ASPA Arizona State Physicians Association

We are pleased that you have expressed an interest in becoming a member of the Arizona State Physicians Association (ASPA). Enclosed are the following:

- ASPA Application
- ASPA Payor Participation Attachments
- Copy of Physician/Provider Affiliate Agreement (**see below**)
- **Please see attached Checklist on next page regarding items needed for your application.**

Please complete the application in full **(any items that pertain to you and your Specialty MUST be filled out) (See Attached, See CV, and CAQH applications will not be accepted)** return **ALL** enclosures with the documentation requested on the application. **PLEASE DO NOT SUBMIT THE APPLICATION 2 SIDED.**

Please review and sign a copy of the contract on page 10. Please **DO NOT** date the contract cover or the 2nd page of the contract. This is to be completed on the date of approval by the Board of Directors. A dated and signed copy will be returned to you for you records following application approval.

Upon receipt of the required information, your application will undergo the credentialing process. **This process takes between 90-120 days.** The contract shall be deemed executed when signed by an official representative of the Arizona State Physicians Association. At that time you will be notified regarding which plans you will be participating in through ASPA.

Additionally, a site visit and chart audit will be required on ALL OB/GYN and Primary Care provider offices as well as Nurses in those same fields. Once your application has been submitted to our credentialing department, our QA Nurse will be calling to schedule a convenient time to come out to your office. We strongly advise you allow our nurse to come out to your office as soon as possible as your application will not be finalized and sent to committee for review until this component of the initial credentialing process has been complete.

As a Member, you may or may not have access to all ASPA's current contracted plans. Your name, specialty, and location(s) will be presented to our current contract plans for consideration of participation.

DO NOT provide services to any contracted plans **UNTIL THE EFFECTIVE DATE WITH EACH OF THE PLANS HAS BEEN CONFIRMED.** Services prior to that effective date **WILL NOT BE COVERED. PLEASE NOTE** your effective date with the plans **WILL BE DETERMINED BY THE INDIVIDUAL PLAN, NOT ASPA.**

If, of course you already have a direct contract with any of the offered plans, you should continue under that contract until your ASPA contract is in effect, at which time you have a choice to either continue under your individual contract or utilize the contract available through ASPA. We suggest you evaluate your contracts to determine which contract is better for your office.

Once you have been approved as a Member you will have access to many other services offered by ASPA.

If you require further clarification or have any questions regarding the application or credentialing processes you may contact Angie at **angie@azspa.com** or 602-265-2524 Ext. 222.

For questions regarding ASPA Contracted Plans and other ASPA services please contact Connie at connie@azspa.com.

Sincerely,
Angie Higgins

3030 N. Central Ave. Suite 1405, Phoenix, AZ 85012 Email: angie@azspa.com Fax: 602-865-7022

ASPA Arizona State Physicians Association

ASPA Initial Application Checklist

DUE TO NEW STATE REQUIRMENTS, ALL APPLICATIONS MUST BE FILLED OUT COMPLETELY OR IT WILL NOT BE PROCESSED. IF SOMETHING DOES NOT APPLY, PLEASE PUT N/A.

Payment is REQUIRED BEFORE the credentialing process can be started, please see fee structure below: (EFFECTIVE June 4th, 2018 all fees have been INCREASED $25)

Specialty Physicians: $550

Primary Care Physicians: $450

ALL NURSES: $375 (NP's, FNP's, CNM's, RN's, etc)

Allied Health Member $350 (PA's, PT's, Ph.D.'s, DC's etc)

This fee includes your first year annual dues and Credentialing costs. **YOUR APPLICATION WILL NOT BE PROCESSED UNTIL THIS FEE HAS BEEN RECEIVED**. This fee should be sent in with the application or paid online at http://azspa.com/pay-your-bill-online/(with a copy of the receipt attached), if a fee is not received within 30 days of ASPA receiving the application, the application will be shredded.

Please make sure the following items are attached upon completion and return of your ASPA Application:

- **Copy of DEA Certificate:** (if applicable) (**MUST** show **ARIZONA** address and **Current Expiration date**)
- **Documentation of Arizona State License:** (showing **current expiration date**)
- **Copy of Current Malpractice Facesheet:** (showing **current expiration date**)(Limits no less than $1 Million/$3Million)
- **Copy of Workman's Comp AND a Copy of General Liability Facesheets:** (**BOTH** showing **current expiration dates**)
- **Copy of SAMs certificate:** (Sexual Misconduct and Molestation)
- **Copy of Curriculum Vitae:** with minimum 5 years Work History. All dates (**Education and Work History**) **MUST** be in a Month/Year Format. **(MM/YYYY)**
- **Proof of CME Hours:** (**Chiropractors & Physical Therapist ONLY**)
- **ALL NURSES** must be **Board Certified.** ASPA does not accept Nurses that are not Board Certified. **(Please note this is not the same as being licensed with the State of Arizona)**
- **A Current W9:** (**showing Billing Address that is listed on the application**.)
- **Current CLIA Certificate(s):** if applicable
- **Please provide Current Fraud, Waste and Abuse Certificates for the applicant (See last page of Application)** (Please contact Connie with any questions, connie@azspa.com)
- **NPI Assignment Letter(s)** (Please provide BOTH Individual **AND** Group NPI Letters
- **AHCCCS ID Number Approval Letter**
- **Medicare Approval Letter** (Letter from Noridian)
- **EIN Letter regarding your Tax-ID**

ARIZONA STATE PHYSICIANS ASSOCIATION
STANDARD APPLICATION TO PARTICIPATE
Please Type or Print Legibly. If more space is needed, use supplementary pages.
("SEE ATTACHED" "SEE CV", "SEE CAQH" ARE NOT ACCEPTED)

DUE TO NEW STATE REQUIRMENTS, ALL APPLICATIONS MUST BE FILLED OUT COMPLETELY OR IT WILL NOT BE PROCESSED. IF SOMETHING DOES NOT APPLY, PLUS PUT N/A.

PERSONAL INFORMATION:

Title: _____ **Last Name**: _____ **First Name:**_____

Middle Name:_____ Suffix: _____ Salutations: Professional _____ Personal _____

Degree: _____ **Date of Birth**: ____/___/_____ **Age**: _____ **Sex:** □ Male □ Female

Social Sec. # _____ **E-Mail Address:** _____

Primary Care: _____ **Specialist**: _____ **Allied Health:** _____ ASPA ID# _____

ALIAS:

Type: Maiden Name: _____Other:_____

Title: _____ Last Name: _____ First Name: _____

Middle Name: _____ Suffix: _____ Start Date: _____ End Date: _____

Comment: _____

HOME AND PERSONAL INFORMATION:

Address:_____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ Listed: _____ **Telephone 2:** _____ Listed: _____

Cell Phone: _____ **Beeper:**_____

Birthplace City: _____ **State:** _____ **Country:** _____

Languages: _____ **Write**:_____ **Read:** _____**Speak:** _____

Languages: _____ **Write**:_____ **Read:** _____**Speak:** _____

Citizenship: _____

If not a Citizen of the United States please indicate the status of your visa at the present time: _____

Ethnic Background: _____ **Date of Last Physical Exam:** _____

Marital Status: _____**Spouse's Name**: _____

CREDENTIALING CONTACT INFORMATION:

Contact Name: _____ **Title:** _____

Company Name: _____

Address:_____

Suite: _____ **City:** _____

State: _____ **Zip Code:** _____ **Telephone:** _____

Cell Phone: _____ **Fax#:** _____

E-Mail: _____

OFFICE INFORMATION:

Location #1 ☐ **Primary Office** ☐ **Mailing Address** ☐ **Billing Address**

Date started at this location: _____/____/ _____ **Is Office Handicap Accessible?:** Yes ___ No ___

Office Name:_____

Address:_____**Suite#:** _____**City:** _____

State: _____ **Zip:** _____ **County:** _____

Web Site: _____ **E-mail:** _____

EMR: YES NO EMR Company Name:_____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ **Legal Name:** _____

Legal Identity: ☐ **PC** ☐ **PA** ☐ **LLC** ☐ **Other** _____ Group NPI #:_____

Practice Status: ☐ **Group** ☐ **Individual** ☐ **Partnership** ☐ **Employee** **Accepting New Patients: ___Yes ____No**

CLIA Certificate #:_____ **CLIA Certificate Expiration Date:**_____
(Please provide copies for all practicing locations)

List Service you provide in this office: ___EKG ___GYN Exam ___Immunizations Other: _____

Days and Hours of Operation:

SUNDAY	_____	_____	THURSDAY	_____	_____
MONDAY	_____	_____	FRIDAY	_____	_____
TUESDAY	_____	_____	SATURDAY	_____	_____
WEDNESDAY	_____	_____			

Office Contact:

Name: _____ **Title:** _____ **Salutation:** _____

Primary Contact: ___ Yes ___ No Type: __ Office __ Business ___Insurance/ Billing _____Administrator _____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other):_____

E-Mail: _____

#2 OTHER OFFICE LOCATION: **□ Satellite Office □ Mailing Address □ Billing Address**

Date started at this location: _____/____/ _____ **Is Office Handicap Accessible?:** Yes ___ No ___

Office Name:_____

Address:_____**Suite#:** _____**City:** _____

State: _____ **Zip:** _____ **County:** _____

Web Site: _____ **E-mail:** _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ **Legal Name:** _____

Legal Identity: □ **PC** □ **PA** □ **LLC** □ **Other** _____ Group NPI #:_____

Practice Status: □ **Group** □ **Individual** □ **Partnership** □ **Employee** **Accepting New Patients: ___Yes ____No**

CLIA Certificate #:_____ **CLIA Certificate Expiration Date:**_____
(Please provide copies for all practicing locations)

List Service you provide in this office: ___EKG ___GYN Exam ___Immunizations Other: _____

Days and Hours of Operation:

SUNDAY	_____	_____	THURSDAY	_____	_____
MONDAY	_____	_____	FRIDAY	_____	_____
TUESDAY	_____	_____	SATURDAY	_____	_____
WEDNESDAY	_____	_____			

Office Contact:

Name: _____ **Title:** _____ **Salutation:** _____

Primary Contact: ___ Yes ___ No Type: __ Office __ Business ___Insurance/ Billing _____Administrator _____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other):_____

E-Mail: _____

 # 3 OTHER OFFICE LOCATION: ☐ **Satellite Office** ☐ **Mailing Address** ☐ **Billing Address**

Date started at this location: _____/____/ _____ **Is Office Handicap Accessible?:** Yes ___ No ___

Office Name:_____

Address:_____**Suite#:** _____**City:** _____

State: _____ **Zip:** _____ **County:** _____

Web Site: _____ **E-mail:** _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ **Legal Name:** _____

Legal Identity: ☐ **PC** ☐ **PA** ☐ **LLC** ☐ **Other** _____ Group NPI #:_____

Practice Status: ☐ **Group** ☐ **Individual** ☐ **Partnership** ☐ **Employee** **Accepting New Patients: ___Yes ____No**

CLIA Certificate #:_____ **CLIA Certificate Expiration Date:**_____
(Please provide copies for all practicing locations)

List Service you provide in this office: ___EKG ___GYN Exam ___Immunizations Other: _____

Days and Hours of Operation:

SUNDAY	_____	_____	THURSDAY	_____	_____
MONDAY	_____	_____	FRIDAY	_____	_____
TUESDAY	_____	_____	SATURDAY	_____	_____
WEDNESDAY	_____	_____			

Office Contact:

Name: _____ **Title:** _____ **Salutation:** _____

Primary Contact: ___ Yes ___ No Type: __ Office __ Business ___Insurance/ Billing _____Administrator _____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other):_____

E-Mail: _____

LIST ADDTIONAL ADDRESS INFORMATION ON A SEPARATE SHEET OF PAPER

SUBMIT A W-9 FORM FOR EACH TAX ID NUMBER USED

SHARE CALL

List the names of physicians with whom you share call:

NAME: _____ Title:_____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

PHYSICIAN/PROVIDER SPECIALTIES: (ALL APPLICANTS HAVE A SPECIALTY)

My Primary Specialty: _____

Specialize or limit my Practice to: _____

Certified: YES NO **Name of Board:** _____

Cert. #: _____ **Date:** ___/____/____ **Expires:** ___/ ____/ _____ Original Cert Year _____

Re-Cert Year: _____ Not certified, are you eligible? □ YES □ NO Exam Date: _____

Sub-Specialty: _____Certified: □ YES □ NO

Cert. #: _____ **Date:** ____/___/____ **Expires:** ____/___/ _____ Original Cert Year _____

If not certified, are you eligible? □ YES □ NO Exam Date: _____

HAVE YOU EVER BEEN EXAMINED BY ANY SPECIALTY BOARD, BUT FAILED TO PASS THE EXAMINATION?
□ YES □ NO IF YES, EXPLAIN: _____

HOSPITAL / ADMIT LIST

PLEASE LIST ARIZONA HOSPITALS WHERE YOU HOLD PRIVILEDGES INCLUDING ANY THAT ARE PENDING. IF MORE SPACE IS REQUIRED, ATTACH ADDITIONAL SHEET:

HOSPITAL & ADDRESS **DATES FROM & TO (Mo, day & Yr)** PRIMARY HOSPITAL

#1_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#2_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#3_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#4_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#5_____ _____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#6_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

IF YOU DO NOT HAVE HOSPITAL PRIVILEGES, PLEASE INDICATE WHO WILL BE ADMITTING FOR YOU INCLUDE NAME OF ALL HOSPITALIST GROUPS USED:

#1 Physician Name / Hospitalist Group Name: _____ Title: _____

Phone: _____ Fax: _____

Effective: ___/___/_____ Through ____/____/_____

#2 Physician Name / Hospitalist Group Name: _____ Title: _____

Phone: _____ Fax: _____

Effective: ___/___/_____ Through: ____/____/_____

IF MORE THAN TWO PHYSICIANS OR GROUPS ARE USED, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH.

