. Provider Services. Provider will provide Covered Services to Covered Persons in accordance with the terms set forth in the relevant Payor Agreement in the same manner, in accordance with the same standards, and within the same time availability as provided to other patients, including accessibility on a twenty-four (24) hour-per-day, seven (7) day-per-week basis, either personally or by covering arrangements with Participating Providers or non-Participating Providers who agree to comply with the terms of this Agreement. Provider shall not be obligated to accept an individual Covered Person as a patient; provided, however, Provider shall not refuse to accept any Covered Person as a patient on the basis of race, color, ancestry, religion, sex orientation, age, national origin, handicap (except to the extent that different treatment is medically necessary because of the Covered Person's medical condition), Health Benefit Plan or health status or medical condition of such patient. Provider shall assist Network in monitoring accessibility of care for Beneficiaries, including scheduling of appointments and waiting times. Provider shall provide only those services that Provider customarily and usually provides to its patients.

3.14. Name, Symbols and Service Marks. Provider agrees to permit Network or its designee to use Physician's name, specialty, office address, telephone number, and description of services in any directory of Participating Providers or other listing distributed by Network. Provider agrees not to

use the name, symbols, trademarks, services marks, designs, data, procedures or information of Network unless prior approved in writing by Network.

3.15. Membership Fees. Provider agrees, as a condition of initial and continued membership in Network, to pay on behalf of each of its Physicians an annual membership fee and any other fees for credentialing and recredentialing services as determined solely by the Board of Directors. Provider agrees to make payment of such fees on a timely basis and per the policies and procedures of Network which will be made available to Provider upon request.

IV. COMPENSATION

4.1. Compensation – Special Provisions. Network shall have the authority to enter into Payor Agreements for the provision of Covered Services to Covered Persons and to bind Provider to Payor's Health Benefit Plan subject to the following contracting guidelines:

A. Conforming Agreements. Provider authorizes and appoints Network as Provider's agent and attorney-in-fact to enter into and to amend Payor Agreements which do not materially vary from the rights and obligations of Provider under this Agreement and which are consistent with the contracting guidelines adopted by Network and the Compensation Schedules included herein as Attachment A as approved by Provider.

B. Non-Conforming Agreements. If a Payor desires to enter into a Payor Agreement or if a Payor desires to modify any existing Payor Agreement in such a way that the rights or obligations of Provider would materially vary from this Agreement, Network shall provide written notice to Provider of the Payor's proposal ("Messenger Notice"). Provider shall have the option of accepting or rejecting the Payor Agreement as presented in the Messenger Notice by providing written notice to Network within the time period specified in the Messenger Notice, which period of time shall be not less than ten (10) days or such other time as identified by Network. Provider shall make an independent decision whether to accept or reject the proposed Payor Agreement. Upon receipt of Provider's response to the Messenger Notice, Provider agrees to provide Covered Services as required by the Payor Agreement. Failure of Provider to respond to the Messenger Notice within the time period specified shall be deemed a rejection by Provider of the Messenger Notice. Network shall notify the Payor of Provider's acceptance or rejection of the Payor Agreement. Rejection of a new or modified Payor Agreement shall not terminate Provider's obligations under this Agreement with respect to Covered Services to be provided to Covered Persons under other Payor Agreements as previously accepted by Provider. For Non-Conforming Agreements, Network and Provider agree to comply with the policies and procedures set forth in Attachment B.

4.2. Antitrust Compliance. All review of Payor Agreements by Network for either Conforming or Non-Conforming Agreements (together referred to hereafter as "Payor Agreements") shall be in accordance with the Network's Antitrust Policy, which is attached as Attachment B. Such policy may be amended from time to time by Network to reflect changes in laws or regulations.

4.3. Reasonable Assurances. Network shall use best efforts to enter into Payor Agreements that obligate the Payor to:

A. Make payments for Covered Services on the basis of the applicable payment methodology as agreed to by Provider;

B. Make payments to Provider within forty-five (45) days after receipt of a Clean Claim, unless otherwise agreed; and

C. Provide an Identification System to assist in the identification of Covered Persons and the scope of Covered Services applicable to Covered Persons if applicable to the Payor Agreement.

