Colorado Indigent Care Program Manual

Fiscal Year 2018-19

Section II: Data Collection

Effective July 1, 2018

COLORADO
Department of Health Care Policy & Financing

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ARTICLE I. PROGRAM OVERVIEW

Section 1.01 Program Data Definition

The Colorado Indigent Care Program (CICP) collects program utilization data from each of its providers on an annual basis. This data is aggregate and does not include information on individual patients. The CICP collects data on the total number of patients served, the total number of inpatient admissions and outpatient visits for those clients, and the total charge and liability amounts for services provided.

ARTICLE II. BILLING INFORMATION

Section 2.01 Definitions

CICP Data Collection System: Includes the specifications on how providers must submit inpatient and outpatient billing information to the Department. There is no electronic submission of claims, nor are paper claims accepted.

County Codes: County codes are used to track patient visits. Providers should include the patient's county code on the CICP discount card.

Indigent Patient (client): A person who meets the guidelines outlined in the Colorado Indigent Care Program Manual – Eligibility Section, which stipulates that the individual must have income and liquid resources combined at or below 250% of the current Federal Poverty Level (FPL).

Emergency (Urgent) Care: Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

Non-Emergency (Non-Urgent) Care: Treatment for any conditions not included in the emergency care definition and any additional medical care for those conditions the Department determines to be the most serious threat to the health of medically indigent persons.

Patient Liability: Client copayments are required for the CICP. Enter the amount due as a CICP copayment or copayment due from third-party insurance, whichever is lower. Enter the required copayment even if the provider did not receive full payment.

Total Charges: Total amount billed. The total charges billed to the CICP must be equal to the total charges billed to payers for equal medical services. Bill only one charge value, which is the sum of the detailed charge lines on a claim. Do not subtract Medicare or third-party payments from line charge amounts. This field cannot be negative.

Third-party Liability: Payments due from third-party insurance, including Medicare. These are not payments received, but the amount owed by the client's primary

insurance. Do not include contractual adjustments as a payment due or as a liability. The CICP will reimburse for contractual adjustments.

Section 2.02 Provider Billing Information

There are four different types of billing information for the CICP:

Inpatient & Outpatient Service: All inpatient admissions and outpatient visits are billed using the CICP Data Collection System - Summary Format. This is the only required billing information and is due to the Department on an annual basis.

Outpatient Pharmaceutical: Providers that choose to report outpatient pharmaceutical charges to the Department shall separate Outpatient Pharmacy visits from regular inpatient and outpatient charges. If a client has an Outpatient Pharmacy visit (prescription only) that information will be reported separately from the regular billing information. If a client receives a pharmaceutical during an outpatient visit or inpatient admission, the pharmacy charge can be included on the regular claim information and it does not need to be separated out. Your facility must notify the Department of the intent to bill for Outpatient Pharmaceuticals on the Provider Application prior to the start of each fiscal year.

Physician Charges: Hospital providers have an option to bill the CICP for physician charges. Physician charges associated with clinic visits are considered part of the outpatient service and are included in the CICP Data Collection System.

Hospital physician charges are associated with care provided at the facility for CICP clients. The physician charges must not be included in the charges submitted under the CICP Data Collection System and must not be reimbursed by another source. Prior to billing, physicians must have an appropriate contract with the facility stating that the physician will follow the statutes and rules governing the CICP. An example of this contract is provided in Appendix I, of this section. Physicians cannot bill the CICP directly. The provider must handle all the billing for physician charges. No provider is obligated to bill for physician charges. Prior to the start of each fiscal year, your facility must notify the Department on the Provider Application of the intent to bill for physician charges.

Ambulance Charges: Hospital providers have an option to bill the CICP for emergency transportation charges associated with an ambulance service they own or have contracted with. The ambulance charges must not be included in the charges submitted under the CICP Data Collection System and must not be entirely reimbursed by another source. Prior to the start of each fiscal year, your facility must notify the Department on the Provider Application of the intent to bill for ambulance charges.

Section 2.03 Summary Format

The CICP Data Collection System – Summary Format includes the specifications on how providers must submit billing information to the Department. There is no electronic or paper submission of claims. The information is requested so that the Department can

identify funding available to specific providers and write the CICP Annual Report for the Colorado General Assembly.