EDUCATIONAL BACKGROUND (Please provide ALL DATES in a MM/YYYY format)

UNDERGRADUATE

University:_____ Phone: _____

Address:_____ _____City: _____State:_____

Zip code: _____ Attention: _____ Country: _____

From: _____/_____/_____ Through: ____/____/_____ Date Graduated: ____/_____/_____

Degree Earned: _____

MEDICAL/DENTAL COLLEGE

University:_____ **Phone:** _____

Address:_____**City:** _____**State**:_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ Specialty: _____

OTHER PROFESSIONAL TRAINING

University:_____ Phone: _____

Address:_____ _____City: _____State:_____

Zip code: _____ Attention: _____ Country: _____

From: _____/_____/_____ Through: ____/____/_____ Date Graduated: ____/_____/_____

Degree Earned: _____ Specialty: _____

POST GRADUATE EDUCATION

University:_____ Phone: _____

Address:_____ _____City: _____State:_____

Zip code: _____ Attention: _____ Country: _____

From: _____/_____/_____ Through: ____/____/_____ Date Graduated: ____/_____/_____

Degree Earned: _____ Specialty: _____

INTERNSHIP

University:_____ **Phone:** _____

Address:_____**City:** _____**State**:_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ **Specialty:** _____

IF MORE THAN ONE INTERNSHIP WAS COMMENCED OR COMPLETED, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH

 # 1 RESIDENCY

University:_____ **Phone:** _____

Address:_____**City:** _____**State:**_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ **Specialty:** _____

#2 RESIDENCY

University:_____ **Phone:** _____

Address:_____**City:** _____**State:**_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated**: ____/_____/_____

Degree Earned: _____ **Specialty:** _____

IF MORE THAN TWO RESIDENCIES WERE COMMENCED OR COMPLETED, PLEASE SUPPLY THE ADDITIONAL INFORMATION ON A SEPARATE SHEET AND ATTACH.

FELLOWSHIP

University:_____ **Phone**: _____

Address:_____**City:** _____**State**:_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ Specialty: _____

IF MORE THAN ONE FELLOWSHIP WAS COMMENCED OR COMPLETED, PLEASE SUPPLY THE ADDITIONAL INFORMATION ON A SEPARATE SHEET AND ATTACH.

PLEASE LIST ANY GAPS OF 180 DAYS OR MORE DURING EDCATION:

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

If you need more space please attach information on a separate piece of paper.

LICENSE AND PROVIDER NUMBER INFORMATION

NPI#: _____ **Group NPI#:** _____

Medicare Provider #:_____ Effective: _____ UPIN #: _____

Accept Medicare Assignment? □ YES □ NO Group Medicare # _____

Medicaid/ AHCCCS Provider #: _____ Effective Date: _____

ECFMG Certificate #: _____ Issue Date: _____

DEA#:_____ DEA Schedules: _____

DEA Effective:_____ DEA Expiration Date: _____

Other DEA #S You Use: _____

Arizona License#:_____Original Date Issued:_____Effective:_____ **Expires:** _____

Original State Licensure: State: _____ Number: _____ Original Date issued: _____

List All Other State(s) And License Number(s) In Which You Are/Or Have Been Licensed To Practice:

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

PLEASE ATTACH COPIES OF YOUR DEA, EACH STATE LICENSE & ECFMG CERTIFICATE

LIABILITY CARRIERS:

Current: _____ YES _____ NO

Insurance Company Name: _____

Address:_____**Suite:** _____ **City:** _____

State: _____**Zip Code**: _____**Phone:** _____

Amount of Coverage: $_____/_____ **Policy #:**_____

From:____/_____/_____ **To:**_____/_____/_____ Certificate Holder: _____YES _____ NO

Current: _____ YES _____ NO

Insurance Company Name: _____

Address:_____**Suite:** _____ **City:** _____

State: _____**Zip Code:** _____**Phone:** _____

Amount of Coverage: $_____/_____ **Policy #**:_____

From:____/_____/_____ **To:**_____/_____/_____ Certificate Holder: _____YES _____ NO

FOR LIABILITY CARRIERS WITHIN THE PAST 10 YEARS -- PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH. ATTACH COPIES OF YOUR CERTIFICATES FOR MALPRACTICE INSURANCE

REFERENCES

ON YOUR BEHALF, PLEASE HAVE THREE (3) LETTERS OF REFERENCE FORWARDED TO OUR OFFICE. YOUR APPLICATION **IS NOT** CONSIDERED TO BE COMPLETE UNTIL THESE LETTERS ARE COMPLETED AND RECEIVED BY ASPA. **PLEASE DO NOT HOLD THE APPLICATION WAITING FOR REFERENCES TO BE RETURNED TO YOU AS ASPA MAY HAVE ALREADY RECEIVED THEM**. REFERENCES WILL BE EVALUATED ACCORDING TO THE EXTENT OF THEIR DIRECT CLINICAL OBSERVATION OF YOUR WORK AND OTHER KNOWLEDGE OF YOU. LIST BELOW THE NAMES, ADDRESSES, AND PHONE NUMBERS OF THE **PHYSICIANS (OTHER THAN YOUR CURRENT ASSOCIATES)** AND **FORMER ASSOCIATES** WHO WILL BE SUPPORTING YOUR MEMBERSHIP IN ASPA. REFERENCE SHOULD BE FROM A PEER OF THE SAME SPECIALTY. **REFERENCES MUST BE FROM OTHER PHYSICIANS, ALLIED HEALTH PROVIDERS(NURSES, PT'S, PA'S, ETC) ONLY DRS CAN FILL OUT FOR OTHER DRS, DRS CAN FILL OUT FOR ALLIEDS, ALLIEDS CANNOT FILL OUT FOR DRS.** THE PEERS LISTED BELOW WILL BE USED ON PAGES 22-24 OF THIS APPLICATION.

Name: _____ Title: _____

Salutation: _____ **Specialty:**_____

Address: _____**Suite#:**_____ **City:** _____

State: _____ **Zip Code**: _____ Country:_____ **Phone Number**: _____

Fax Number: _____ **Email Address:** _____

☐ PROFESSIONAL

Name: _____ Title: _____

Salutation: _____ **Specialty**:_____

Address: _____**Suite #**_____ **City**: _____

State: _____ **Zip Code:** _____ Country: _____ **Phone Number:** _____

Fax N umber: _____ **Email Address:** _____

☐ PROFESSIONAL

Name: _____ Title: _____

Salutation: _____ **Specialty**:_____

Address: _____**Suite #**_____ **City:** _____

State: _____ **Zip Code:** _____ Country: _____ **Phone Number:** _____

Fax N umber: _____ **Email Address:** _____

SOCIETIES, COLLEGES AND ACADEMIES

List Memberships In Professional Societies, Colleges, And Academies (Local, State Or National)

ORGANIZATION:	MEMBER SINCE:	THROUGH:
_____	_____	_____

Elected or Appointed Position Held: _____

_____	_____	_____

Elected or Appointed Position Held: _____

_____	_____	_____

Elected or Appointed Position Held: _____

**********PLEASE ATTACH CURRICULUM VITAE WHICH INCLUDES YOUR WORK HISTORY*******(Dates MUST BE in a MM/YYYY Format)**********

WORK HISTORY

Please list your work history starting with your current position of who you are being credentialed with. **Please provide dates in a MONTH/YEAR format.** If you need more room, please attach a separate piece of paper with the following information

("SEE CV" WILL NOT BE ACCEPTED)

#1 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____**Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____**Title:** _____ **Contact Phone:**_____

#2 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____ **Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____Title: _____ **Contact Phone:**_____

#3 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____ **Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____Title: _____ **Contact Phone:**_____

#4 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____ **Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____Title: _____ **Contact Phone:**_____

PLEASE LIST ANY GAPS IN TIME (EMPLOYMENT) FOR SIX MONTHS OR MORE:

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

If you need more space please attach information on a separate piece of paper.

PHYSICIAN PHILOSOPHY:

1. DO YOU UNDERSTAND THE CONCEPT OF MANAGED HEALTH CARE AND ARE YOU WILLING TO WORK WITHIN THE GUIDELINES ESTABLISHED BY CONTRACTED HEALTH PLANS? ☐ **YES** ☐ **NO**

2. DO YOU RECOGNIZE AND ACCEPT THAT UTILIZATION REVIEW AND PEER REVIEW ARE FUNDAMENTAL PRINCIPLES OF THIS ORGANIZATION? ☐ **YES** ☐ **NO**

3. DO YOU AGREE THAT MEDICAL RECORDS/CHARTS WILL BE AVAILABLE FOR UTILIZATION/QUALITY ASSURANCE REVIEW? ☐ **YES** ☐ **NO**

4. ARE YOU WILLING TO ACTIVELY PARTICIPATE ON ANY COMMITTEES REPRESENTING THIS ORGANIZATION (i.e., CREDENTIALING, QA/UR, BOARD OF DIRECTORS)? ☐ **YES** ☐ **NO**

5. WOULD YOU BE AVAILABLE TO PROVIDE EDUCATIONAL PROGRAMS IN YOUR SPECIALTY FOR MEMBERS OF THIS ORGANIZATION? ☐ **YES** ☐ **NO**

FAILURE TO ANSWER THE FOLLOWING QUESTIONS TRUTHFULLY WILL RESULT IN DENIAL OF MEMBERSHIP IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, PLEASE GIVE A FULL EXPLANATION OF THE DETAILS ON A SEPARATE SHEET AND ATTACH HERETO.	**YES**	**NO**
1. ASIDE FROM THE ROUTINE CREDENTIALS SCRUTINY (INCLUDING ROUTINE REVIEW OF A SAMPLING OF YOUR CHARTS) WHICH OCCURRED AT YOUR INITIAL APPOINTMENT OR YOUR REAPPOINTMENT TO THE MEDICAL STAFFS OF HOSPITALS AT WHICH YOU HAVE OBTAINED CLINICAL PRIVILEGES, HAVE YOU EVER BEEN THE SUBJECT OF A PEER REVIEW PROCEEDING, INQUIRY OR INVESTIGATION? THIS INCLUDES, BUT IS NOT LIMITED TO, THE COMMENCEMENT OF A PROCEEDING BEFORE A MEDICAL STAFF REQUESTING ANY FORM OF CORRECTIVE ACTION INCLUDING REPRIMAND SUSPENSION OF PRIVILEGES, OR REVOCATION OF MEDICAL STAFF MEMBERSHIP, AND COVERS ALL SUCH PROCEEDINGS REGARDLESS OF THE FINAL OUTCOME.		
2. IN THE PAST 3 YEARS, HAVE YOU RESIGNED FROM A HOSPITAL OR RELINQUISHED CLINICAL STAFF PRIVILEGES TO AVOID DISCIPLINARY ACTIONS?		
3. HAVE YOU SUBMITTED AND SUBSEQUENTLY WITHDRAWN AN APPLICATION FOR MEDICAL STAFF MEMBERSHIP WITHIN THE PAST THREE YEARS?		
4. HAVE ANY INVESTIGATIVE ACTIONS PAST OR PRESENT BEEN INITIATED OR ARE ANY PENDING AGAINST YOU BY ANY STATE LICENSURE BOARD?		
5. HAS ANY STATE LICENSURE BOARD ISSUED ANY LETTERS OF CONCERN/ADVISORY LETTERS TO YOU IN THE PAST THREE YEARS?		
6. IN THE PAST 3 YEARS HAVE YOU VOLUNTARILY SURRENDERED OR HAD YOUR LICENSE TO PRACTICE MEDICINE DENIED, REFUSED, RESTRICTED, SUSPENDED, REVOKED OR CENSURED IN THIS OR ANY OTHER JURISDICTION?		