4.4. Provider Compensation. Network shall secure from Payor a commitment to pay Provider, based on the terms and conditions of reimbursement under a Payor Agreement. Provider shall bill only for Covered Services performed by Provider. Provider agrees to accept as payment in full for Covered Services the Compensation Schedule specified in the Payor Agreement or as specified and accepted in Attachment A of this Agreement. Provider agrees that in no event, including, but not limited to non-payment, Payor's refusal to pay for services or supplies deemed not to meet contractual definitions of medical necessity in Health Benefit Plans as interpreted by Payor, Payor's insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, or have any recourse against Beneficiaries, or persons other than the Payor acting on Covered Person's behalf for Covered Services provided pursuant to this Agreement other than that which is provided for in the applicable Health Benefits Plan. Provider agrees that for Covered Services rendered prior to the termination of this Agreement, this Section shall survive the expiration or termination of this Agreement regardless of the reason for termination, including insolvency of a Payor, and shall be construed to be for the benefit of Beneficiaries.

4.5. Claims Submission. Provider agrees to submit Clean Claims within ninety-five (95) days from the date of service. Provider agrees that failure to submit Clean Claims within the time required by the Health Benefit Plan may result in disallowance of payment.

4.6. Coordination of Benefits. Provider agrees to cooperate with Payors in the coordination of benefits, to provide Payor any relevant information that Provider may have relating to any other coverage held by a Covered Person, and to abide by the coordination of benefits, subrogation and duplicate coverage policies and procedures of Payor. Provider consents to the release of medical information by Payor as necessary and lawful to accomplish coordination of benefits as permitted by law. If Payor determines that Payor is not the primary carrier, and Provider's bill to the primary carrier(s) was not computed on the basis specified in this Agreement, any further reimbursement to Provider from a Payor may not exceed an amount which, when added to amounts shown on the explanation of benefits from the primary carrier(s), equals the amounts specified in the Compensation Schedule.

4.7. Copayments and Deductibles. Provider is entitled to bill and has the responsibility to collect from a Covered Person any applicable copayments, coinsurance or deductibles for Covered Services according to the terms of the applicable Health Benefit Plan. Provider shall bill and collect copayments, deductibles and any other fees that are the Covered Person's responsibility. Provider may bill Covered Person or other responsible party at Provider's usual and customary charge for non-Covered Services. Provider agrees to use best efforts to notify Covered Person, in advance of providing any non-Covered Service that the service is not covered by the Health Benefit Plan and that Covered Person will be responsible for all charges.

V. RELATIONSHIP OF PARTIES

5.1. Independent Contractors. In the performance of the work, duties and obligations of the parties pursuant to this Agreement, each of said parties shall at all times be acting and performing as an independent contractor, and nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee, partnership, joint venture, or principal and agent.

5.2. Non Exclusive Participation. None of the Participating Providers, including Provider, be or consider themselves to be exclusive or guaranteed Participating Providers to Network or any Payor hereunder. Participating Providers, including Provider, may participate in any other provider network or contract direct with a Payor(s) to and provide medical and healthcare services independent of and apart from the Covered Services to be provided to Covered Persons pursuant to this Agreement, as long as such participation or practice does not preclude Provider from complying with the terms of this Agreement.

5.3. No Guarantee of Utilization. Provider acknowledges that there is no warranty or guarantee that (1) Provider will be selected to participate as a member of any particular Health Benefit Plan, or (2) if

selected, Provider will be utilized by a Covered Person or any number of Covered Persons within the Health Benefit Plan.

5.4. Confidential Information. Both parties acknowledge that each has developed certain symbols, trademarks, trade names, service marks, designs, data, processes, plans, procedures and information, all of which is proprietary information and trade secrets of each party, and may not be used by either, or by any other person or entity except as contemplated by this Agreement, or with the prior express written consent of the other party. Upon termination of this Agreement, both parties shall cease any and all usage of any Confidential Information.

VI. TERM AND TERMINATION

6.1. Term. This Agreement shall remain in force and effect for a period of twelve (12) months from the effective date as set forth on the signature page of this Agreement ("Initial Term"). At the end of the Initial Term, this Agreement shall automatically renew for one (1) year periods thereafter unless terminated as provided in this Agreement.

