Dear Psychiatric/Substance Abuse Credentialing Department,

Preferred Mental Health Management, L.L.C. (PMHM) was founded in 1987 and is one of the nation's oldest, most respected behavioral care companies. PMHM provides services for more than a million members nationwide through its medical network partners and payers. PMHM is expanding its provider network in your area and your facility is invited to join the network. PMHM's system is provider and patient friendly and requires little to no paperwork.

There is no fee for joining the network and contracting with PMHM does not restrict you from contracting with other PPO's. By contracting with PMHM you will receive a larger volume of patients.

If you have additional facility locations, you may make copies of the Application. Return your Application by mail to PMHM, LLC 7309 E. 21st St North, Suite 110, Wichita KS 67206, by fax to 316-262-5723 or by email to **ProviderRelations@PMHM.com**.

- ❒ **Completed Facility Application (attached)**
- ❒ **Signed PMHM LLC Preferred Provider Agreement (attached)**
- ❒ **Copy of Facility State License (each facility)**
- ❒ **Copy of Facility Accreditation(s) and/or State Certification(s)**
- ❒ **Copy of Facility Professional Liability Insurance Policy**

We look forward to receiving your Application and look forward to having your facility as a member of the PMHM quality care network. Please call me at 800-776-6793, ext. 233, if you have any questions.

Sincerely,

Angie Byrd

Provider Relations
Preferred Mental Health Management, L.L.C.

PREFERRED MENTAL HEALTH MANAGEMENT, LLC
FACILITY APPLICATION

FACILITY INFORMATION

Portions of this information may be used in directories and on referral websites. Make additional copies of this section of the form for each additional location.

Legal Name of Facility ____________________

Type of Facility ____________________

DBA Name ____________________

Address ____________________

City ____________________ State / Zip ____________________

Phone ____________ Fax ____________ Website ____________________

Administrator ____________________ Phone ____________________

Credentialing Contact ____________________ Title ____________________

Email ____________________ Phone ____________________

TAX ID Number ____________________ NPI Number ____________________

☐ Yes ☐ No Is this facility handicap accessible?
☐ Yes ☐ No Does this facility have translation services available? If yes, list languages available for translation.
____
☐ Yes ☐ No Is there equipment or sign language services available for hearing impaired patients?
☐ Yes ☐ No Is this facility owned, managed or affiliated with a local, regional or national corporation?
If Yes, Name(s) ____________________
☐ Yes ☐ No Is this facility affiliated with an IPA, PHO or group?
If Yes, Name(s) ____________________

SERVICES - Check All That Your Facility Currently Provides.

SUBSTANCE ABUSE:

☐ Detoxification: ☐ Adolescents ☐ Adults
☐ Inpatient Treatment: ☐ Adolescents ☐ Adults
☐ Partial Hospitalization: ☐ Adolescents ☐ Adults - List hours ____________________
☐ Formal Outpatient Program: ☐ Adolescents ☐ Adults

Note: If you offer a formal outpatient program, please list specifics concerning the number of weeks for the program, the number of weekly sessions and meeting times: ____________________
____
What aftercare is offered and is there a fee? ____________________
Who should be called to arrange aftercare? ____________________ Phone # ____________________

PSYCHIATRIC:

☐ Inpatient Treatment: ☐ Children ☐ Adolescents ☐ Adults
☐ Partial Hospitalization: ☐ Children ☐ Adolescents ☐ Adults - List hours ___________________
☐ Formal Outpatient Program: ☐ Children ☐ Adolescents ☐ Adults

Note: If you offer a formal outpatient program, please list specifics concerning the number of weeks for the program, the number of weekly sessions and meeting times:____

____

What aftercare is offered and is there a fee?____
Who should be called to arrange aftercare?_______________________________Phone # _______________________

Do you offer any other programs we should be aware of?____

LICENSURE INFORMATION - Attach a current copy of your State/ Business license.

State/Business License #____State________Expiration ________________

Medicare # ____________________________________Medicaid # ____

ACCREDITATION/CERTIFICATION INFORMATION

If applicable, attach a current copy of your accreditation/certification.

