



## Pacific Foundation for Medical Care

### **Application for Physician Membership to the Pacific Foundation for Medical Care**

The undersigned physician duly licensed to practice medicine under the laws of the State of California (“PROVIDER”) hereby applies for membership in the Pacific Foundation for Medical Care (“FOUNDATION”) and for participation in FOUNDATION’S Preferred PROVIDER Organization (“PPO”).

#### **Section 1: General Terms**

- A. PROVIDER agrees to abide by and support the Articles of Incorporation, Bylaws, Policies and Procedures of FOUNDATION. PROVIDER also agrees to recognize and abide by the interpretation thereof by the authorized officers of FOUNDATION reserving all rights of appeal as may be set forth in the Bylaws.
- B. PROVIDER understands that it is the intent of this Agreement to facilitate a health care delivery program which shall maintain existing patient/provider relationships, preserve the private practice of health care, contain the cost of health care and assure the quality of health care.
- C. During the term of this Agreement and for any extensions or renewals, PROVIDER agrees to follow and be bound by the Membership and Credentialing Procedures and the Corrective Action and Fair Hearing Procedures adopted by FOUNDATION as amended from time to time. All remedies under such procedures will be exhausted before pursuing any remedies at law.
- D. PROVIDER shall be responsible for notifying FOUNDATION within five (5) working days of any change to address, tax identification number or status such as loss, restriction or suspension of license to practice medicine or DEA certificate; loss or restriction of hospital privileges or suspension of hospital privileges for a cumulative total of thirty (30) or more days in any twelve (12) month period; reduction or cancellation, for any reason, of professional liability insurance; dismissal, settlement or entry of judgment in any malpractice action in which PROVIDER is a named defendant; occurrence of any other situation which might materially affect the ability of PROVIDER to carry out duties or obligations under this Agreement.
- E. In performing obligations under this Agreement, PROVIDER is and shall remain at all times, an independent contractor with a license in good standing and is not an employee or agent of FOUNDATION.

- F. FOUNDATION reserves the right to modify this Agreement during the contract term. Such modification shall be effective thirty (30) days after mailing of written notice by FOUNDATION and shall be deemed accepted by PROVIDER unless a written objection to such modification is received by FOUNDATION within such thirty (30) days.
- G. The duties and obligations established by this Agreement are personal in nature and shall not be transferred, delegated or assigned by PROVIDER.
- H. This Agreement shall be governed by the laws of the State of California.

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

## **Section 2: PPO Panel**

- A. PROVIDER understands that FOUNDATION maintains a PPO Panel for the purpose of making the professional services which PROVIDER agrees to perform hereunder available under certain terms and conditions to third-party payors (PAYOR[S]) of health care costs and to PAYORS which have contracted with the California Foundation for Medical Care (“CFMC”), Health Care Foundations of the California Coast, Health Care Foundations of Central and Northern California, and Health Care Foundation of Southern California (“REGION”), with which FOUNDATION is affiliated. Collectively, these affiliated entities form the PPO Panel.
- B. PROVIDER is familiar with the purposes of FOUNDATION and shall be bound by any agreements, contracts, procedures or statements of policy entered into or adopted by FOUNDATION, CFMC, or REGION concerning peer review, quality assurance or other health care programs it may undertake or sponsor. PROVIDER understands that upon written request, FOUNDATION will allow PROVIDER to review any agreement, contract or statement of policy under which PROVIDER has agreed to provide services.
- C. PROVIDER agrees to participate on the PPO Panel and hereby authorizes and directs FOUNDATION to identify PROVIDER as a PPO Panel participant and to provide PAYORS with relevant information as may be necessary for this purpose.
- D. PROVIDER hereby grants FOUNDATION, CFMC, and REGION the right to list PROVIDER as a FOUNDATION, CFMC and REGION PPO Panel participant.
- E. PROVIDER is not obligated to participate solely on the PPO Panel and may participate in other alternative health care delivery programs at PROVIDER’S sole discretion.

## **Section 3: PROVIDER Services**

- A. In accordance with generally accepted professional standards, PROVIDER agrees to render appropriate and medically necessary services to any person, referred to herein as a “PATIENT”, who is covered under an applicable benefit agreement of a PAYOR with which FOUNDATION, CFMC, or REGION has contracted. This provision does not

affect any right which PROVIDER may otherwise have to elect not to provide treatment to any PATIENT.