6.2. Without Cause Termination. In the event either party shall, with or without cause, at any time give to the other party at least ninety (90) days advance written notice, this Agreement shall terminate on the future date specified in such notice.

6.3. Termination for Breach. This Agreement may be terminated by either party for the failure, by omission or commission in any substantial manner, of the other party to keep, observe or perform any covenant, agreement, term or provision of this Agreement by either party and such default shall have continued for a period of thirty (30) days after receipt of written notice thereof from the non-defaulting party to the defaulting party.

6.4. Effect of Termination. Upon termination of this Agreement, neither party shall have any further obligation hereunder, except that termination of this Agreement shall not affect the rights and obligations of the parties hereto either arising out of transactions occurring prior to termination or obligations, promises and covenants expressly made to extend beyond the term of this Agreement, including without limitation Confidential Information.

6.5. Post-Termination Obligations. Following termination of this Agreement, other than for reasons concerning Provider's medical incompetence, professional status or behavior, Provider shall continue to provide Covered Services to, and will cooperate in arranging for appropriate referrals for, any Covered Person who is under active treatment either until such treatment is completed or responsibility is assumed by another Participating Provider. Provider shall be compensated for such Covered Services per the applicable Compensation Schedule. Disputes regarding the necessity for continued treatment by Provider in situations involving termination shall be resolved in accordance with the state and federal rules and regulations.

VII. MISCELLANEOUS

7.1. No Indemnity. The parties agree that any liability arising from this Agreement shall be borne by the responsible party. Each party shall be responsible for its own defense and resolution of any claims against that party.

7.2. Governing Law. This Agreement has been executed and delivered, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Texas shall be the sole and exclusive venue for any litigation, special proceeding, or other proceeding between the parties that may be brought or arise out of or in connection with or by reason of this Agreement.

7.3. Third Party Covered Person. This Agreement is entered into by and between the parties hereto for their sole benefit. Unless explicitly provided in this Agreement, there is no intent by either party to create or establish third party Covered Person status or rights by any Covered Person, or other third

party to this Agreement, and no such third party shall have any right to enforce any right or enjoy any benefit created or established under this Agreement. This Agreement shall inure to the benefit of and be binding upon only the parties hereto and not to their respective legal representatives, successors and assigns, without the prior written consent of the other party.

7.4. Assignment. No assignment of this Agreement or the rights and obligations hereunder shall be valid without the specific written consent of both parties hereto, which consent shall not be unreasonably withheld, except that Network may assign this Agreement and all of Network's rights, duties and obligations hereunder to a successor organization. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties thereto.

7.5. Waiver of Breach. The waiver by either party of any breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof.

7.6. Force Majeure. Neither party shall be liable nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from any cause beyond the reasonable control of either party, including without limitation, acts of God, civil or military authority, acts of public enemy, fires, floods, strikes or regulatory delay or restraint.

7.7. Notice. Any material notice affecting the terms of this Agreement shall be in writing and shall be deemed to have been made three (3) days after it is deposited in the United States mail, postage prepaid, return receipt requested, and addressed as follows:

To Provider:
to the address shown in the most current Network Provider Directory.

To Network:

Physician Optimal Network, Inc. ("PONI")
% Cypress Healthcare Consultants
2929 N Central Expressway, Suite 205
Richardson Texas 75080
or to such other address as shall have been given in writing by either party to the other.

7.8. Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason and in any respect, such invalidity, illegality or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall be in full force and effect and enforceable in accordance with its terms.

7.9. Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

7.10. Divisions and Headings. The divisions of this Agreement into sections and subsections and the use of captions and headings in connection therewith are solely for convenience and shall have no legal affect whatsoever in construing the provisions of this Agreement.

7.11. Entire Agreement. This Agreement and all Attachments shall constitute the entire agreement relating to the subject matter between the parties. Each party acknowledges that no representation, inducement, promise or agreement has been made, orally or otherwise, by the other party, or anyone acting on behalf of the other party, unless such representation, inducement, promise or agreement is embodied in this Agreement, expressly or by incorporation.

7.12. Amendments. This Agreement may be amended or modified in writing as mutually agreed upon by the parties. Network may modify any provision of this Agreement upon thirty (30) days prior written notice to Provider. Provider agrees to accept the Network's modification if Provider fails to object to such modification, in writing, within the thirty (30) day notice period. Amendments or

modifications of this Agreement that would materially affect the responsibilities or rights of Provider shall require the written consent of both parties. . This Agreement and the amendments thereto, if any, shall be in writing and executed in two or more counterparts by officials of each party specifically authorized to execute such instruments.