Providers must submit billing information under the Summary Format and follow the guidelines set forth in Article IV Data Collection System – Summary Format. By using the Summary Format, the Department does not receive claim level details, but rather summary totals for clients served at each provider. The summary information is submitted annually. The summary information can be sent to the Department as an e-mailed attachment.

Section 2.04 Timely Filing Requirement

Beginning in program year 2017-18, clinic providers will be required to submit their program data on an annual basis with their annual application, and hospital providers will be required to submit their data to Myers & Stauffer in conjunction with their data validation. This data will cover visits and admissions during the previous calendar year. In other words, any admissions or visits with a date of service between January 1, 2017 and December 31, 2017 will need to be included in the data submitted.

Section 2.05 Retention of Billing Records

All billing records related to the contractor's or subcontractor's participation in the CICP must be maintained in a central location by the providers for a period of six State fiscal years after the expiration of each State fiscal year. This includes all the detailed information used to support the summary information submitted to the CICP. The Provider Compliance Audit mandated by the CICP requires that providers be able to identify all claims used to create the Summary Format submitted to the Department. Providers must keep the claim detail for a period of six State fiscal years to justify the information submitted to the Department.

ARTICLE III. THIRD-PARTY INSURANCE

Section 3.01 Medical Insurance

Charges to the CICP are secondary to all insurance programs.

1. Group and Individual Health Insurance applicants may be eligible for CICP coverage. The provider is required to bill the resource listed before submitting the claim to CICP. If the CICP provider is out of the client's primary insurance network, CICP clinic providers may seek a waiver from the Department regarding the necessity of providing proof of claim denial, prior to adjusting the patient account to reflect CICP discount and writing off charges to CICP. A waiver from this requirement is not available to CICP hospital providers.
2. Workers' Compensation applicants can participate in the CICP. However, the provider must bill Worker's Compensation before billing the CICP.
3. Victim's Compensation is the only third-party coverage billed after CICP coverage. Victim's Compensation may be used to cover the client's CICP copayment.
4. Health Maintenance Organization's (HMO) clients can participate in CICP. However, out of network services are not covered for CICP hospital providers. Services not available in the commercial HMO insurance policy and deemed medically necessary can be billed by hospital CICP providers to CICP minus the insurance copayment paid by the client. CICP clinic providers may submit write-off charges to CICP for primary care services provided to clients within an HMO, regardless if those services are a covered benefit under their HMO. If the CICP provider is out of the HMO network, CICP clinic providers may seek a waiver from the Department regarding the necessity of providing proof of claim denial, prior to adjusting the patient account to reflect CICP discount and writing off primary care charges to CICP.
5. Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits are continued health plan benefits provided by the employer. Terminated employees or those who lose coverage because of reduced work hours may purchase the group coverage for themselves and families for a limited period of time. They have 60 days to accept coverage or lose all rights to these benefits. Once COBRA coverage is chosen, they will be required to pay for their coverage.
6. Medicare eligible clients have CICP coverage for amounts and services NOT covered by Medicare. Medicare has three main types of coverage:

   (1) Medicare Part A is inpatient hospital coverage available to all people over age 65;

   (2) Medicare Part B, outpatient services, requires clients to pay a monthly premium; and

   (3) Medicare Part D is for prescription drug coverage.

   (4) Some Medicare beneficiaries qualify for Health First Colorado as a Qualified Medicare Beneficiary (QMB). If an applicant has QMB coverage, they can participate in the CICP.

7. CICP can be used to satisfy the deductible or coinsurance for primary insurance, including Medicare. Clients are responsible for the CICP copayment or the copayment of the primary insurance, whichever is lower. The deductible or coinsurance should be included in Total Charges billed to the CICP. The only entry into Client Liability is the copayment required.

Section 3.02 Third-party Insurance

If the client has third-party insurance, including Medicare, the provider will bill the commercial health insurance policy first for all medical expenses incurred. Providers can report contractual adjustments negotiated under commercial health insurance contracts and Medicare contractual adjustments in Total Charges. The CICP will reimburse providers for contractual adjustments. Do not include contractual adjustment under Third-party Liability.