- B. PROVIDER further agrees to provide health care services to PATIENTS accessing PROVIDER through third-party payor contracts entered into by FOUNDATION, CFMC and REGION under the same terms and conditions set forth in this Agreement.
- C. PROVIDER agrees to cooperate with the policies and procedures established by FOUNDATION, CFMC, or REGION. PROVIDER further agrees to participate in peer review programs and procedures developed or adopted by FOUNDATION and to abide by peer review decisions once the appeals process which has been established by CFMC has been exhausted. All criteria and guidelines for such peer review shall be in accordance with FOUNDATION'S procedures.
- D. PROVIDER agrees that PROVIDER'S patterns of practice are subject to peer review and a report under Section 805 of the Business and Professions Code may result.
- E. Consistent with exercise of PROVIDER'S best professional judgment, PROVIDER agrees to refer PATIENTS, when necessary, to other members of the PPO Panel. For out-of-area referrals, PROVIDER agrees to, whenever it is consistent with PROVIDER'S best professional judgment, refer PATIENTS to PROVIDERS under contract with another Foundation for Medical Care.

#### **Section 4: Compensation**

- A. PROVIDER agrees to accept assignment of benefit payments for services provided to PATIENT, and to bill FOUNDATION or the designated claims PAYOR on HCFA 1500 billing forms, or equivalent, which includes diagnoses, service procedure codes, detail of charges, assignment of benefits, and PROVIDER'S identification and address, including federal tax identification number or social security number.
- B. In the event a co-payment is required from a PATIENT, PROVIDER may collect such co-payment directly from PATIENT.
- C. For services rendered to a PATIENT, PROVIDER agrees to accept the allowance in accordance with the uniform reimbursement methods set forth in Exhibit A, attached hereto and incorporated herein by this reference, as payment in full. Such allowance shall be administered to PROVIDER in accordance with the terms and conditions of the applicable benefit agreement.
- D. Following submission of claims, in the event PROVIDER is not paid within ninety (90) days after rendering services, PROVIDER shall have the right to bill the PATIENT for services rendered at the rates set forth on the reimbursement schedule attached hereto as Exhibit A.
- E. PROVIDER agrees to refrain from demanding payment from a PATIENT at the time covered services are rendered (excluding co-payments). If fees are collected for services PROVIDER believes to be non-covered services and are subsequently determined by a

PAYOR to be covered services, PROVIDER agrees to refund any fee collected which is in excess of fees allowed for covered services. PROVIDER will make this refund within thirty (30) days after receipt of a demand for a refund, or if PROVIDER appeals the demand, within fifteen (15) days after notice is received that the appeal has been denied.

- F. PROVIDER understands it is the PATIENT'S responsibility to disclose multiple insurance coverage. In the event a PATIENT has multiple insurance coverage and compensation thereunder and PAYOR is the primary payor, PROVIDER agrees to accept up to the allowed rate from such PAYOR and may recover an additional amount from the secondary payor. If PAYOR is secondary, PROVIDER agrees to look to such PAYOR only for the difference between the payment received from the primary payor and FOUNDATION allowance set forth in Exhibit A, if any.
- G. The PAYOR shall be responsible for PATIENT eligibility verification. This responsibility shall in no event obligate PAYOR for deductibles, co-insurance, exclusions or other limitations as may apply in accordance with the terms of an applicable benefit agreement.

## **Section 5: Records**

- A. PROVIDER agrees to provide medical records (operative reports and chart notes), at no charge, as requested for necessary information to adjudicate claim(s) and for the purposes of cost containment, quality assurance and peer review.
- B. To the extent required by law, PROVIDER shall maintain confidentiality of medical records.
- C. PROVIDER authorizes good faith disclosure by FOUNDATION of information which has a bearing on PROVIDER'S professional competence, character, and ethical qualification to all hospitals and medical licensing or disciplinary boards that request such information. Upon written request, FOUNDATION shall make all such information available to PROVIDER.