7. IN THE PAST 3 YEARS HAVE YOU HAD YOUR MEMBERSHIP IN ANY PROFESSIONAL OR SPECIALTY ORGANIZATION, HMO, PPO, MEDICARE, AHCCCS/MEDICAID OR OTHER PREPAID HEALTH PLAN PARTICIPATION, OR HOSPITAL STAFF DENIED, REFUSED, SANCTIONED, SUSPENDED OR REVOKED?		
8. IN THE PAST 3 YEARS HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION BY ANY PRIVATE, FEDERAL, OR STATE AGENCY CONCERNING YOUR PARTICIPATION IN ANY PRIVATE, FEDERAL, OR STATE HEALTH INSURANCE PROGRAM?		
9. IN THE PAST 3 YEARS HAVE YOU HAD YOUR LICENSE TO PRESCRIBE OR DISPENSE NARCOTICS REFUSED, SUSPENDED OR REVOKED?		
10. IS YOUR NARCOTICS REGISTRATION CERTIFICATE CURRENTLY BEING CHALLENGED?		
11. IN THE PAST 3 YEARS HAVE YOU BEEN NAMED AS A DEFENDANT IN ANY CRIMINAL PROCEEDING?		
12. IN THE PAST 3 YEARS HAVE YOU BEEN CONVICTED OF A FELONY OR ANY CRIME OTHER THAN A TRAFFIC OFFENSE?		
13. HAVE YOU HAD A JUDGMENT RENDERED AGAINST YOU IN ANY COURT ON A CLAIM ALLEGING PROFESSIONAL MALPRACTICE OR PROFESSIONAL NEGLIGENCE SINCE MEDICAL SCHOOL?		
14. AT ANY TIME SINCE MEDICAL SCHOOL, HAS ANYONE ASSERTED (REGARDLESS OF OUTCOME) A CLAIM AGAINST YOU ALLEGING PROFESSIONAL MALPRACTICE OR PROFESSIONAL NEGLIGENCE?		
15. HAVE YOU ANY MENTAL ILLNESS, CHRONIC ILLNESS, OR PHYSICAL DEFECT THAT MAY ADVERSELY AFFECT YOUR ABILITY TO PRACTICE MEDICINE?		
16. HAVE YOU TESTED POSITIVE FOR ANY CONTAGIOUS HEALTH CONDITION THAT WOULD ENDANGER PATIENTS YOU ARE TREATING?		
17. DO YOU NOW OR HAVE YOU EVER HAD AN ALCOHOL OR DRUG DEPENDENCY?		
18. DO YOU CURRENTLY USE ILLEGAL DRUGS?		
19. ARE YOU CURRENTLY TAKING ANY MEDICATION THAT MAY AFFECT EITHER YOUR CLINICAL JUDGMENT OR MOTOR SKILLS?		
20. DO YOU HAVE ANY LIMITATIONS ON YOUR HEALTH, LIFE OR DISABILITY INSURANCE?		
21. N THE PAST 3 YEARS HAVE YOU BEEN DENIED HEALTH, LIFE, OR DISABILITY INSURANCE?		
22. ARE YOU CURRENTLY UNDER ANY LIMITATIONS CONCERNING YOUR ACTIVITIES OR WORKLOAD?		
23. HAS YOUR PROFESSIONAL LIABILITY INSURANCE COVERAGE BEEN TERMINATED BY ACTION OF THE INSURANCE COMPANY IN THE PAST 3 YEARS?		
24. HAVE YOU BEEN DENIED PROFESSIONAL LIABILITY INSURANCE?		
25.HAS YOUR PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER EXCLUDED ANY SPECIFIC PROCEDURES FROM YOUR COVERAGE?		

POSITIONS AND MEMBERSHIPS

FACILITY POSITIONS: (DOES NOT INCLUDE STAFF MEMBERSHIPS, I.E. HOSPITALS, MED SCHOOLS, ETC.)

NAME OF FACILITY: _____

FROM _____/_____ /_____ TO _____/_____/_____

POSITION: _____

NAME OF FACILITY: _____

FROM _____/_____ /_____ TO _____/_____/_____

POSITION: _____

IF NEEDED FOR ADDITIONAL POSITIONS, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH HERETO.

HAVE YOU SERVED OR ARE YOU CURRENTLY SERVING IN THE US MILITARY? □ YES □ NO
(PLEASE INCLUDE DISCHARGE PAPERS.)

I verify that the information contained in this application is accurate and complete to the best of my knowledge. I understand that: it is my responsibility and to produce adequate information in a timely manner; any omissions or misrepresentations may result in an automatic denial of application or termination of ASPA membership; and that this application will not be processed until application is deemed complete by ASPA, and that it is my responsibility to provide all information requested to make a complete application.

Signature: **DATE:**

PRINT NAME HERE: _____

BEHAVIORAL HEALTH PROVIDERS ONLY (COMPLETE PAGES 15 THROUGH 17)

PLEASE ATTACH A COPY OF YOUR CERTIFICATES

EDUCATION AND HIGHEST DEGREE:

HIGHEST DEGREE IN SOCIAL WORK/COUNSELING YOU HAVE ATTAINED (CHECK ONE):

□ ASSOCIATE OF ARTS □ BACHELOR'S DEGREE □ MASTER'S DEGREE □ DOCTORAL DEGREE

HIGHEST DEGREE EARNED IN (CHECK ONE):

□ Ph.D □ Ed.D □ Psy.D □ Other (Specify) _____

INDICATE THE SPECIFIC PROGRAM/TRACK, DEPARTMENT AND INSTITUTION GRANTING THIS DEGREE:

NAME & ADDRESS OF INSTITUTION:
_____

NAME OF DEPARTMENT/SCHOOL: _____

NAME OF SPECIFIC PROGRAM/TRACK: _____

YEAR IN WHICH DEGREE WAS CONFERRED: _____

DID YOU COMPLETE A FORMAL RESPECIALIZATION PROGRAM IN CLINICAL COUNSELING OR SCHOOL PSYCHOLOGY AFTER COMPLETION OF DOCTORAL DEGREE IN PSYCHOLOGY? □ YES □ NO

IF YES, WAS THIS RESPECIALIZATION PROGRAM OFFERED BY A DOCTORAL PROGRAM THAT WAS ACCREDITED BY APA? □ YES □ NO NAME OF PROGRAM: _____

PSYCHOLOGIST:

WAS YOUR FORMAT INTERNSHIP OR ORGANIZED HEALTH SERVICE TRAINING PROGRAM:

□ FULL-TIME BASIS □ PART-TIME BASIS

WAS THIS TRAINING AT: □ ONE SITE □ TWO OR MORE SITES

INDICATE TOTAL NUMBER OF HOURS SUPERVISED EXPERIENCED THAT YOU RECEIVED IN EACH INTERNSHIP:

SITE ONE _____ SITE TWO_____ OTHER SITES _____ TOTAL HOURS _____

INTERNSHIP SITE ONE:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF INTERNSHIP: FROM: _____ TO: _____

HOURS SPENT PER WEEK IN INTERNSHIP: _____

YOUR TITLE IN INTERNSHIP: _____

NAME OF TRAINING DIRECTOR: _____

NAME & TITLE OF DIRECT SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

DID YOUR DIRECTOR OF DOCTORAL TRAINING APPROVE THE INTERNSHIP AS PART OF THE REQUIREMENTS OF THE DEGREE? □ YES □ NO

INTERNSHIP SITE TWO:
NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF INTERNSHIP: FROM: _____ TO: _____

HOURS SPENT PER WEEK IN INTERNSHIP: _____

YOUR TITLE IN INTERNSHIP: _____

NAME OF TRAINING DIRECTOR:_____

NAME & TITLE OF DIRECT SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

DID YOUR DIRECTOR OF DOCTORAL TRAINING APPROVE THE INTERNSHIP AS PART OF THE REQUIREMENTS OF THE DEGREE? □ YES □ NO

INDICATE TOTAL NUMBER OF HOURS SUPERVISED POST-DOCTORAL EXPERIENCED THAT YOU RECEIVED IN EACH SITE:

SITE ONE _____ SITE TWO_____ OTHER SITES _____ TOTAL HOURS _____

POSTDOCTORAL SITE ONE:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF POST-DOCTORAL EXPERIENCE: FROM: _____TO: _____

HOURS SPENT PER WEEK: _____

YOUR TITLE IN THIS SETTING: _____

NAME OF SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

POSTDOCTORAL SITE TWO:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF POST-DOCTORAL EXPERIENCE: FROM: _____TO: _____

HOURS SPENT PER WEEK: _____

YOUR TITLE IN THIS SETTING: _____

NAME OF SUPERVISOR:_____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

SOCIAL WORKER/COUNSELOR:

NAME OF FACILITY/EMPLOYMENT: _____

ADDRESS: _____

NAME OF SUPERVISOR: _____

DEGREE: _____**TELEPHONE:** _____**DATES FROM/TO:** _____

□ **FULL-TIME** □ **PART-TIME** □ **HALF-TIME OR MORE**

DESCRIBE NATURE OF WORK: _____

_____

_____

_____

_____

_____

_____

NAME OF FACILITY/EMPLOYMENT: _____

ADDRESS: _____

NAME OF SUPERVISOR _____

DEGREE:_____**TELEPHONE:** _____**DATES FROM/TO:** _____

□ **FULL-TIME** □ **PART-TIME** □ **HALF-TIME OR MORE**

DESCRIBE NATURE OF WORK: _____

_____

_____

_____

_____

STATEMENT OF INFORMATION RELEASE

All information in this application is true to my best knowledge and belief. I understand that any misleading statement or material omission in this application may constitute cause for denial or cancellation of membership.

By applying to, and/or continuing participation as a member in the Arizona State Physicians Association (ASPA), I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including ASPA and its agent(s), engaged in quality assessment, peer review and credentialing on behalf of ASPA, and **all persons and entities** providing **credentialing information to such representatives of ASPA, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in ASPA, to the extent that those acts and/or communications are protected by state or federal law.**

I authorize any third parties (including, but not limited to, individuals, agencies, medical groups, corporations, companies, employers, hospitals, health plans, licensing agencies, insurance companies, medical societies, etc.) to release information concerning my qualifications, credentials, clinical competence, quality insurance data, information pertaining to character, physical or mental health condition, behavior, ethics, claims history, disciplinary action, or any other matter reasonably having a bearing on his or her qualifications. I further authorize ASPA to release my completed credentialing file to any organization where I have applied for membership or participation and ASPA is the delegated credentialing entity.

A photocopy of this waiver shall be as effective as the original when so presented and shall be considered valid for a minimum of three (3) years from the date of signing.

NAME: _____

SIGNATURE: _____ **DATE:** _____

Arizona State Physicians Association
3030 North Central Avenue, Suite 1405
Phoenix, AZ 85012 / 602-265-2524
REVISED 9-17-08

MEMORANDUM OF UNDERSTANDING

Arizona State Physicians Association (ASPA) is a physician initiated and controlled organization which seeks to form an economic unit to promote delivery to the public of high quality, cost effective medical care through managed care and peer review techniques. Membership rights should not be considered an investment for profit and will not be transferable. Membership is limited to licensed health care providers who reside in Arizona and practice their profession in Arizona.

The ultimate accomplishment of the goals of ASPA cannot be guaranteed and membership as a physician provider does not ensure your participation in all ASPA contracts.

An Application for Participation in ASPA is attached. With the accompanying completed application for participation, please enclose the appropriate non-refundable credentialing processing fee indicated on attached instructional letter. By signing below, you agree that this fee is reasonable and it implies no obligation by ASPA to accept you as a member in ASPA.