Is this facility accredited or does it hold any of the certifications listed below? Check all that apply or add applicable entities.

☐ CARF ☐ CHAP ☐ CLIA ☐ JCAHO ☐ NCQA ☐ URAC ☐ AOA ☐ Other: _____________________________________

Has the Facility been sanctioned, placed on probation or lost accreditation, licensure or certification status during the last five (5) years by any of the following agencies or organizations? If yes, please check the appropriate box; provide the date of the sanction and reason. Add additional pages as needed.

☐ JCAHO/AOA Date ______________Reason____
☐ Medicare Date ______________Reason____
☐ Medicaid Date ______________Reason____
☐ State License Date ______________Reason____
☐ Other Date ______________Reason____

INSURANCE COVERAGE

Provide the following information regarding medical malpractice and comprehensive general liability maintained by your Facility and attach a copy of your current policy.

Carrier____Expires

Amount - Occurrence $____ Aggregate $

Policy Covers ☐ Business Only ☐ Business + Employed Health Care Providers

The Facility agrees to either (a) maintain medical malpractice insurance in the amounts of One Million ($1,000,000) per occurrence and Three Million ($3,000,000) aggregate or, (b) ensure that all employed Health Care Providers maintain medical malpractice insurance in the amount of the same ($1,000,000/$3,000,000).

CLAIMS, SUITS AND SETTLEMENTS SUMMARY FORM

Please provide the following information for EACH closed, settled or pending case within the last 5 years. Copy this form for each additional case. If no claims, suits or settlements in the last 5 years, check the "N/A" box below & sign.

*****INFORMATION WILL BE KEPT CONFIDENTIAL*****

Claims Information ☐ **N/A in last 5 years**

Claims Information

Current Health of Patient ______________________________

Date of Occurrence ____________________ Date Claim Filed ____________________

Claim/Case Status ☐ Closed – Payment Amount ____________ ☐ Closed – No Payment ☐ Pending ☐ Dismissed

☐ Yes ☐ No Do you believe there is merit to this case? (If yes, please explain.)

____

____

____

Please describe the pertinent details of the patient's history and the allegations made against you.

____

____

____

____

Please provide clinical details regarding the treatment and care of the patient.

____

____

____

____

What insurance company was involved, if any? ______________________________

City, State ______________________________ Phone Number ____________________

Name of Defense Counsel ______________________________

City, State ______________________________ Phone Number ____________________

I hereby certify that the above information is, to the best of my knowledge, an accurate response to the requested information.

Provider's Name (Please Print) ______________________________

Authorized Representative Signature ______________________________ Date ____________________

STAMPED SIGNATURES WILL NOT BE ACCEPTED

RELEASE OF INFORMATION AND STATEMENT OF PARTICIPATION

I fully understand by completing and signing this application that information provided is being evaluated for participation in the Preferred Mental Health Management LLC (PMHM) Provider Network. In the event this facility chooses to contract for any other product or service offered by PMHM, the information associated with this application may be used to satisfy the credentialing requirements of that product.

Preferred Mental Health Management LLC (PMHM) will be entitled to terminate this agreement for breach if any matter stated in this application and all attachments is or becomes false. All information submitted in this application is warranted to be true, correct and complete.

As the duly authorized representative of this facility, I hereby authorize Preferred Mental Health Management LLC (PMHM) to contact third parties to verify information regarding facility participation in the PMHM program. PMHM is authorized to receive and inspect all documents pertaining to facility licensure, accreditation, certification, and competence. Such contacts may include, but not be limited to, state licensing board(s), medical and specialty organizations, malpractice insurance carriers, courts of law, and any other entity from/which information may be needed and/or is reasonably relevant to complete the credentialing process or to obtain information concerning the facility's membership, and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges.