## **Section 6: Term and Termination**

- A. This Agreement shall be effective when approved by the Board of Trustees and shall remain in effect until June 30 following approval, whereupon it shall be renewed for periods of one (1) year, unless terminated by either party.
- B. This Agreement may be terminated without cause by either party only upon sixty (60) days written notice to the other party or upon thirty (30) days written notice if the party to whom notice is given has materially breached any provision hereof.
- C. In the event treatment for which PROVIDER is compensated hereunder is commenced prior to termination of this Agreement and continues beyond that date, PROVIDER agrees to notify the PATIENT of termination of this Agreement and further agrees to accept payment in accordance with this Agreement as payment in full for services

covered by the applicable benefit agreement until the conclusion of the course of treatment or for thirty (30) days following termination of this Agreement, whichever comes first.

**Section 7: Insurance**

- A. PROVIDER agrees to maintain adequate limits of liability for comprehensive general liability and professional liability insurance issued by a company authorized to conduct the business of insurance in the State of California and PROVIDER shall provide FOUNDATION with evidence of insurance coverage upon request. For purposes of this Agreement, professional liability insurance in the minimum amounts of One Million Dollars (\$1,000,000) per claim and Three Million Dollars (\$3,000,000) aggregate shall be deemed adequate.

**Section 8: Professional Practice and Quality**

- A. PROVIDER and FOUNDATION acknowledge that PROVIDER shall remain in complete control of PROVIDER’S professional practice and shall remain solely responsible for acts and decisions in rendering professional services. FOUNDATION shall at no time control or be responsible to any extent for the professional practice of PROVIDER or the quality of services delivered by PROVIDER.

PROVIDER hereby makes application for membership in the Pacific Foundation for Medical Care and to participate in the PPO Panel. PROVIDER fully understands and agrees that acceptance of PROVIDER’S application does not constitute approval of membership in FOUNDATION until such time as PROVIDER receives written notice of approval of this Application. PROVIDER further understands that any misstatements in or omissions from this Application will constitute cause for denial of this Application for membership, or termination of membership. In support of this Application, PROVIDER agrees to the terms and conditions stated herein, and certifies that all of the information provided in this Application is true and accurate.

\_\_\_\_\_  
NAME (Please print)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## Exhibit A

**Note:** Reimbursement rates differ for each county. To get rates for your county, contact PFMC at 800-548-7677 or kpass@rhs.org.

### PPO Reimbursement Schedule for \_\_\_\_ County

Each PAYOR contracting with FOUNDATION, CFMC or REGION shall select either the California Relative Value Studies (CRVS) or the Resource-Based Relative Value Scale (RBRVS) method of reimbursement as described below from the start date or next renewal date of the PAYOR'S contract. The selected method of reimbursement shall remain in effect until revised.

Where not so assigned in the CRVS or RBRVS, applicable relative values or maximum allowable fees are determined by PAYOR. All reimbursements are less any deductibles, co-payments, or other payments for which the patient may be personally responsible under the terms of the applicable benefit agreement.

#### 1974 CRVS

For covered services rendered to a PATIENT, PROVIDERS participating in the FOUNDATION'S PPO agree to accept the lesser of the PROVIDER'S usual and customary charge for such services or the payment as determined by the responsible PAYOR by taking either the unit values assigned to the particular services in the 1974 CRVS, or for anesthesia services, the current American Society of Anesthesiologists Relative Value Guide (ASA) and multiplying them by the appropriate conversion factor set forth below, or in the case of obstetrical services, the package rate as set forth below.

#### CONVERSION FACTORS (effective 1/1/97)

Medicine	\$
Medicine E & M	\$
Surgical	\$
Anesthesia (ASA)	\$
Pathology	\$
Radiology	\$
Total OB Normal/C-Section (Global)	\$

#### RBRVS

For covered services rendered to a PATIENT, PROVIDERS participating in the FOUNDATION'S PPO agree to accept the lesser of the PROVIDER'S usual and customary charge for covered services, or the payment as determined by the responsible PAYOR using the current RBRVS maximum allowable fees at \_\_\_\_% or, for anesthesia services, \$ \_\_\_\_ per American Society of Anesthesiologist Relative Value Guide (ASA) unit. The payment for pathology services shall be at \_\_\_\_% of the current Medicare carrier fee schedule.