Upon signing and returning this memorandum, together with the non-refundable processing fee (payable to ASPA), and application, the credentialing process will begin. You will maintain the right to review all information obtained by ASPA to evaluate the credentialing application. This review excludes confidential references, recommendations, or other information that is Peer Review Protected. Your completed application and other information will be reviewed by the Central Credentialing Committee composed of members from each Operating Division, or Arizona State Physicians Associations designee. Approval must be gained from this committee or designee, the Utilization and Quality Review Committee and the Board of Directors of ASPA. Such evaluation constitutes a peer review action under the Health Care Quality Improvement Act of 1986. Accordingly, any adverse decision based upon your competence or professional conduct is required to be reported to the State Board of Medical Examiners or the State Board of Osteopathic Examiners, or other appropriate State Authorities. By execution and delivery to Arizona State Physicians Association of this application, you hereby acknowledge receipt of this notice.

Print Name: _____

_____
SIGNATURE:

_____
DATE:

Arizona State Physicians Association
3030 North Central Avenue, Suite 1405
Phoenix, AZ 85012 / 602-265-2524
REVISED 05/22/2012

Arizona State Physician's Association
License Actions Report

PHYSICIAN NAME: _____

Please supply the following information for each Open or Dismissed Investigation; Advisory Letter; Letter of Reprimand; Decree of Censure; Suspension of License; Loss of License; Loss or Restriction of DEA License; or Probation, made in the past ten (10) years to allow proper review and evaluation by the credentials committee. If more than one license action exists, please photocopy this page and submit information for each. A full disclosure of the following details is necessary prior to completion of credentialing. All information will be kept in strict confidence. Attach any related correspondence, including letters of dismissal, etc. **PLEASE DO NOT INCLUDE ANY PATIENT NAMES IN REPORT(S)**

Allegation: _____

_____

_____

_____

_____

Condition and diagnosis at time of incident:_____

_____

Treatment and procedures provided: _____

Patient condition subsequent to treatment:_____

_____

_____

Final outcome of the action: _____

Your relationship to Patient: ___ PCP ____Surgeon ____Assistant Surgeon ____ Consultant

Other:_____

Incident Location: _____ Date: _____

TYPE of ACTION: Open Investigation ____ Dismissed Complaint ____ Advisory Letter ____

Letter of Reprimand ____ DeCree of Censure ____ Probation ____ Loss of License ____

Restricted License _____ Other _____ _____

I understand information submitted herein becomes part of my application as submitted.

Signature: _____ **Date**:_____

Arizona State Physician's Association
Malpractice Claim Report

PHYSICIAN NAME: _____

Please supply the following information for each malpractice claim made or settled in the past five (5) years to allow proper review and evaluation by the credentials committee. If more than one malpractice action exists, please photocopy this page and submit information for each. A full disclosure of the following details is necessary prior to completion of credentialing. All information will be kept in strict confidence. **PLEASE DO NOT INCLUDE ANY PATIENT NAMES IN REPORT(S)**

Allegation: _____

_____

_____

_____

Condition and diagnosis at time of incident:
_____

_____

Treatment and procedures provided: _____

_____

_____

Patient condition subsequent to treatment:
_____

Final outcome of the claim:_____

_____

Your relationship to Patient: ___ PCP ____Surgeon ____Assistant Surgeon ____ Consultant

Other:_____

Incident Location: _____ Date: _____ Insurance Carrier: _____

YOUR STATUS: ____ Primary Defendant ____ Co-defendant ____Other (Describe)_____

Claim Disposition: ____ Open ____ Closed by Dismissal ____ Closed Date Closed: _____

Amount of settlement / Judgment: _____ Amount paid on YOUR behalf: _____

I understand information submitted herein becomes part of my application as submitted.

Signature: _____ **Date:** _____

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name):_____

FROM:_____ (Please Print) **TITLE**:_____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ **SPECIALTY:** _____

ADDRESS: _____

CITY, STATE ZIP:_____**PHONE**:_____**FAX:**_____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation – Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS:_____

_____

ADDITIONAL COMMENTS ARE APPRECIATED:_____

_____

_____

_____

SIGNATURE OF RECOMMENDING PHYSICIAN

_____

DATE:

Return to: ARIZONA STATE PHYSICIANS ASSOCIATION, INC
3030 North Central Avenue, Suite 1405, Phoenix, AZ 85012
602-265-2524/800-522-9619
Direct Fax: 602-865-7022
Email: angie@azspa.com

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name):_____

FROM:_____ (Please Print) **TITLE**:_____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ **SPECIALTY:** _____

ADDRESS: _____

CITY, STATE ZIP:_____**PHONE**:_____**FAX:**_____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation – Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS:_____

_____

ADDITIONAL COMMENTS ARE APPRECIATED:_____

_____

_____

_____

SIGNATURE OF RECOMMENDING PHYSICIAN

_____

DATE:

Return to: ARIZONA STATE PHYSICIANS ASSOCIATION, INC
3030 North Central Avenue, Suite 1405, Phoenix, AZ 85012
602-265-2524/800-522-9619
Direct Fax: 602-865-7022
Email: angie@azspa.com

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name):_____

FROM:_____ (Please Print) **TITLE**:_____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ **SPECIALTY:** _____

ADDRESS: _____

CITY, STATE ZIP:_____**PHONE**:_____**FAX:**_____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation – Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS:_____

_____

ADDITIONAL COMMENTS ARE APPRECIATED:_____

_____

_____

_____

SIGNATURE OF RECOMMENDING PHYSICIAN

_____

DATE:

Return to: ARIZONA STATE PHYSICIANS ASSOCIATION, INC
3030 North Central Avenue, Suite 1405, Phoenix, AZ 85012
602-265-2524/800-522-9619
Direct Fax: 602-865-7022
Email: angie@azspa.com

ASPA Arizona State Physicians Association

July 17, 2018 **www.azspa.com**

Fraud Waste and Abuse Training and General Compliance

ASPA is contracted with plans that have Medicare and AHCCCS products. It is a requirement of ASPA through our delegation with our contracted plans, we show proof that our Members are in compliance with all training and policy requirements under CMS and AHCCCS. Going forward ASPA will require this attestation to be completed, and kept in our records.

2018

Here are FOUR options to complete the compliance training requirements. Please select the method by which your practice chose to comply (check one):

- Completed the General Compliance and/or FWA training modules located on the CMS MLN. Once an individual completes each of the modules, the MLN system will generate a certificate of completion.
- Downloaded and incorporated the content of the CMS standardized training modules from the CMS website into your Practices existing compliance training materials/systems.
- Incorporated the content of the CMS training modules into written documents for the practice (e.g. provider guides, participation manuals, business association agreements, etc.
- **THIS PRACTICE DOES NOT TREAT/PARTICIATE WITH ANY MEDICARE OR AHCCCS PRODUCTS/PATIENTS**

CMS Compliance Program requirements are located in Chapter 9 and 21 of the Medicare Care Manual.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

AHCCCS Compliance Program is located in the AHCCS Contractor Operations Manual (Policies 103, 104, and 438); the AHCCS Medical Policy Manual (AMPM): https://azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html

Copies of Compliance Programs of our contracted plans will be posted on the ASPA Web site www.azspa.com

Attestation and Participation Acknowledgement

By signing below I attest that the practice identified below, and any participating providers, employees and contractor (including temporary employees and volunteers) therein, comply with the Medicare/AHCCCS Compliance and FWA training requirements for **2018** as marked above.

Practice Name: _____

Signature (of individual with legally finding authority): _____ Date _____

Print Name and Title: _____

Tax ID: _____ Group NPI: _____ Phone: _____

Email _____

Please attach a list of employees, and practitioners in your practice as well as proof of training certificates and a current W9. Please fax to 602-265-3289 or email connie@azspa.com or cathy@azspa.com.

Helping the Independent Provider Stay Independent

3030 N. Central Ave. Suite 1405, Phoenix, AZ 85012
www.azspa.com
Phone: 602.265.2524
Fax: 602.265.3289

ASPA Arizona State Physicians Association

ASPA PAYOR PARTICIPATION ATTACHMENT

Please Review the list of Payor Below. Should you wish to make any changes, i.e. add or drop a plan please indicate below. If you do not wish to make any changes to the plans you are currently active with you do not need to fill out this form.

PLEASE NOTE: If you have changed practices all plans you were contracted with prior to the change will follow you. If you are adding a 2nd Tax ID you will need to fill out a new ASPA PAYOR PARTICIPATION ATTACHMENT FORM. If you do not wish to remain on the same plans you will need to indicate this below.

ACPN- AMERICA'S CHOICE PROVIDER NETWORK	☐	**ADD**	☐	**DROP**
ALIERA HEALTHPASS ADVANTAGE DISCOUNT CARD	☐	**ADD**	☐	**DROP**
ALIERA HEALTHPASS DIRECT PRIMARY CARE MEDICAL HOME	☐	**ADD**	☐	**DROP**
ALIERA HEALTHPASS GYN –WELL WOMEN SERVICES	☐	**ADD**	☐	**DROP**
ALIERA HEALTHPASS IMMUNIZATION CENTER FOR HEALTH PASS AND CARE PLUS PLANS	☐	**ADD**	☐	**DROP**
ALIERA HEALTHPASS PEDICATRIC SERVICES	☐	**ADD**	☐	**DROP**
ALIERA HEALTHPASS PLUS/PREMIUM (PCP & URGENT CARE)	☐	**ADD**	☐	**DROP**
ALLWELL DUAL MEDICARE – AMBER (HMO SNP) FORMALLY BRIDGEWAY ADVANTAGE	☐	**ADD**	☐	**DROP**
AMERIPLAN HEALTH & MEDICAL PLANS OF AMERICA	☐	**ADD**	☐	**DROP**
CORVEL AUTO MEDICAL	☐	**ADD**	☐	**DROP**
CORVEL PPO	☐	**ADD**	☐	**DROP**
CORVEL WORKERS COMPENSATION	☐	**ADD**	☐	**DROP**
FORTIFIED AUTO MEDICAL PLAN	☐	**ADD**	☐	**DROP**
FORTIFIED PROVIDER NETWORK	☐	**ADD**	☐	**DROP**
FORTIFIED WORKERS COMPENSATION	☐	**ADD**	☐	**DROP**
GALAXY HEATHCARE PPO	☐	**ADD**	☐	**DROP**
GALAXY HEATHCARE DISCOUNT CARD	☐	**ADD**	☐	**DROP**
GALAXY WORKERS COMP	☐	**ADD**	☐	**DROP**
HEALTH CHOICE (AHCCCS)	☐	**ADD**	☐	**DROP**
HEALTH CHOICE GENERATIONS (AHCCCS)	☐	**ADD**	☐	**DROP**
HEALTH NET	☐	**ADD**	☐	**DROP**
HEALTH NET AMBETTER MARKET PLACE PLANS			☐	**DROP**
HEALTH NET AHCCCS			☐	**DROP**
HEALTHSMART ACCEL	☐	**ADD**	☐	**DROP**
HEALTHSMART AUTO	☐	**ADD**	☐	**DROP**
HEALTHSMART HPO	☐	**ADD**	☐	**DROP**
HEALTHSMART PPO	☐	**ADD**	☐	**DROP**
HEALTHSMART WORKERS COMP	☐	**ADD**	☐	**DROP**
HUMANA CHOICECARE NETWORK PPO	☐	**ADD**	☐	**DROP**
HUMANA MEDICARE PPO	☐	**ADD**	☐	**DROP**
INTEGRATED HEALTH PLAN AUTO MEDICAL PLAN	☐	**ADD**	☐	**DROP**
INTEGRATED HEALTH PLAN DISCOUNT SAVINGS CARD	☐	**ADD**	☐	**DROP**
INTEGRATED HEALTH PLAN PPO	☐	**ADD**	☐	**DROP**
INTEGRATED HEALTH PLAN WORKERS COMP	☐	**ADD**	☐	**DROP**