The parties agree that applicable state and/or federal laws and/or regulations may make it necessary to include in this Agreement specific provisions relevant to the subject matter contained herein. In the event state and/or federal laws and/or regulations enacted after the Effective Date expressly require specific language be included in this Agreement, such provisions are hereby incorporated by reference without further notice or action of the parties and such provisions shall be effective as of the effective date stated in such laws, rules or regulations.

7.13. Dispute Resolution. Any controversy, dispute or disagreement arising out of or relating to this Agreement or the breach of this Agreement shall first be referred to mediation through the American Health Lawyers Association using the dispute resolution procedures of the applicable state Civil Remedies Code. Any issue or dispute remaining unresolved through mediation shall be submitted to binding arbitration, which shall be conducted within the county of Collin in the state of Texas in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and judgment on the award rendered by the arbitrator shall be binding, and may be entered in any court having jurisdiction.

7.14. Access to Books and Records. If this Agreement is determined to be subject to the provisions of Section 952 of P.L. 96-499, or its equivalent, which governs access to books and records of subcontractors of services to Medicare providers where the cost or value of such services under the contract exceeds $10,000 over a 12-month period, Provider agrees to permit representatives of the Secretary of the Department of Health and Human Services and the Comptroller General, in accordance with criteria and procedures contained in applicable federal regulations, to have access to its books, documents and records as necessary to verify the cost of services provided under this Agreement.

The individual executing this Agreement on behalf of Provider hereby represents that such individual has all necessary authority to enter into this Agreement and to bind the Physicians of Provider to the terms of this Agreement.

---------- ***The Remainder of this Page Intentionally Left Blank***----------

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date set forth below.

I certify that I am authorized to bind this practice and the individual providers, if applicable, to the terms and conditions of this agreement

PROVIDER	**Physician Optimal Network, Inc. ("PONI")**
Signature: _____	Signature: _____
Print Name: _____	Print Name: Susie White
Title: _____	Title: President
Date: _____	Date: _____

(The Effective Date shall be the date of execution by Network)

ATTACHMENT A

REIMBURSEMENT METHODOLOGY

A list of Conforming Agreements and Non-Conforming Agreements will be provided to Participating Physicians as requested or periodically as provided for in PONI's policies and procedures. Non-Conforming Payor Agreements requiring individual Physician acceptance are incorporated into this Attachment A by reference.

DISCOUNT FROM BILLED CHARGES METHODOLOGY

Physician agrees to accept the following as payment in full for Covered Services. Reimbursement will be at the lesser of Physician's usual and customary charges less any amounts specified in the applicable Health Benefit Plan for deductibles, copayments or coinsurance as the responsibility of the Covered Person.

PHYSICIAN SERVICES

SERVICE	
1. Global	

Signature (only if accepted by Provider)_____

RBVRS REIMBURSEMENT METHODOLOGY

Physician agrees to accept the following RBRVS conversion factors as payment in full for Covered Services. Reimbursement will be at the lesser of Physician's usual and customary charges less any amounts specified in the applicable Health Benefit Plan for deductibles, copayments or insurance as the responsibility of the Covered Person.

Reimbursement will be based on an RBRVS methodology. The following minimum conversion factor or factors will be based on RBRVS as available from Ingenix or successor entity.

SERVICE	REIMBURSEMENT
By Service	
A. Evaluation and Management	130%
B. All Other	130%
C. HCPCS	100%

Signature (only if accepted by Provider) _____

ATTACHMENT B

ANTITRUST POLICIES AND PROCEDURES

1. Purpose: Network will facilitate Payor Agreements as follows:

   A. Offering payors the competitive advantage of a Participating Provider panel for managed care plans while minimizing the need for extensive administrative costs from contracting with individual healthcare providers.

   B. Offering payors a new product--a diverse panel of Participating Providers from a variety of locations and specialties who agree to participate in the Payor Agreement through Network.

   C. Offering payors a single, more efficient source to contract for a variety of healthcare providers by affiliating with Network for purposes of managed care contracting.