The Facility hereby releases from liability Preferred Mental Health Management LLC (PMHM), its employees and all those whom PMHM contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information. This release applies to PMHM and its agents and employees regarding consideration of this or any other application facility may file, or any proceeding for reappointment, reduction, suspension, de-participation or review of professional services Facility may provide in affiliation with the corporation. Facility agrees to promptly notify PMHM of any changes to information on this Facility form as well as any future adverse actions and determinations. All information will be treated as confidential by PMHM and its clients.

Facility Name (Please print) ____________________

By signing hereunder, I certify that I have full authority to do so on behalf of the corporation, partnership, Facility or other legal entity.

Authorized Representative (Please print) ____________________

Authorized Representative Signature ____________________ Date ____________

STAMPED SIGNATURES WILL NOT BE ACCEPTED

Please submit Name, Title and Phone Number of person completing this application.

Name ____________________ Title ____________________

Phone____________________ Fax____________________ Email ____________________

PREFERRED MENTAL HEALTH MANAGEMENT LLC
PREFERRED PROVIDER AGREEMENT

THIS PREFERRED PROVIDER AGREEMENT ("Agreement") is made and entered into as of the ___ day of ______________, 20___, by and between Preferred Mental Health Management LLC (PMHM), a Kansas corporation ("Manager") and ____, a __________________________("Provider").

WITNESSETH:

WHEREAS, Manager provides mental health care and substance abuse utilization review services and PPO access for employee benefit Plans throughout the United States; and

WHEREAS, Provider is a duly licensed or certified mental health care Provider in the State(s) in which it operates which provides mental health care Treatment and/or substance abuse Treatment and care, and other related services as allowed by its licenses and certifications; and

WHEREAS, Manager wishes to contract with Provider to become a preferred Provider for Manager's clients, and Provider desires to become a preferred Provider for Manager, under the terms and conditions set forth herein.

NOW, THEREFORE, for and in consideration of the mutual promises, covenants and agreements set forth herein, the receipt and sufficiency of which are hereby acknowledged, Manager and Provider agree as follows:

ARTICLE 1: DEFINITIONS

1.1 The following terms shall have the meaning assigned to them wherever used herein:

(A) Commencement Date: The date upon which this Agreement is approved and signed by both parties.

(B) Participant: An individual eligible for health care under an employee benefit Plan which is managed by or in which PPO access is arranged by Manager or its agent.

(C) Plan: An employee benefit Plan subject to the provisions of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. ("ERISA"), an insurance indemnity Plan, HMO, POS or other benefit Plan approved by Manager.

(D) Plan Administrator: The individual, committee, trust or other entity charged with administering and making covered payments under the Plan.

(E) Provider: An Individual or facility offering mental health and/or substance abuse services, limited to Psychiatrists, Licensed Doctorate Level Psychologists and Social Workers who are licensed at the highest level in their state or substance abuse counselors.

(F) Treatment: Professional mental health care and Treatment or substance abuse care and Treatment to be rendered by Provider to a Participant, together with any professional services ancillary to such care and Treatment rendered by Provider.

ARTICLE 2: PARTICIPANT REFERRALS

2.1 Manager hereby agrees to refer certain Participants to Provider on a preferential basis for Treatment.

2.2 Unless legally or ethically prohibited from doing so, Provider agrees to accept all such referrals, and render Treatment to any such Participant as Provider deems, in its sole discretion, to be prudent and necessary.

2.3 In the event that any Participant under a Plan managed by Manager presents himself or herself to Provider for Treatment without a direct referral by Manager, Provider shall provide notice to Manager of such fact as soon as possible, but in no event later than the next succeeding business day.

2.4 Except in the case of an emergency, Provider agrees not to refer any Participant to an outside nonpreferred Provider without the prior authorization of Manager.

2.5 Provider agrees to schedule first appointments for referred Participants within 24 hours in emergency situations and within 5 business days for all other referrals. Participants will be referred to Manager when Provider and Participants are unable to make scheduling arrangements.

ARTICLE 3: TREATMENT

3.1 Provider shall be solely responsible for the Treatment of any Participant under Provider's care. Provider shall make all decisions regarding the Treatment of Participants, including determining the manner of Treatment which is needed to competently and safely treat and care for the Participant.