MAGELLAN AHCCCS	☐	**ADD**	☐	**DROP**
MEDSOLUTIONS – HEALTH CHOICE	**Closed Panels**		☐	**DROP**
MULTIPLAN AUTO	☐	**ADD**	☐	**DROP**
MULTI PLAN MEDICARE ADVANTAGE PLANS	☐	**ADD**	☐	**DROP**
MULTI PLANS PPO	☐	**ADD**	☐	**DROP**
MULTIPLAN VALUE POINT ACCESS CARD PROGRAM	☐	**ADD**	☐	**DROP**
MULTIPLAN WORKERS COMP.	☐	**ADD**	☐	**DROP**
PRIME HEALTH SERVICES IME PROGRAM	☐	**ADD**	☐	**DROP**
PRIME HEALTH SERVICE PPO, AUTO, WORKERS COMP.	☐	**ADD**	☐	**DROP**
PRIME HEALTH SERVICES TELEMEDICINE PROGRAM FOR WC	☐	**ADD**	☐	**DROP**
PROVIDER NETWORK OF AMERICA AUTO	☐	**ADD**	☐	**DROP**
PROVIDER NETWORK OF AMERICA PRIMARY	☐	**ADD**	☐	**DROP**
PROVIDER NETWORK OF AMERICA SUPPLEMENTAL	☐	**ADD**	☐	**DROP**
PROVIDER NETWORK OF AMERICA WORKERS COMP	☐	**ADD**	☐	**DROP**
PROVIDER SELECT INC.	☐	**ADD**	☐	**DROP**
THREE RIVERS PPO	☐	**ADD**	☐	**DROP**
TRICARE (Health Net Federal Services)	☐	**ADD**	☐	**DROP**
UNIVERSITY OF ARIZONA	☐	**ADD**	☐	**DROP**
USA AUTO	☐	**ADD**	☐	**DROP**
USA MANAGED CARE – PPO	☐	**ADD**	☐	**DROP**
USA WORKERS COMP	☐	**ADD**	☐	**DROP**
ZELIS HEALTHCARE AUTO	☐	**ADD**	☐	**DROP**
ZELIS HEALTHCARE MEDICAID	☐	**ADD**	☐	**DROP**
ZELIS HEALTHCARE MEDICARE	☐	**ADD**	☐	**DROP**
ZELIS HEALTHCARE PRIMARY PLAN	☐	**ADD**	☐	**DROP**
ZELIS HEALTHCARE SUPPLEMENTAL PLANS	☐	**ADD**	☐	**DROP**
ZELIS HEALTHCARE TRICARE	☐	**ADD**	☐	**DROP**
ZELIS HEALTHCARE WORKERS COMP	☐	**ADD**	☐	**DROP**

PLEASE NOTE – ASPA's plans retain the right to refuse a provider access to participate under the ASPA contract**.** ASPA will make every effort to assist you in this process; we recommend that if you are transitioning from a direct contract or another network into an ASPA contract, that you should contact the plan prior to contacting ASPA to make sure they will allow the transfer. Please send copies of any correspondence to ASPA regarding your request to the plan.

_____	_____	_____
PRINT PROVIDER NAME	**PROVIDERS** AHCCCS Number	**PROVIDERS** Medicare Number
_____	_____	_____
PROVIDER SIGNATURE	**DATE**	**PROVIDERS TAX ID**

** This form must have a provider's signature in order to be completed for processing. If no signature is present plans will not be notified of the above changes

COMPLETED W-9 MUST BE ATTACHED. NOTE: YOUR ADDRESS ON YOUR W-9 MUST MATCH YOUR BILLING ADDRESS.

ARIZONA STATE PHYSICIANS ASSOCIATION

Physician Agreement Attachment

New ASPA Contract for Primary Care Members (FP, IM & Peds)
EverMed Direct

ASPA is excited to announce a new contract effective 7/1/18 to be the preferred network for EverMed DPC. All primary care providers and pediatricians are included in this contract with strong referral impact for non-primary care ASPA members.

BACKGROUND:
EverMed DPC contracts with employer groups to provide primary care homes for employees and their families. Delivering consistent patient and revenue flow to the practice, total healthcare cost savings for the employer and improved access to care while lowering out-of-pocket costs for families, this is truly a win-win-win providing healthy change in the marketplace.

Why the ASPA preferred contract with EverMed DPC:
- Healthy flow of patients via employer health plans, age cap at 64.5 years of age
- Revenue positive
- Avg. EverMed patient delivers $720/year revenue v. $450/year Fee for Service patient
- Avg. RVU is 28% higher for EverMed DPC patient versus most commercial payers
- Consistent Monthly Clinic Revenue
- Low Administration with no billing for included services
- Limited menu of included services for the fee schedule, all other services performed as billed to the employer wrap plan as customary
- Highly efficient care model enjoyed by the practice and the patient

REIMBURSMENT:
Primary Care members for a fixed **Per Member/Per Month fee** as follows: (for a list of the covered services contact the ASPA Office)

Individual	$60
Individual + 1	$125
Family up to 4	$180
Additional Family Member	$33

Under the ASPA preferred contract, EverMed will actively market for all ASPA Member Practices to employers throughout the region to deliver additional revenue opportunities.

Please indicate your current level capacity for EverMed patients:

___ Our Practice is ready to accept as many new patients as we can get right now.
___ Our Practice is able to accept up to _____number of new patients right now.

Our Practice does not have capacity and cannot accept additional patients at this time. Please keep me informed as new groups are added to this contract.

Complete the information below for **each** provider _____ If you have any questions please call Connie Richardson at 602-265-2524, ext. 212. Please include an updated W9 form

Yes _____ I want to Participate with EverMed Direct
No _____ I do not want to Participate with EverMed Direct

Provider Signature_____ Date_____

Please Print Name: _____Tax ID #_____

Specialty _____ Email Address: _____

3030 N. Central Ave., Suite 1405, Phoenix, Arizona 85012 *(602) 265-2524*

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 entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of *5%* or greater, 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 form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) 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 as specified in 42 CFR 455.416.

Practice Information

Check one that most closely describes you:	Individual ☐	Group Practice ☐	Disclosing Entity ☐
Name of Individual, Group Practice, or Disclosing Entity:			
Entity: DBA Name:			
Address:			
Federal Tax Identification Number:		Provider CAQH #:	

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

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

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

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

CENTENE Corporation

arizona complete health

Disclosure of Ownership And Control Interest Statement

Section IV

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 IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this 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

Have you identified your status (under Practice Information 1) as a Disclosing Entity? Yes ☐ No ☐

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or Authorized Agent)** _____

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

Disclosure Of Ownership And Control Interest Statement Form Instructions

Practice/Entity Information Section

Type of Entity Check Box – Check the box that most closely describes the type of entity you are contracting as. See the Definitions Page to assist in determine if the practice/entity is an Individual, Group Practice or Disclosing Entity.

Name of Individual, Group Practice or Disclosing Entity – Provide the name of the entity you are contracting as. If you are an individual practitioner who is participating through a Group Practice, enter your individual name here.

DBA name (if applicable) – If you are completing the form as a Disclosing Entity or Group Practice, enter any DBA name that your entity may utilize here. If you are an individual practitioner who is participating through a Group Practice, enter the Group Practice name here.

Address – Provide the main physical address of practice/Entity you are contracting as.

Federal Tax ID Number – Enter the Federal Tax ID Number for your Disclosing Entity or Group Practice. If you are an individual who is also participating through a Group Practice, enter your individual Federal Tax ID number here.

Provider CAQH # - If completing this form as an Individual, enter the CAQH number here if applicable.

Section I – Provide the all information requested for any individual or entity with an ownership or controlling interest in the Practice/Entity completing the form. See the "Determination of ownership or control interest guidelines" on page 3. Attach a separate sheet as necessary to provide complete information. Write "None" if you are an individual practitioner or if this does not apply.

Section II – Indicate whether or not any individuals listed in Section I are related to each other by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, list any owners that are related to each other and the type of relationship in the rows provided, attach a separate sheet if necessary to provide all information.

Section III – Indicate whether or not the Disclosing Entity has a 5% or more direct or indirect ownership in a subcontractor by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each subcontracted entity of which the Disclosing Entity has a 5% or more direct or indirect ownership.

Section IV – Indicate whether or not there are any individuals who have an ownership or control interest in the Disclosing Entity, or is an agent or managing employee of the Disclosing Entity who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Social Security Title XX services program since the inception of those programs by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each individual.

Section V – Indicate by checking either the Yes or No box whether or not the practice/entity has had any financial transaction with a subcontractor totaling more than $25,000 in the 12 months prior to the completion date of this form or any significant business transaction (see definitions) between the practice/entity and a wholly owned supplier or between the practice/entity and any subcontractor in the 5 years prior to the completion date of this form. If yes, provider the Name, address

Section VI – If the practice/entity is completing this form as a Disclosing Entity, as indicated in the Practice/Entity Information section, check yes and list each member of the Board of Directors or Governing Board including the name, date of birth, address, social security number (SSN) and percent of interest (if known at the time of completion). If your practice/entity is not a Disclosing Entity,

Signature/Title/Date – Provide the printed name, signature and title of the individual completing the form either for themselves if an individual practitioner on behalf of a disclosing entity. In the date field, enter the date the form was completed.

Disclosure Of Ownership And Control Interest Statement Form Instructions

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Disclosure Of Ownership And Control Interest Statement Form Instructions

Determination of Ownership or Control Percentages

Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Provider Type Scenarios

Sole Practitioner – Sole Practitioners would identify themselves as Individuals, indicate “None” in Section I, indicate “Yes” or “No” in the remaining check boxes as appropriate then sign and date the form.

Group of Practitioners – the Group Practice being contracted with the Health Plan would fill out one Disclosure and Control Interest form for the Group Practice. The individual practitioners participating in the Group Practice, either as employees or co-owners, would each fill out a Disclosure and Control interest form for themselves as an Individual and list the Group Practice name in the “DBA Name” section, use the Group Practice address and use their own individual Federal Tax ID number.

Hospital or Hospital System – The Hospital would fill out one Disclosure and Control Interest form as a Disclosing Entity. We do not need a separate Disclosure and Control interest form for each practitioner who contracts and bills through the Hospital entity.

Independent Clinical Lab – The entity would fill out one Disclosure and Control Interest form as a Disclosing Entity. If the Independent Clinical Lab employs a group of practitioners that will be enrolled with the Health Plan, each practitioner would fill out a Disclosure and Control Interest form for themselves as an Individual and list the Independent Clinic Lab name in the “DBA Name” section, use the Independent Clinic Lab address and use their own individual Federal Tax ID number.

ASPA | Connected Community

Independent physicians working together for a healthier community

HELPING INDEPENDENT PHYSICIANS TO STAY INDEPENDENT!

ASPA Connected Community – Clinically Integrated Network

BACKGROUND:

ASPA is a messenger-model IPA. ASPA created ASPA-Connected Community (ASPA CC), which is a wholly-owned affiliate of ASPA. The ASPA CC was created as an additional option for ASPA Members to participate in a clinically integrated network, physician owned and governed, formed to make available new payor agreements and programs that reward participants financially for delivering value-based services. Our goal is to effectively manage all patients attributed to us by a payor through clinical alignment. ASPA CC will help its members clinically cooperate with other physicians and practitioners in the delivery of care for the patients we manage. ASPA includes all specialties, outpatient facilities, and other ancillary services outside the hospital system setting. ASPA CC will leverage our network to pursue multiple value-based payer contracts in which ASPA-Connected Participating Providers may participate. In pursuit of this strategy, ASPA-Connected is delivering enabling technology, care management and other services that allows Participating Providers to share clinical data and initiate coordination of care across ASPA CC.

To participate with this contract, participating practitioners must agree to:

- Cooperate with ASPA CC to meet any compliance, reporting and quality reporting requirements
- Follow established protocols and pathways established/adopted by ASPA CC
- Cooperate with terms of contracted participation with all payors – Commercial, AHCCCS, Medicare Advantage or MSSP-provider chooses to participate
- If you so choose to participate in the MSSP contract you must be a participating provider with Medicare
- Is an active in good standing Member of ASPA, or other ASPA CC Collaborative Network
- Provider understands and agrees that his/her initial and continued participation as an ASPA CC Provider under this Agreement is contingent upon meeting and complying credentialing standards
- Participate in meeting

For most contracts you will continue to be reimbursed fee for service, however, these opportunity may bring **additional** monies through shared savings and other incentive payments based on meeting quality measures. Reporting will be required as achievement of targets and quality measures based on Medicare (CMS) /AHCCCS or commercial payor, is necessary, however, participants will have the assistance of ASPA CC, our connecting technology and care management program to help achieve these goals. Shared Savings will be based on the ability to improve on the quality measures required by this contract, and reducing the overall cost of care.