2. Role of Network in Conforming Agreements.

   A. Provider shall authorize Network, or Network's designee, to execute on Provider's behalf any Payor Agreement that conforms to the Provider's established criteria (Conforming Agreements), which criteria has become Network's approved contracting criteria.

   B. If requested in writing by a Payor, Network will provide information on the Provider's approved reimbursement methodologies.

   C. Upon execution of a Conforming Agreement, Network shall notify each Participating Provider of the Payor Agreement.

   D. Payors remain free at all times to contract directly with Provider for Conforming Agreements.

3. Role of Network in Non-Conforming Agreements.

   In all dealings with Payors involving contract opportunities that do not conform to the criteria established by Participating Providers (Non-Conforming Agreement), Network will facilitate Payors' attempts to assemble Participating Provider panels as follows:

   A. Network will designate a non-Participating Provider employee or agent or independent third party "(Liaison") to objectively convey all price information between Payor and Participating Providers. The Liaison will not negotiate for the Participating Provider, communicate to any Participating Provider the Liaison's or any other Participating Provider's views or intentions as to the proposal, or otherwise facilitate any agreement among Participating Providers on prices or other competitive terms under a Non-Conforming Agreement.

   B. Network may present objective information to each Payor regarding current market forces, including an indication of the historical rates in the market and the rates Participating Providers might be likely to accept if requested by the Payor.

   C. Network may review non-price elements of the Non-Conforming Agreements that are not competitively sensitive (e.g., timeliness of payment, mechanics of payments) on behalf of the Participating Providers.

   D. The Liaison will objectively convey each Non-Conforming Agreement to each Participating Provider without recommending acceptance or rejection of any offer or otherwise indicating "disapproval."

   E. The Liaison will solicit clarifications of any information regarding the Non-Conforming Agreement and convey to Participating Providers any response from the Payor.

   F. The Liaison will convey to the Payor the acceptance, rejection or specific views from each Participating Provider regarding the Non-Conforming Agreement.

G. Each individual Participating Provider will make a separate, independent and unilateral decision to accept or reject a Non-Conforming Agreement.

H. Any information on prices or other competitive terms and/or any decision to accept or reject a Non-Conforming Agreement will be obtained separately from each individual Participating Provider and conveyed by the Liaison to the Payor in a neutral manner.

I. Payors remain free at all times to contract directly with Provider for Non-Conforming Agreements.

4. Restrictions: In all circumstances Network will not:

A. Promote, condone or participate in collective decisions by competing Participating Providers to participate in or refuse Payor's fee-for-service plans;

B. Dictate terms (price or otherwise) on which Participating Providers will participate in Payor's fee-for-service plans;

C. Share information among competing Participating Providers as to terms (price or otherwise) on which they will contract or do business with any Payor's fee-for-service plan, whether a Conforming Agreement or a Non-Conforming Agreement, other than disclosing the terms agreed to with a particular Payor in the course of discussions as described above; or

D. Deny Payors direct access to Participating Providers nor inhibit Participating Providers' direct contracting with Payors.

ATTACHMENT C

LIST OF PROVIDERS IN PROVIDER AS OF THE EFFECTIVE DATE OF THIS AGREEMENT

ATTACHMENT D

MEDICARE ADVANTAGE HMO, PPO, POS and PFFS AMENDMENT TO THE PONI PROVIDER PARTICIPATION AGREEMENT

CMS requires that specific terms and conditions be incorporated into the Physician Agreement to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Publ. L. No. 108-173, 117 Stat. 2006 ("MMA") and except as provided herein, all other provision of the Agreement not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA Organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, papers records or other documents (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with the applicable MA Organization through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. Physician will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner,

and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Physician or Downstream Entity may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a MA Organization. Providers will: (1) accept the MA Organization payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreements by Physician or a Downstream Entity are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Physician and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

7. Physician agrees to provide to Medicare Advantage Members the health care services for which Physician is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Physician shall make Covered Services available and accessible to Medicare Advantage Members, including telephone access to Physician, on a twenty-four (24) hours, seven (7) days per week basis.