Health Insurance Billing Examples:

Example #1: Medicare Third-party Payment with CICP as Secondary Payer

Total Charges billed to Medicare	$150 (Enter in Total Charges line in Summary)
Minus Payment due from Medicare	$100 (Enter in Third Party Liability line)
Equals Hospital Charges Remaining	$50
Minus Client Copayment	$25 (Enter in Patient Liability line)
Equals Amount Charged to CICP	$25 (Goes into Total Write Off Charges)

Example #2: Third-party Payment with CICP as Secondary Payer

Total Charges billed to Insurance	$350 (Enter in Total Charges line in Summary)
Minus Payment due from Insurance	$150 (Enter in Third Party Liability line)
Equals Hospital Charges Remaining	$200
Minus Client Copayment	$50 (Enter in Patient Liability line)
Equals Amount Charged to CICP	$150 (Goes into Total Write Off Charges)

Section 3.03 Medicare Bad Debt

A provider can declare the percentage of Medicare deductibles or coinsurance not reimbursed by the client or a state program as Medicare Bad Debt. If a client qualifies for a state low-income program, such as CICP, the debt may be deemed uncollectible without applying a reasonable collection effort (such as turning the debt over to a collection agency). The maximum a provider can collect from a CICP eligible client is the CICP copayment, even if that client has another primary insurance such as Medicare.

Section 3.04 Subsequent Insurance Payments

If clients receive coverage under the CICP, and their insurance subsequently pays for services, or if the client is awarded a settlement, the provider must document any subsequent reimbursement received when submitting their summary data information.

Section 3.05 Previously Charged Claim Adjustments

General Information

Providers who receive payment for claims that have already been reimbursed by the CICP are required to report these payments. These payments can be made under the following circumstances:

- Client became enrolled in Health First Colorado or CHP+;
- Settlement of lawsuits or other court ordered action in which the client or other 3rd party was required to pay the medical bill; or
- Client was incorrectly included on the CICP data submission.

Previously charged claim adjustments are charges that the provider submitted to the CICP in a previous fiscal year. For example:

- The provider submits a $100 charge to the Department with its annual provider application for FY 2017-18. Six (6) months later the provider learns that the client was enrolled in Health First Colorado during that period. The provider then submits the bill to Health First Colorado for proper reimbursement, but is unable to adjust its annual reporting to the Department since the data has already been submitted. The provider will submit the required information listed below with their annual provider application the following year to correct the charge that was incorrectly submitted to the Department.

Reporting Requirements

The following information is required for charges submitted to the Department that need to be adjusted after the close of the fiscal year in which the service was provided. Adjustments for different fiscal years must not be combined into one report and must be reported separately. The following information must be included in the report:

- Provider name;
- Fiscal year that the claim was incorrectly reported;
- Number of visits incorrectly reported;
- Number of admissions incorrectly reported;
- Total charges incorrectly reported;
- Third-party liability incorrectly reported; and
- Patient liability incorrectly reported

Filing Requirements

Providers are required to notify the Department of any charges that need to be adjusted. This notification should be made in a letter to be included with the annual provider application. The facility's Chief Financial Officer (CFO) or Administrator should sign this letter.

ARTICLE IV. DATA COLLECTION SYSTEM – SUMMARY FORMAT

Section 4.01 Definition

Providers submitting billing information under the Summary Format must follow the guidelines set forth in this Article. In the Summary Format, the Department shall receive totals for clients served at each provider rather than claim-level detail.

Section 4.02 Outpatient Visits

Providers are requested not to use a span date when billing for outpatient services because a bill using a span date could be mistaken as one visit under the CICP Data Collection System, whereas the client might have actually received services several times in the month. Claims with a span bill date will still be allowable.

However, when counting the number of outpatient visits, providers are requested not to count claims, since many providers use a span billing. Instead, providers should count the actual number of visits by all CICP clients. If a client had four visits on one claim, four visits should be reported.

Section 4.03 Unduplicated Client Count

The unduplicated client count is the number of unique clients served by the provider. The Total Number of Unique Clients (not claims) by Age is the unduplicated client count of all clients served by the provider. The Total Number of Unique Inpatient Clients (not claims) by Age is the unduplicated client count for all clients served on an inpatient basis. The Total Number of Unique Outpatient Clients (not claims) by Age is the unduplicated client count for all clients served on an outpatient basis. For example:

- A single client could have two inpatient admissions and six outpatient visits at the hospital provider over the fiscal year. This client is counted once in the total unduplicated client count, only once in the unduplicated inpatient client count, and only once in the unduplicated outpatient client count.
- A single client could have four outpatient visits at the clinic provider over the fiscal year and is counted only once in the total unduplicated client count.