Please fax back to ASPA at (602) 265-3289. A Completed current W-9 Must be attached.

Yes ___ I agree to participate in ASPA Connected Community (a complete contract packet will be sent out to my attention for review, and only by signing that contract am I obligated to participate)

No ____ I do not want to participate in this contract.

Please Print Provider's Name: _____Tax ID #_____ Date_____

Provider Signature_____ Specialty _____

Providers NPI #_____ Phone: _____ Email: _____

Helping the Independent Provider stay Independent!

The ASPA Connected Community LLC is an ASPA offering. www.ASPAConnectedCommunity.com
Contact us for more information: 602-265-2524 or 800.522.9616 or via email at connie@azspa.com

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ACO Partners – Blue Cross PCP Shared Savings

Background: Effective November 1, 2016 ASPA Connected Community (ASPA CC) entered into a contractual relationship with ACO Partners (ACOP). ACO Partners is a value based services organization that provides PCP's with a broad range of services required to succeed in new arena of value based payor contracts. ACOP is not an **ACO**, and is not exclusive. Providers can participate in any ACO's if they so choose. ASPA CC is contracted with ACOP for access to the ASPA CC CIN network for a collaborative effort to bring to our Members a new Shared Savings Value Based Agreement with Blue Cross of AZ. Working together to reduce the cost of healthcare without reducing quality of care for our patients. This will deliver 50% of the shared savings back directly to the physician.

To participate with this contract, participating practitioners must agree to:

- To be a Member of ASPA Connected Community Clinically Integrated Network
- Cooperate with ACOP to meet any compliance, reporting and quality reporting requirements
- Comply with ACOP Measures minimum performance standards
- Attend periotic physician/OM meetings presented by ACOP or Blue Cross in regards to this contract.
- Provider understands and agrees that his/her initial and continued participation as an ASPA CC Provider under this Agreement is contingent upon meeting and complying credentialing standards
- Hold a current contract with Blue Cross and maintain a minimum 50 active Blue Cross patients
- Agree to share data (quality measures results, encounter data and other data regarding this contract) through ACOP, in a HIPAA secure compliant manner, with ASPA CC .

ASPA Members are eligible to participate if they are a participating provider with Blue Cross of Arizona. You will continue to be reimbursed fee for service, however, this opportunity may bring **additional** monies through shared savings. Reporting will be required as achievement of quality measures is necessary, however, this will be provided by ACO Partner, and participants will have the assistance of ASPA CC, our connecting technology (under implementation) and care management programs to help achieve these goals. Shared Savings will be based on the ability to improve on the quality measures required by this contract, and reducing the overall cost of care.

ASPA Connected Community is a wholly owned subsidiary of ASPA developed and designed to contract with payors above and beyond straight fee for service agreements. All ASPA CC Members are eligible to participate in this agreement.(contact Connie@azspa.com for more information about ASPA CC participation) (a complete ACO Partners contract packet will be sent out to your attention for review, or an in office meeting can be arranged and only by signing that contract am I obligated to participate).

Please fax back to ASPA at (602) 265-3289. A Completed current W-9 Must be attached.

Yes ___ I agree to participate with ACOP Blue Cross Shared Savings Program through ASPA CC

No ____ I do not want to participate in this contract.

Please Print Provider's Name: _____Tax ID #_____ Date_____

Provider Signature_____ Specialty _____

Providers NPI #_____ Phone: _____ email: _____

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Medicare Shared Savings Program - MSSP

ASPA CC: Effective January 1, 2015 ASPA Connected Community (ASPA CC) was approved as a MSSP participating network. We are contracted with CMS for a Shared Savings Agreement for which we must work together and prove we can reduce the cost of healthcare without reducing quality of care for our patients. To participate with this contract, participating practitioners must agree to:

- Cooperate with ASPA CC to meet any compliance, reporting and quality reporting requirements
- Follow established protocols and pathways established/adopted by ASPA CC
- Reduce ER Utilization visits; Reduce readmissions within 30 days of Discharge; Comply with follow up after hospitalization within 7 days
- Comply with Medicare CMS Measures minimum performance standards met
- Comply with Annual Medicare Well Visits
- Participate in the ASPA CCM program
- Provider understands and agrees that his/her initial and continued participation as an ASPA CC Provider under this Agreement is contingent upon meeting and complying credentialing standards

Primary Care Physicians are only allowed to participate in only one ACO (MSSP or Pioneer Program) Specialist can participate in as many ACOs as they choose as long as they are not attributed beneficiaries from CMS.

ASPA Members are eligible to participate if they are a participating provider with Medicare. You will continue to be reimbursed fee for service, however, this opportunity may bring **additional** monies through shared savings. Reporting will be required as achievement of targets Medicare (CMS) quality measures is necessary, however, participants will have the assistance of ASPA CC, our connecting technology (under implementation) and care management program to help achieve these goals. Shared Savings will be based on the ability to improve on the quality measures required by this contract, and reducing the overall cost of care.

ASPA Connected Community is a wholly owned subsidiary of ASPA developed and designed to contract with payors above and beyond straight fee for service agreements. All ASPA Members are eligible to participate in this agreement.

Yes ___ I agree to participate with Medicare Shared Savings Program through ASPA CC (a complete contract packet will be sent out to my attention for review, and only by signing that contract am I obligated to participate)

No ____ I do not want to participate in this contract.

Please Print Provider's Name: _____Tax ID #_____ Date_____

Provider Signature_____ Specialty _____

Providers NPI #_____ Phone: _____ email: _____

Please fax back to ASPA at (602) 265-3289. A Completed current W-9 Must be attached.

Helping the Independent Provider stay Independent!

The ASPA Connected Community LLC is an ASPA offering. www.ASPAConnectedCommunity.com
Contact us for more information: 602-265-2524 or 800.522.9616 or via email at connie@azspa.com

ARIZONA STATE PHYSICIAN ASSOCIATION

Physician Agreement

Effective Date: _____

3030 North Central, Suite 1405, Phoenix, Arizona 85012
(602) 265-2524 FAX (602) 265-3289

ARIZONA STATE PHYSICIAN ASSOCIATION
Physician Agreement

This Agreement is made and entered into as of the _____day of _____, 201___by and between **Arizona State Physicians Association**, an individual practice association incorporated under the laws of the state of Arizona (Association) and _____ a Physician licensed to practice medicine in the State of Arizona (Physician).

I. GENERAL

1.1 Physician intends to participate in Association for purposes of providing Health Care Services to members of contracted health maintenance organizations, preferred Physician organizations, and other payor groups and programs. Physician may also participate in various Association-sponsored programs that are developed from time to time to create a benefit of membership or opportunity to satisfy a need for Physician and Association.

1.2 Physician's membership in Association does not guarantee or require that Physician participate in any or all Association-sponsored programs.

1.3 Nothing in this Agreement is intended to create, nor shall it be construed to create, any right of Association to intervene in any manner with the method by which Physician renders Health Care Services to his or her patients, whether or not they may be Members of any Association contracted entities.

1.4 Nothing herein is intended to interfere with the Physician's own interpretation of Physician's professional ethics.

1.5 Association and Physician agree that Patients to whom Health Care Services are provided by Physician and for which Physician is compensated hereunder shall not be third party beneficiaries of the rights and obligations assumed by either party hereto.

II. DEFINITIONS

2.1 Credentialing Program: A continuous process whereby Association seeks and maintains professional information on all Physicians and other Association members in order to document the professional quality and integrity of the Association's health care service Physicians.

2.2 Health Care Service: The service to be provided through Association by Participating Physicians and Physicians and for which the Physician is duly licensed by state to provide.

2.3 Health Care Service Organization (HCSO): An organization, such as a health maintenance organization (HMO), licensed to conduct business in the State of Arizona.

2.4 Member: Any person and /or family dependent covered under a group or individual benefit agreement with any payor or any beneficiary of an agreement under Section 3.4.

2.5 Non-Participating Physician: A Physician or other health care service Physician not under contract with Association or contracted payor.

2.6 Patient: A Member covered under a contracted health plan or Payor requiring Health Care Services.

2.7 "Medically Necessary" or "Medical Necessity" shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. in accordance with the generally accepted standards of medical practice;

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, jury or disease; and

c. not primarily for the convenience of the patient or Physician, or other Physician; or other Physicians of care, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
- Physician Specialty Society recommendations;
- the views of Physicians practicing in the relevant clinical area; and
- any other relevant factors.

Preventive care may be Medically Necessary but coverage for Medically Necessary preventive care is governed by terms of the applicable Plan Documents.

2.8 Participating Physician: Any Physician or other health care service Physician of Health Care Services who has entered into a contract with Association for the provision of Health Care Services to Patients under a payor benefit agreement or an agreement under Section 3.4.

2.9 Payor: An entity such as an insurance company, HMO, PPO or other party, responsible for paying for Health Care Services and defined by a benefit program.

2.10 Third Party Administrator (TPA): An entity licensed by the State of Arizona to pay claims, collect premiums, and perform other functions involved in an administrative process for health insurance companies or self-funded employer groups.

2.11 Active ASPA Member: A member of ASPA, (Physician, Physician, or facility) who has completed all requirements of credentialing, and is current with payment of ASPA annual dues.

III. ASSOCIATION PERFORMANCE PROVISIONS

3.1 Association shall cause Physician's name, address, phone number and areas of practice to be disseminated to Members and to other Physicians, hospitals, and others associated with HCSOs, TPAs or other Payors in Section 3.4.

3.2 Association shall maintain and be responsible for administrative, accounting, enrollment and similar functions inherent in and appropriate for the provision of Health Care Services to Members in accordance with Association's agreements with contracted HCSOs, TPAs, or other Payors, under Section 3.4.

3.3 Association shall institute and maintain utilization management programs, peer review programs, and any other programs deemed necessary to promote quality, efficient health care and to monitor the cost and utilization of medical services rendered to Members whenever feasible.

3.4 It is agreed that Association, in an effort to promote a cost-effective practice of medicine, may establish (itself or through a duly designated independent agent) exclusive and preferred Physician and other alternate delivery system relationships between its Affiliated Physician and contracted Payors under which Affiliated Physician may be rendering professional Health Care Services to individuals. Physician hereby grants Association (or a duly designated independent agent) the authority to act as Affiliate Physician's agent seeking out and entering into such contracts with HCSOs, TPAs or other contracted Payors on Affiliate Physician's behalf. Association agrees that it will use (and will require any duly designated independent agent to use) its best efforts to seek out and secure such contracts for its Physician for the provision of professional Health Care Services with duly qualified Payors on terms and conditions advantageous to Physician and Association, Physician may select on a case-by-case basis with which Payors he or she wishes to becomes Participating Physician.

3.5 Association shall maintain professional information on Physician through Association's Credentialing Program. This information may be made available to contracting payors or state or federal agencies required by law to access such information.

3.6 Neither the Association nor any of its officers, directors, shareholders, employees, agents, affiliates or other representatives shall be in any way liable or responsible to any party or person for any act or omission of Physician in connection with their rendering Health Care Services to Patients.

IV. PHYSICIAN PERFORMANCE PROVISIONS

4.1 Physician shall render Health Care Services to Patients in a reasonable, efficient, and professional manner, which shall be in accordance with the standards of the community, and within the same time availability as offered to Patients who are not Members.

4.2 Physician may not differentiate or discriminate in the treatment of Patients or in the quality of services delivered to Patients on the basis of race, color, national origin, sex, age, religion, ancestry, marital status, and sexual orientation, place of residence, health status, or source of payment.

4.3 Physician may not refuse to provide Health Care Services to any Patient on the basis of the extent of such Member's requirements for Health Care Services, consistent with Physician's capabilities and resources.

4.4 Physician shall cooperate with Association to assure twenty-four (24) hour accessibility for Patients.

4.5 If Physician is unable to provide services to a Member, Physician agrees to refer such Member to another Participating Physician consistent with the terms and conditions of the agreement and Patient medical needs for which Physician is providing Health Care Services through Association. A copy of such referral terms and conditions shall be furnished to Affiliate Physician for each agreement under which Physician furnishes Health Care Services. Any emergency referral to a Non-Participating or unapproved Physician shall be subject to peer and utilization review by Association or contracted Payor.

4.6 Physician agrees, to the extent legally and reasonably possible and consistent with good patient care, to cooperate with Association programs designed to share medical records among Participating Physicians who have contracted with Association.

