Provider Agreement

Thank you for your decision to accept members of Altrua HealthShare into your service and billing system. Upon your signature and submission of this form, we will add you to our recommended provider directory. Reimbursement will reflect the rate shown on this form and will be sent to the provider within the specified time period.

SECTION A
Provider Information

Office Name

Specialty

Provider Tax ID

Contact Person

Position

E-mail

Phone ( ) –

Fax ( ) –

Mailing Address

City

State Zip

SECTION B Agreement

Reimbursement Schedule

Physician Related Office Visits	Payment shall be reimbursed at Medicare rate plus 50% for prevailing area where service is rendered within 30 days of billing receipt.
Inpatient Related Services	Payment shall be reimbursed at Medicare rate plus 60% for prevailing area where service is rendered within 30 days of billing receipt.
Outpatient Related Services	Payment shall be reimbursed at Medicare rate plus 70% for prevailing area where service is rendered within 30 days of billing receipt.

By signing this document, I am authorized to approve the above reimbursement schedule for all Altrua HealthShare members as billed per the following terms:

- Provider agrees to accept the adjusted rate for the services rendered, and to not back bill the member/patient or other responsible party(ies) for the adjusted amounts listed on each individual medical claim submitted for sharing.
- All member share amounts (payments) are distributed per the terms and conditions of the member's program guidelines.
- Provider may bill the member/patient or other responsible party(ies) for any medical need ineligible for sharing on billed charges related to the services rendered.
- Any eligible medical need (claim) in the amount of $10,000–$29,999 may be subject to an agreed payment schedule, to not exceed 90 days, that both Parties hereto.

All general terms and conditions of the Agreement are expressly incorporated herein. In the event the terms and conditions stated within this Agreement conflict with the terms and conditions stated within the member's/patient's program guidelines, the terms and conditions stated within the member's/patient's program guidelines shall have precedence over the terms and conditions stated in this Agreement.

The agreement term is at the discretion of both parties, which have the freedom to cancel or change the terms any time for any reason. In doing so, changes to the adjusted rate can be handled easily and either party may modify, amend or terminate the agreement for any reason with 30 days' written notice.

Signature

By signing this Agreement, the Parties hereto agree to all terms, conditions and covenants contained herein and that they are authorized to make such decisions for their respective organizations. The Parties acknowledge that this is a legally binding Agreement and the Parties fully acknowledge that they each have accepted this Agreement of their own free will and that the signing of this document was not the result of coercion or duress and that both Parties sought and received, or had the opportunity to seek and receive, the advice of legal counsel, of their choice, prior to signing this Agreement.

Print Name Title

Authorized Signature

Signature Date / /

Do not send unless you have ***completed* SECTION A *in full***.

E-mail, fax or mail this completed form.

To avoid delays, please make sure you *submit* all required information.

For questions, please call our Negotiations Department at: 888.244.3839 ext. 409, or e-mail us at negotiations@altruahealthshare.org.