Section 4.04 Summary Information Format

The Excel template for transmitting summary information to the Department was revised in April 2017. Providers must use this new reporting form. The form is part of the annual clinic provider application due each spring and should be completed and returned at the same time the application is submitted. The form will be distributed to hospital providers by Myers & Stauffer and will be due with their annual data validation.

An example Hospital provider template is as follows:

Total Charges	
Total Charges	$0.00
3rd Party Liability	$0.00
Patient Liability	$0.00
Write-Off Amount	$0.00

Charges	
Outpatient Urgent & Emergency	$0.00
Outpatient Non-Urgent & Non-Emergency	$0.00
Inpatient Urgent & Emergency	$0.00
Inpatient Non-Urgent & Non-Emergency	$0.00
Total Charges	$0.00

Inpatient Admits

Total Number of Admissions
Total Number of Days

Number of Admissions by FPL

- 0-100%
- 101-250%
- Unknown

Total

Number of Days by FPL

- 0-100%
- 101-250%
- Unknown

Total

Number of Admits by Age

- 0-17
- 18-64
- 65+

Total

Inpatient Charges by Age

- 0-17
- 18-64
- 65+

Total

Outpatient Visits

Total Number of Visits

Number of Visits by FPL

- 0-100%
- 101-250%
- Unknown

Total

Number of Visits by Age

- 0-17
- 18-64
- 65+

Total

Outpatient Charges by Age

- 0-17
- 18-64
- 65+

Total

Unduplicated Patient Count

Total Number of Unique Clients Served (not claims) by Age

- 0-17
- 18-64
- 65+

Total

Total Number of Unique Inpatient Clients Served (not claims) by Age

- 0-17
- 18-64
- 65+

Total

Total Number of Unique Outpatient Clients Served (not claims) by Age

- 0-17
- 18-64
- 65+

Total

An example Clinic provider template is as follows:

Total Charges	
Total Charges	$0.00
3rd Party Liability	$0.00
Patient Liability	$0.00
Write-Off Amount	$0.00

Charges	
Outpatient Urgent & Emergency	$0.00
Outpatient Non-Urgent & Non-Emergency	$0.00
Total Charges	$0.0

Outpatient Visits

Total Number of Visits

Number of Visits by FPL
- 0-100%
- 101-250%
- Unknown

Total

Number of Visits by Age
- 0-17
- 18-64
- 65+

Total

Outpatient Charges by Age
- 0-17
- 18-64
- 65+

Total

Unduplicated Patient Count

Total Number of Unique Clients Served (not claims) by Age
- 0-17
- 18-64
- 65+

Total

County Utilization

Admits & Visits by County (County code)

01 Adams	23 Garfield	45 Otero
02 Alamosa	24 Gilpin	46 Ouray
03 Arapahoe	25 Grand	47 Park
04 Archuleta	26 Gunnison	48 Phillips
05 Baca	27 Hinsdale	49 Pitkin
06 Bent	28 Huerfano	50 Prowers
07 Boulder	29 Jackson	51 Pueblo
08 Chaffee	30 Jefferson	52 Rio Blanco
09 Cheyenne	31 Kiowa	53 Rio Grande
10 Clear Creek	32 Kit Carson	54 Routt
11 Conejos	33 Lake	55 Saguache
12 Costilla	34 La Plata	56 San Juan
13 Crowley	35 Larimer	57 San Miguel
14 Custer	36 Las Animas	58 Sedgwick
15 Delta	37 Lincoln	59 Summit
16 Denver	38 Logan	60 Teller
17 Dolores	39 Mesa	61 Washington
18 Douglas	40 Mineral	62 Weld
19 Eagle	41 Moffat	63 Yuma
20 Elbert	42 Montezuma	64 Broomfield
21 El Paso	43 Montrose	Unknown
22 Fremont	44 Morgan	Total

ARTICLE V. OUTPATIENT PHARMACEUTICAL

Section 5.01 Definition

Outpatient Pharmaceuticals: Providers are required to separate Outpatient Pharmacy visits from regular inpatient and outpatient claims (charges). If a client has an Outpatient Pharmacy visit (prescription only) that information will be reported separately from the regular claim information. If a client receives a pharmaceutical during an outpatient visit or inpatient admission, the pharmacy charge is included on the regular claim information as it does not need to be separated out. Your facility must notify the Department prior to the start of the fiscal year of the intent to bill for Outpatient Pharmaceuticals on the Provider Application.