4.7 Physician agrees to look solely to the entity designated by the Association for compensation for Health Care Services rendered to Members, and will not, under any circumstances (including nonpayment by an HCSO or other payor), assert any claim for compensation, other than for collection from Members of co-payments, payments for non-covered services, and if provided for in the applicable agreements any deductibles and coinsurance. This promise not to seek payment from the Member (except for applicable co-payments, payments for non-covered services, co-insurance and applicable deductibles) shall survive any termination of this Agreement with respect to services provided during the term of this Agreement pursuant to its terms and shall govern any agreement that Physician may have now or in the future with a Member during the term of this Agreement.

4.8 In presenting its claim for collection to Payors, Physician shall submit claims for payment within Ninety (90) days of the date of service or, if Patient is hospitalized, from the date of discharge. Claims submitted after Ninety (90) days may not be eligible for payment, unless otherwise specified in a specific Association/Payor contract.

4.9 Physician warrants that if Health Care Services are provided by a Non-Participating Physician who is providing practice coverage for Physician the Non-Participating Physician agrees to accept all payment and utilization management provisions set forth for Physician in this Agreement and shall hold Members harmless from any payment made in contravention of this Agreement.

4.10 Physician shall keep accurate and current medical files/records concerning Members seen pursuant to this Agreement. Medical records will be kept for the minimum time required by state and federal laws. Physician shall cooperate fully with any utilization review, peer review, and other programs that may be established by Association or contracted Payors to promote quality medical care and to monitor the cost and utilization of medical services. Physician agrees to allow Association or its designee to review all phases of Physician's patient-care activities, including, but not limited to, review and copying of medical records and inspection of Physician's facilities and practice management. Nothing in this section shall require Physician to reveal any confidential information of a Member without such Member's consent or be inconsistent with HIPAA regulations.

4.11 Physician shall establish and maintain procedures and controls so that no medical or enrollee information contained in Physician's records be used by or disclosed by Physician, Contractor Representatives, or Contractor's agents, officers, or employees except as provided in Section 1106 of the Social Security Act, as amended, and regulations prescribed there under.

4.12 Physician shall procure and shall maintain policies of general liability, professional liability with minimum coverage in the amount of $1,000,000 per incident and $3,000,000 aggregate, and any other insurance that is required by Association during the term of this Agreement and shall provide proof of such coverage upon request.

4.13 Physician shall comply with all policies and procedures and protocols as established and modified from time to time by Association or contracted Payors relating to the provision of Health Care Services to Patients, including, but not limited to, policies and procedures of the Board and the various advisory committees of Association and protocols related to precertification of hospital admissions, lengths of stays, referrals to Physicians and other health care Physicians, purchase or rental of prosthesis and durable medical equipment, and use of non-emergency ambulance service as long as such agrees with community standards for the provision of medical care.

4.14 Physician hereby represents and warrants that Physician is currently and for the duration of this Agreement shall remain licensed to practice Physician's health care profession in the State of Arizona, and shall comply with all State and Federal laws and regulations pertinent to such practice. Physician shall immediately notify Association in the event of loss of license.

4.15 In the event that Physician changes the location in which Health Care Services are provided, Physician shall notify Association not less than thirty (30) days prior to such relocation.

4.16 Physician shall notify the Association within ten (10) calendar days of any of the following:

(a) any action taken to restrict, suspend or revoke Physician's license to practice his or her health care profession in this state; or (b) any action taken to restrict, suspend or revoke Physician's medical staff privileges; or (c) any suit brought against Physician for malpractice and the final disposition of such action; or (d) any other situation which might materially effect Physician's ability to carry out his/her duties under this Agreement.

4.17 Physician warrants that the statements set forth in his/her application for membership are true and may be relied upon by Association and will continue to be true throughout the term of this Agreement and any renewal thereof unless Physician notifies Association in writing that any such statements are no longer true.

4.18 Physician shall comply with all of the terms contained within Exhibit A to the Physician Agreement, "Required Contract Language in Support of Medicare Advantage Agreements" attached hereto and incorporated here by this reference.

V. PAYMENTS

51 Physician agrees that the fees payable to Physician, under the fee schedules for Health Care Services covered under the various Benefit Agreements between the Members and contracted Payors, are such fees as shall be specified by Association (or its duly designated agent) to Affiliated Physician from time to time for the various agreements for the provision of Health Care Services.

5.2 Physician shall be entitled to bill and collect from Patients those amounts for co-payment, non-covered services, and applicable deductibles or co-insurance identified to Physician by Association or contracted Payor under various agreements.

5.3 Physician shall obtain a valid assignment of benefits form from Patients annually and shall retain a copy of assignment in Patient's medical record. Physician may use its customary assignment form or a form furnished by Association. Physician's failure to obtain a valid assignment of benefits shall not negate the prohibition against Physician seeking from a Patient any payment for Health Care Services different from the amounts specified by Association from time to time under the various agreements.

VI. TERMS OF AGREEMENT

6.1 This Agreement shall be in full force and effect for a period of one year commencing on the date first written above, and shall continue in effect under identical terms and conditions for additional one year periods thereafter unless either party terminates this Agreement in accordance with the provisions of this Article VI.

6.2 Either party shall have the option of terminating this Agreement, without cause, upon providing at least ninety (90) days' prior written notice to the other party. Physician may also terminate as a Participating Physician with a Payor upon providing Association with ninety (90) days' prior written notice.

6.3 Except as provided otherwise in this Agreement, Physician shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to Association of a material breach of this Agreement. Remedy of such breach by Association within twenty (20) days of the receipt of such notice shall revive the Agreement in effect for the remainder of its term, subject to any other properly exercised rights of termination contained in this section, in any other provision of this Agreement, or in the rules and procedures, Articles of Incorporation or Bylaws of Association as in force at time of termination.

6.4 In addition to the right to terminate without cause in Section 6.2, Association shall have the right to terminate or not to renew this Agreement on the terms and conditions of the policies and procedures, Articles of Incorporation, and Bylaws of Association as then in force. This includes the non payment of ASPA Membership Dues.

6.5 Each party acknowledges the right and obligation of the other to inform Patients that this Agreement has been terminated. If a Patient is under active treatment by Physician on the date this Agreement terminates, Physician shall abide by all the laws and ethical principles against the abandonment of patients and will accept Association's reimbursement schedule for this patient during the course of treatment. Following any notice of termination, Physician shall fully cooperate in all matters relating to the orderly transfer of Patient care to other Participating Physicians.

6.6 This Agreement shall automatically terminate upon the revocation or suspension of Physician's license.

VII. ARBITRATION

7.1 Before instituting arbitration under the terms of this Agreement, Physician must exhaust any and all administrative relief that is available under the Articles of Incorporation, Bylaws, or policies and procedures of Association then in force. The parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.

7.2 If any dispute or controversy arising out of this Agreement is not covered by duly adopted policies and procedures of Association and cannot be informally settled by the parties, such controversy or dispute

shall be submitted to arbitration in Phoenix, Arizona, and for this purpose each party hereby expressly consents to such arbitration in such place. If the parties cannot mutually agree upon an arbitrator to settle their dispute or controversy, each party shall then select one arbitrator and the two arbitrators so selected shall select a third person who shall be the third arbitrator. The decision of the arbitrator shall be binding upon the parties hereto for all purposes, and judgment to enforce any such binding decision may be entered in Superior Court, Maricopa County, Arizona. For this purpose each party hereby expressly and irrevocably consents to the jurisdiction of said court. If either party fails to select any arbitrator within fifteen (15) days after written demand from the other party to do so, or if the two arbitrators selected fail to select a third person to serve as arbitrator within fifteen (15) days after the last of such selected arbitrators is appointed the then Presiding Civil Judge of the Maricopa County Superior Court shall select such arbitrator, or at the election of the parties hereto, the arbitrator shall be selected pursuant to the then-existing rules and regulations of the American Arbitration Association governing commercial transactions. At the request of either party, arbitration proceedings shall be conducted in utmost secrecy. In such case, all documents, testimony and records shall be received, heard, and maintained by the arbitrator in secrecy, available for inspection only by either party and by their attorneys and experts who shall agree, in advance and in writing, to receive all such information in secrecy. In all other respects, the arbitrator shall conduct all proceedings pursuant to the Uniform Arbitration Association governing commercial transactions to the extent such rules and regulations are not inconsistent with such Act or this Agreement.

7.3 Nothing contained herein is intended to create nor shall it be construed to create any right of any Patient to initiate independently the arbitration procedure specified in Section 8.2 above. This limitation shall also apply to Association and to Physician to prevent either or both parties from initiating such procedure in any representative capacity on behalf of a Patient.

7.4 Each party agrees to provide timely notice to each other if either party becomes aware of facts of circumstances which indicate a reasonable possibility of litigation with any third person or entity and which are relevant to any rights, obligations, or other responsibilities or duties provided for under this Agreement with respect to any party hereto. Each party further agrees not to counsel or encourage any third party or entity to pursue litigious action against the other party.

VIII. INDEPENDENT CONTRACTOR

8.1 Physician enters into this Agreement as an independent contractor and not otherwise and this Agreement does not make Physician or Association employees, agents, partners, or joint venturers of the other. Physician shall not publicize any relationship with Association without prior written permission. This Agreement in no way prevents Physician from participating in or contracting with any payor organization, other health care service organization or health care systems.

8.2 Physician agrees that, in the case of dual contracts with any Payor, the contract between Payor and Association will become the primary contract for Physician's services unless Physician notifies Association in writing of desire to act otherwise.

8.3 Nothing in this Agreement shall be construed or deemed to create, between the parties of this Agreement or Payors, a relationship of employer and employee or principal and agent, or any relationship other than that of independent parties contracting solely for the purpose of carrying out the provisions of this Agreement. Neither party shall be liable to third parties for acts or omissions of agents, representatives or employees of the other party.

IX. NOTICES

9.1 Any notice required to be given pursuant to the terms and provisions of this Agreement, unless otherwise indicated herein, shall be in writing and shall be sent by certified mail, return receipt requested, postage pre-paid, to Association and to Physician at the addresses appearing at the end of this Agreement. Notwithstanding the above, information pertaining to participation with new or existing Payors shall be sent via fax, e-mail or other electronic medium as determined appropriate by Association.

9.2 Notices shall be deemed received upon receipt by the addressee.

X. MODIFICATIONS

Association and Physician expressly intend that the terms of this totally integrated writing shall comprise the entire Agreement between the parties and shall not be subject to rescission, modification, or waiver except as defined in a subsequent written instrument executed by both parties hereto and, if required by applicable law, approved by the Arizona Department of Insurance.

XI. INVALIDITY OR UNENFORCEABILITY

The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability or any other term or provision.

XII. ATTORNEY'S FEES

If any action at law or in equity, including an action for declaratory relief, is brought to enforce or interpret the provisions of the Agreement, the prevailing party shall be entitled to recover reasonable attorney's fees and all court costs from the other party, which fees may be sat by the court in the trial of such action or may be enforced in a separate action brought for that purpose, and which fees shall be in addition to any other relief which may be awarded.

XIII. MISCELLANEOUS

13.1 No waiver of any right hereunder shall be effective for any purpose unless it is in writing and signed by the party waiving such rights and shall not constitute waiver of any other right.

13.2 No right created under the provisions of this Agreement may be assigned and no duty hereunder may be delegated without the prior written consent of the other party.

13.3 Each party hereto agrees to perform all such acts as reasonably may be necessary to fulfill the purposes and intent of this Agreement. The toleration by either party of defective performance of any provision of this Agreement shall not be construed as a waiver of either the right to performance or the terms and conditions expressed in this Agreement.

13.4 The terms and provisions of this Agreement shall be construed in accordance with the laws of the State of Arizona, as they may exist from time to time.

EXECUTED on the day and year written above.

Physician

_____
Signature

_____
Printed Name:

_____
Title

_____
Date:

_____
Address

_____
City, State Zip Code

_____
Telephone Number

Arizona State Physicians Association Inc.