8. Physician understands and agrees that payments received by the MA Organization Medicare Advantage MA Organization from CMS pursuant to MA Organization's contract with CMS are Federal funds. As a result, Physician, by entering into this Agreement and the terms of the Product Attachment, is subject to laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

9. In the event MA Organization's Medicare Advantage contract with CMS terminates or MA Organization becomes insolvent, Physician shall continue to provide Covered Services to Medicare Advantage Members who are hospitalized through the later of: (a) the date for which premiums were paid, or (b) through the date of discharge. Physician is prohibited by law from billing Medicare Advantage Members for such Covered Services. This provision shall survive the termination of this Agreement or Product Attachment, regardless of the reason for termination, including the insolvency of MA Organization, and shall supersede any oral or written agreement between Physician and a Medicare Advantage Member.

10. Physician agrees to comply with MA Organization's policies and procedures which operationalize many of the requirements of the Agreement, this Product Attachment, and the Medicare Advantage program. Physician agrees to comply with MA Organization's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies the MA Organization may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a MA Organization policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

11. Physician shall preserve records applicable to Medicare Advantage Members or to MA Organization's participation in the Medicare Advantage Program, for the longer of: (i) the period of time required by State and Federal law, including the period required by Medicare programs and contracts to which MA Organization is subject, or (ii) ten (10) years from the date this Agreement ends or from the date of completion of any audit, whichever is longer, or longer if so required by CMS.

12. Physician shall require all of its subcontractors, if any, to comply with all applicable Medicare laws, regulations and CMS instructions. If Physician arranges for the provision of Covered Services from other health care providers for Medicare Advantage Members, such contracts shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that MA Organization delegates

to Physician a selection of providers, MA Organization retains the right to approve, suspend or terminate such delegation. The term "Subcontractor" as used in this section shall not refer to employees or other individuals that perform services on behalf of Physician for which Physician bills such services under this Agreement. Physician represents and warrants that such persons are subject to all terms and conditions of this Amendment.

13. Physician understands and agrees that no person that provides health care services under this Amendment, or persons that provide utilization review, medical social work or administrative services in support of services billed under this Amendment by Physician may be an individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Physician hereby certifies that no such excluded person will provide such services under this Amendment and no such excluded persons will be employed by or utilized by any "downstream" entity with which Physician contracts relating to the furnishing of these services to Medicare Advantage Members.

14. Physician hereby acknowledges that MA Organization is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Physician and a Medicare Advantage Member. Physician agrees to cooperate with MA Organization and to provide MA Organization with all such information in such form and manner as requested by MA Organization.

15. Physician recognizes that as a Medicare Advantage organization, MA Organization is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to MA Organization by its contractors and subcontractors. Physician and its subcontractors, if any, hereby certify that any such data submitted to MA Organization will be accurate, complete and truthful. Upon request, Physician shall make such certification in the form and manner prescribed by MA Organization.

16. Physician agrees to cooperate with MA Organization in resolving any Medicare Advantage Member complaints related to coverage for the provision of Covered Services. MA Organization will notify Physician as necessary concerning all Medicare Advantage Member complaints involving Physician. Physician shall, in accordance with the Physician's regular procedures, investigate such complaints and respond to MA Organization in the required time. Physician shall use best efforts to resolve complaints in a fair and equitable manner.

17. Physician shall (and shall cause its subcontractors to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse relating to the operation of MA Organization's Medicare Program. Such compliance program shall be appropriate to Physician's or subcontractor's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws; and (b) for all officers, directors, employees, contractors and agents of Hospital or subcontractor, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations.

18. MA Organization shall arrange for Physician to be compensated for health care services rendered to Medicare Advantage Members in accordance with Section 2 of this Product Attachment. The MA organization shall promptly pay the Physician in accordance with [42 C.F.R. §§ 422.520(b) (1) and (2)]. In accordance with 42 CFR 422.520(a)(1), MA Organization shall pay clean claims submitted by Physician for Covered Services provided to Medicare Advantage Members within thirty (30) calendar days of receipt. The term "clean claim" shall have the meaning assigned in 42 CFR 422.500. MA Organization shall pay interest on clean claims that are not paid within thirty (30) calendar days of such receipt by MA Organization at the rate of interest established by the Secretary of the Treasury of the United States, and published in the Federal Register for the most recent period. 42 CFR 422.520(b)(1) and (2).