Section 5.02 Declaring Pharmaceutical Charges

Providers will submit to the Department a completed Pharmaceutical Charges worksheet stating the following summary information:

- Total Number of Visits (or prescription claims);
- Total Charges;
- 3rd Party Liability; and
- Patient Liability.

ARTICLE VI. PHYSICIAN CHARGES

Section 6.01 Definition

Physician Charges: CICP hospital providers have the option to bill the CICP for hospital-based physician charges. These are charges associated with care provided at the hospital facility for CICP clients. The physician charges must not be included in the charges submitted under the CICP Data Collection System or be completely reimbursed by another source. Prior to billing, physicians must have an appropriate contract with the facility stating the physician will follow the statutes and rules governing the CICP. An example of this contract is provided in Appendix I, of this section. Providers are not obligated to bill for physician charges, but if these charges are to be billed to the CICP, they must be submitted by the provider, not the physician. Your facility must notify the Department prior to the start of the fiscal year of the intent to bill for physician charges on the Provider Application.

Section 6.02 File Description

Excel Spreadsheet: Providers will submit to the Department a completed Physician Charges worksheet stating the following summary information:

Inpatients:
Urgent/Non-Urgent Charges
Third Party Liability
Patient Liability
Number of Admissions
Number of Days
Number of Clients

Outpatients:
Urgent/Non-Urgent Charges
Third Party Liability
Patient Liability
Number of Visits
Number of Clients

ARTICLE VII. AMBULANCE CHARGES

Section 7.01 Definition

Ambulance Charges: CICP hospital providers who own their own ambulance service or have a contract with an ambulance service have the option to bill the CICP for emergency transportation or ambulance charges. The ambulance charges must not be included in the charges submitted under the CICP Data Collection System or be completely reimbursed by another source.

Section 7.02 File Description

Excel Spreadsheet: Providers will submit to the Department a completed Ambulance Charges worksheet stating the following summary information:

- Total Charges;
- Third Party Payments;
- Patient Liability; and
- Number of Claims.

PARTICIPATING PHYSICIAN/Nurse Practitioner CONTRACT MEDICAL SERVICES AGREEMENT BETWEEN COLORADO INDIGENT CARE PROGRAM PROVIDER FACILITY AND PHYSICIAN/Nurse Practitioner

Effective Dates:

_____ through _____

Parties:

_____ , a provider facility under contract with the Colorado Indigent Care Program (CICP), and _____M.D. or N.P., "Contractor", whose mailing address is:_____

_____

Purpose: The purpose of this Contract is to establish the terms for provision of care and the associated reimbursement for physician services rendered to medically indigent patients treated on-site at a Colorado Indigent Care Program provider facility.

Indigent patients are those patients determined by a provider facility to be eligible for the Colorado Indigent Care Program according to the Colorado Indigent Care Program Manual. The provider facility is responsible for rating patients in accordance with this Manual and reporting both the patient and the financial information to the CICP.

Covered Services: All medical services that a provider customarily furnishes to patients and can lawfully offer to patients. These covered services include, without limitation, medical services furnished by participating physicians. Covered services must be deemed medically necessary by the responsible physician. Covered services do not include:

a. Non-emergent dental services.
b. Nursing home care.
c. Chiropractic services.
d. Sex change surgical procedures.
e. Cosmetic surgery.
f. Experimental and non-FDA approved treatments.
g. Elective surgeries, not deemed medically necessary.
h. Court ordered procedures such as drug testing.
i. Abortions, except as specified in Sec. 25-15-104.5, C.R.S.
j. Mental health services as a primary diagnosis in an outpatient or clinic setting. The CICP can reimburse for the services if they are a secondary diagnosis.
k. Prescription drugs included in the definition of Medicare Part-D are excluded from CICP eligible clients who are also eligible for Medicare.

The CICP reimburses providers for inpatient psychiatric care and inpatient drug and alcohol services. However, only 30 days per patient per contract year are reimbursable under the CICP. The CICP reimburses providers for outpatient mental health benefits if these services are provided on-site and are normally offered by the provider.