_____
Director of Operations

_____
Date:

3030 N Central Avenue, Suite 1405
Phoenix, AZ 85012
602-265-2524

PHYSICIAN AGREEMENT

REQUIRED CONTRACT LANGUAGE
IN SUPPORT of ALL
MEDICARE ADVANTAGE AGREEMENTS

WHEREAS, Arizona State Physicians Association, ("ASPA") has or intends to contract directly with a Medicare Advantage Plan ("Contractor") who in turn has or seeks to have a contract with the Center for Medicare and Medicaid Services ("CMS") to provide, arrange for or administer the provision of health care services to Medicare beneficiaries; and

WHEREAS, ASPA has or obtains contracts with Physicians, hospitals and other health care practitioners and entities ("Physicians") to provide, arrange for or administer at pre-determined rates, the delivery of such health care services; and

WHEREAS, ASPA and Contractor desire to effect a contract to allow Contractor to provide covered health care services to Medicare beneficiaries enrolled with Contractor; and

WHEREAS, Medicare Advantage Plan, Arizona State Physicians Association and Physicians have negotiated a Definitive Agreement (the "Definitive Agreement")

NOW THEREFORE, in consideration of the mutual covenants and agreements herein, the parties hereto hereby agree as follows:

SECTION 1 DEFINITIONS

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

Medicare Advantage Plan means a health plan that has entered into a contract with CMS to provide services to Medicare beneficiaries under the Medicare Advantage Program.

Medicare Advantage is 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.

Member means an individual who has enrolled in or elected coverage through a Medicare Advantage Plan. A Member is also known as an enrollee.

SECTION 2 EFFECTIVE DATE; SCOPE

This Addendum A is effective as of the date first written in the **Definitive** agreement ("Effective Date"). This Addendum A shall only apply to the provision of covered Medicare Program health care services to Medicare beneficiaries enrolled with Contractor.

SECTION 3 FINANCIAL AGREEMENTS.

Contractor shall pay to Participating Physicians and Participating Physicians shall accept as payment in full from Contractor for services rendered to Contractor members. Contractor agrees that all "clean" claims are processed and paid within thirty (30) days from date of receipt. Amounts to be agreed upon by the parties hereto. Participating Physician shall have the right to determine on a case-by-case basis with which Contractors he or she wishes to become a Participating Physician. [42 CFR 422.520 (b)].

SECTION 4 MEDICARE ADVANTAGE REQUIREMENTS

Physician agrees to comply with the requirements set forth in this addendum for Medicare Members.

1. **Inspection and Audit of Records and Facilities.** Physician shall provide access at reasonable times upon demand by Physician and Government Agencies to periodically audit or inspect the facilities, offices, equipment, books, documents and records of Physician relating to the performance of the Addendum and the Medicare Covered Services provided to Medicare Members, including without limitation, all phases of professional and ancillary medical care provided or arranged for Medicare Members by Physician, Medicare Member medical records and financial records pertaining to the cost of operations and income received by Physician for Medicare Covered Services rendered to Medicare Members. Such access shall be limited to that necessary to perform the audit. Physician shall comply with any requirements or directives issued by Physician and Government Agencies as a result of such evaluation, inspection or audit of Physician. Physician shall retain the books and records described in this Section for at least ten (10) years and acknowledge that Government Agencies may have the right to inspect and audit Physician's books and records for ten (10) years beyond termination of the Addendum or until the conclusion of any governmental audit that may be initiated that pertains to such records, whichever is latest unless: (i) the CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Contractor or Physician at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or fraud or similar fault by Physician, in which case the retention may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or (iii) the CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit Physician at any time. Without limiting the foregoing, following the commencement of any audit by a Government Agency, Physician shall retain its relevant books and records until completion of said audit. The provisions of this Section shall survive termination of the Addendum for the period of time required by State and Federal Law. [42 CRF 422.504 (e) (4) and 422.504(i)(2)(i) and (ii)]

2. **Compliance.** Physician agrees to comply with Contractor's policies and procedures and all applicable Federal, State and local laws, rules and regulations, now or hereafter in effect, including but not limited to 42 CFR §422.118 and 422.504 (a)(13) regarding the performance of Physician's obligations hereunder, including without limitation, laws or regulations governing the record timeliness, adequacy and accuracy, Medicare Member and Beneficiary privacy and confidentiality along with the appeal and dispute resolution procedures related to Covered Services provided to a Medicare Member, to the extent that they directly or indirectly affect Physician, Physician's facilities or Contractor and bear upon the subject matter of this Addendum.

3. **Applicable Federal Laws.** The compensation payable to Physician pursuant to the Addendum consists of Federal funds; accordingly, Physician acknowledges that Physician shall be required to comply with certain laws applicable to entities and individuals receiving Federal funds.

4. **Nondiscrimination.** Physician understands that CMS requires compliance with the provision of

this Section as a condition for participation in Medicare plans. Physician and Contractor Representatives shall comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. Section 200d et. seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Section 794) and the regulation there under, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Section 1681 et. seq.), the Age Discrimination Act of 1975, as amended (42 U.S.C. Section 6101 et. Seq.), Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (42 U.S.C. Section 9849), the Americans With Disabilities Act (P.L. 101-365) and all implementing regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

5. **CMS Agreement Compliance and Delegation Requirements.** PHYSICIAN shall comply with all requirements in the CMS Agreement, which are applicable to Physician as a result of the Addendum. Without limiting the foregoing, Physician shall ensure that all provisions of the CMS Agreement, which are applicable to Physician and Physicians representatives, are included in any of Contractor's subcontracts. A copy of the CMS Agreement shall be made available to Physician upon Physician's request. Physician shall comply with Title XVIII of the Social Security Act and the regulations adopted there under by CMS for the Medicare program. [42CFRs 422.504(i)(3)(iii) and 422.504(i)(4)]

6. **Medicare Participation Standards.** Physician and Contractor Representatives shall meet the standards for participation and all applicable requirements for Physicians of health care services under the Medicare program. In addition, Physician shall require that all facilities and offices utilized by Physician to provide Medicare Covered Services to Medicare Members shall comply with facility standards established by CMS.

7. **Certification of Truth and Accuracy.** Physician is required to submit claims or other data to the contractor that includes a certification from the Physician, that such data is accurate, complete and true.
8. **Submission of Claims.** Physician agrees to submit appropriate encounter to Contractor regardless of payment methodology.

9. **No Billing of Medicare Members (Medicare Member Hold Harmless Provision).** Physician hereby agrees that in no event, including, without limitation, non-payment by Contractor, Contractor's insolvency or breach of the Agreement, shall Physician or any Participating Physician covering for Physician bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Medicare Member or person, other than Contractor, acting on his or her behalf, for Medicare Covered Services provided pursuant to the Addendum. This provision shall not prohibit collection of deductibles, co-payments, co-insurance and/or non-Medicare Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Medicare Members in accordance with terms of the Medicare Member's Subscriber Agreement and Coverage Description.

   Physician shall not maintain any action at law or equity against a Medicare Member to collect sums owed by Contractor to Physician. Upon notice of any such action, Contractor may terminate the Addendum as provided above and take all other appropriate action consistent with the terms of the Addendum to eliminate such charges, including, without limitation, requiring Physician to return all sums collected as surcharges from Medicare Members or their representatives. For purposes of the Addendum, "Surcharges" are additional fees for Medicare Covered Services, which are not disclosed

to Medicare Members in the Subscriber Agreement and Evidence of Coverage, are not allowable co-payments and are not authorized by the Addendum. Nothing in the Addendum shall be construed to prevent Physician from providing non-Medicare Covered Services on a usual and customary fee-for-service basis to Medicare Members provided that Physician has requested that a Medicare Member sign a waiver indicating the Medicare Member's financial responsibility for charges for non-Medicare Covered Services and as long as Medicare Member is informed by Physician that said services are non-Medicare Covered Services prior to being rendered and that Medicare Member signs such waiver prior to or at the time non-Medicare Covered Services are rendered. [422.504(g)(1)(i); 422.504(i)(3)(i)]

Physician agrees that cost sharing for dual eligible Member is limited to the Medicaid (including Medi Cal & AHCCCS) cost sharing limits and that for those dual eligible Members the Physician will accept the Medicare Advantage Plan payment as payment-in –full or will separately bill the appropriate state source for any amounts above the Medicaid (Medi Cal & AHCCCS) cost sharing. [422.504(g)(1)(iii)].

10. Accountability and Contractor Cooperation. Physician acknowledges and agrees that Contractor shall remain accountable to CMS for complying with its obligations under the CMS Agreement. Physician shall cooperate with Contractor in CMS required oversight activities.

11. Confidentiality of Medicare Member Records. Physician shall establish and maintain procedures and controls so that no medical or enrollee information contained in Physician's records be used by or disclosed by Physician, Contractor Representatives, or Contractor's agents, officers, or employees except as provided in Section 1106 of the Social Security Act, as amended, and regulations prescribed there under. [42CFRs 422.118 and 422.504 (a)(13)]

12. Compliance with Reporting Requirements. Physician shall cooperate with Contractor in submitting to the DHHS statistical and encounter data pertaining to Medicare Covered Services provided by Physician, and any other reports that DHHS may reasonably request to carry out its functions under the Medicare Advantage program as specified in Sec 422.310 (risk adjustment data) and Sec 422.516 (informational data). [42 CFR.504(a)(8)]

13. Compliance with Policies and Procedures. Physician shall comply with all Contractor policies and procedures.

14. Specific Provisions Pertaining to Benefits, Coverage and Beneficiary Protections. Without limiting any of Physician's other obligations under this Addendum, Physician specifically agrees to comply with the following policies and procedures:

a. Contractor's policies pertaining to the collection of co-payments, which prohibit the Collection of co-payments for routine injections, routine immunizations, flu immunizations, and the administration of pneumococcal/pneumonia vaccine.

b. Contractor's policies pertaining to pre-certification which provide that Medicare Members may directly access a contracted Physician for mammography and influenza vaccinations and women's health specialists for routine and preventative health care.

c. Contractor's policies pertaining to complex and serious conditions, which provide for procedures to identify, assess, and establish treatment plans for persons with complex or

serious medical conditions.

d. Contractor's policies pertaining to enrollment and assessment of new Medicare Members including requirements to conduct a health assessment of all new Medicare Members within ninety (90) days of the effective date of their enrollment.

15. Term of Addendum, Renewal and Termination.

a. **Termination without Cause.** This Addendum may be terminated at any time by either party without cause upon thirty (30) days prior written notice to the other party.

b. **Termination of CMS Agreement.** In the event that CMS Agreement is not executed, or is terminated or not renewed, the provisions of this Addendum relating to the Medicare Members shall automatically terminate, unless otherwise specified by ASPA.

c. **Medicare Advantage Termination** The termination provisions contained in this Addendum shall permit Contractor to terminate the Physician with respect to Medicare Members in accordance with the terms contained in the applicable provision. In the event Physician or Contractor terminates this Addendum with respect to Medicare Members, the Agreement shall not terminate with respect to non-Medicare Members.

16. Survival of Provisions following Termination. Physician agrees that the provisions of this Section and the obligations of Physician herein shall survive termination of this Addendum regardless of the cause giving rise to such termination, and shall be construed to be for the benefit of Medicare Members.

SECTION 5 NOTICE

Any notice required or permitted to be given pursuant to this Addendum shall be submitted in writing to the Arizona State Physicians Association at the addresses below:

Arizona State Physician Association
3030 North Central Avenue, Suite 1405
Phoenix, AZ 85012
Attn: Executive Director

1. Medicare Participation. Physician agrees to immediately notify ASPA if he/she is excluded from participation in Medicare.

SECTION 6 GENERAL PROVISIONS

1. Confidentiality. The parties acknowledge that as a result of this Agreement, each may have access to certain trade secrets and other confidential and proprietary information of the other. Each party shall hold such trade secrets and other confidential and proprietary information, including the terms and conditions of this Agreement, in confidence and shall not disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party except as may be required by law and except as may be required to fulfill the rights and obligations set forth in this Agreement.

2. Assignment and Delegation of Duties. Neither party may assign duties, rights nor interests under

this Agreement unless the other party shall so approve by written consent.

3. Interpretation. The validity, ability to enforce, and interpretation of this Agreement shall be governed by any applicable federal law and by the applicable laws of the state of Arizona.

4. Amendment.

(a) This Addendum may not be amended without a written notice signed by both of the parties hereto.

(b) In the event that state or federal law or regulation should change, alter or modify the present services, levels of payments, or standards of eligibility of Medicare members, such that the terms, benefits and conditions of this Agreement must be changed accordingly, then upon notice from Contractor, Physician shall continue to perform services under this Addendum as modified.

END OF ADDENDUM