Priority of Care: Payment to Contractor by the provider facility shall be for care rendered to qualifying indigent patients in accord with the following priorities:

a. Emergency care for the contact period.
b. Any additional medical care for those conditions determined to be the most serious threat to the health of medically indigent persons.
c. Any other additional medical care.

Emergency Care: Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 26-15-103, C.R.S.

Urgent Care: To treat an injury or illness of a less serious nature than those requiring Emergency Care but required in order to prevent serious deterioration in the client's health.

Non-Emergency Care: Treatment for any conditions not included in the emergency care definition and any additional medical care for those conditions the Department determines to be the most serious threat to the health of medically indigent persons, Section 26-15-106 (9) (6) (11), C.R.S.

License Requirement: The Contractor must remain properly licensed or certified by the State of Colorado during the contract period, and this Contract shall immediately terminate at the provider facility's sole discretion if the Contractor loses such license or certification.

Reimbursement: The Colorado Indigent Care Program reimburses provider facilities for participating physician services by distributing the fixed State appropriation across all participating providers. The percentage of costs or charges reimbursed to the provider facility cannot be determined in advance.

(Specific terms of reimbursement as negotiated between provider facility and participating physicians should be attached.)

Records Retention and Availability: That all records, documents, communications and other materials (except medical records of Program Patients) related to Contractor's participation in the Program shall be the property of the State and maintained in a central location by Contractor as custodian thereof on behalf of the State, and shall be accessible to the State for a period of six State fiscal years after the expiration of each State fiscal year, or for such further period as may be necessary to resolve any matters which may be pending at the expiration of each six State fiscal year period, or until an

audit performed under the provisions of this Contract has been completed with the following qualification: If an audit by or on behalf of the federal and/or State government has begun, but is not completed at the end of the six State fiscal year period, or if audit findings have not been resolved after the six State fiscal year period, such materials shall be retained for six months after the filing of the final audit report and response thereto.

Patient Copayments: Qualifying indigent patients cannot be billed for physician services rendered in excess of patient copayment amounts.

Management Fee: (If applicable)

Year-end Reconciliation for Changes in the Colorado Indigent Care Program Reimbursement: (If applicable)

Misrepresentation Penalty: Persons who represent that a medical service is reimbursable or subject to payment under the CICP when they know that it is not, commit a Class 2 misdemeanor that is punishable by a minimum of three months' imprisonment or a $250 fine (or both), or a maximum of twelve months' imprisonment or a $1,000 fine (or both).

Independent Contractor Status: The Parties of the Contract intend that the relationship between them contemplated by this Contract is that of independent contractors. No agent, employee, or servant of Contractor shall be or shall be deemed to be an employee, agent or servant of the provider facility. The Contractor shall be solely and entirely responsible for its acts and omissions during the performance of this Contract.

Indemnification: The Contractor shall indemnify the provider facility against all liability, loss, cost or expense the provider facility incurs in connection with the default in any term of this Contract by the Contractor or any negligent or intentional act or omission of the Contractor.

Governing Law: This Contract and all matters relating to it shall be governed by the laws, rules, and regulations of the State of Colorado as are now in effect or as may be later amended or modified. In the event that any provision of this Contract conflicts with, or is inconsistent with the provisions of those laws, rules or regulations, the provisions of the laws, rules or regulations shall govern or supersede.

Entire Contract: This Contract is intended as the complete integration of all understandings between Parties. No prior or contemporaneous additions, deletions or other amendments hereto shall have force or effect whatsoever, unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written contract executed by both Parties.

Term of Contract:

From _____ to_____, subject to termination during the term as provided in sections 9 and 21.

Termination: The Contractor may terminate this Contract without cause with _____ days' notice to this provider facility. The provider facility may terminate this Contract without cause with _____ days' notice to the Contractor. Such termination shall in no way prejudice the obligations of either Party accruing prior to the end of the period of notice.

Provider Contact Person: Bills for physician services rendered should be sent to: (If applicable).

Renewal: This Contract shall be automatically renewed for successive one-year terms on the same terms and conditions as contained in this Contract unless either Party shall, prior to expiration of the term of the Contract, give 90 days' written notice of intent not to renew this Contract. If, however, terms or conditions are changed, a new Contract containing these changes will be required.

This Contract was executed and delivered on the day first written above.

Contractor Signature:_____

Type or Print Name:_____

Provider Facility Signature:_____

Type or Print Name and Title:_____

Date Signed:_____