3.2 Provider shall be responsible for obtaining the necessary consents to Treatment from all Participants or the Participants' legal guardian, conservator or representative.

3.3 Provider shall maintain complete and accurate reports and records regarding all Treatment of Participants. Provider shall obtain appropriate consent from all Participants or the Participants' legal guardian, conservator or representative for the release of such reports and records to Manager. Provider, at Provider's cost, shall diligently provide to Manager copies of all such reports and records generated by Provider during the course of Treatment of the Participant, as may be reasonably requested by Manager to provide utilization review.

3.4 Provider may not discriminate for or against a certain patient because he or she is not a member covered under a health or other insurance plan. Provider also agrees not to discriminate in the provision of Covered Services to members because of race, color, national origin, ancestry, religion, gender, sexual orientation, marital status, age, veteran status, health status, health insurance coverage or any other issue related to differentiate between members and to render services to members in the same manner, in accordance with the same standards and with the same time availability as services are offered to other patients consistent with existing medical, ethical and legal requirements for providing continuity of care to patients.

ARTICLE 4: UTILIZATION REVIEW, CLAIMS PROCEDURE & FEE SCHEDULE

4.1 Utilization Review.

(A) Acknowledgments. The parties acknowledge and agree that:

(1) Manager is responsible for providing utilization review and determination of reimbursement criteria of claims for payment by Provider for the Treatment of Participants.

(2) Manager makes recommendations to the Plan Administrator for the payment of Provider's claims. The recommendations will be based upon Manager's review of the Treatment. If Manager, in Manager's discretion, deems that all or part of the Treatment provided by Provider is or was not therapeutically necessary for the care and Treatment of Participant, Manager will recommend denial of payment for that portion of Provider's claim relating to the unnecessary Treatment.

(3) Manager undertakes no responsibility regarding the Treatment of any Participant. Provider retains the sole professional, ethical and legal obligation to provide appropriate Treatment to the Participant as Provider deems, in its sole discretion, to be required under the circumstances. Provider's professional, ethical and legal obligations for the Treatment of any Participant are not conditioned in any way upon the utilization review to be performed by Manager, regardless of whether any Treatment is approved for payment by Manager.

(B) Review Classifications. Manager's utilization review may fall under any of the following three classifications:

(1) Precertification. Provider may consult with Manager prior to any Treatment to verify whether Provider's charges for the proposed Treatment will be approved for payment. Prior to any Treatment, Provider should have in hand from Manager an authorization of payment for such Treatment, or request that Manager conduct a review with patient, or patient's representative, to determine a length of Treatment for precertification of payment for the duration of the Treatment for Participant. In the event that the specified Treatment is precertified for payment, Manager shall recommend that the Plan Administrator pay the reasonable claims submitted by Provider related to the precertified Treatment in accordance with the certified Treatment Plan and upon the discounted rate for such Treatment as specified on the Fee Schedule. All precertifications must be confirmed in writing, via mail or fax, by Manager.

(2) Concurrent Review. Provider may consult with Manager during the Treatment to verify whether Provider's charges for the continuing or extended Treatment will be approved for payment. Provider should request a review for an extension of Treatment which is expected to continue beyond any precertified Treatment so that payment for this Treatment can be authorized. In the event that the specified Treatment is approved by concurrent review, Manager shall recommend that the Plan Administrator pay the reasonable claims submitted by Provider for the concurrently approved Treatment based upon the discounted rate for such Treatment as specified on the Fee Schedule. Concurrent approval of Treatment must be confirmed in writing, via mail or fax, by Manager.

(3) Peer to Peer Review. Provider must request a peer to peer review while the patient is still in care. Manager's clinical records will be reviewed by a staff psychologist or psychiatrist other than the current case manager. In

the event that the specified Treatment is approved by peer to peer review, Manager shall recommend that the Plan Administrator pay the reasonable claims submitted by Provider for the concurrently approved Treatment based upon the discounted rate for such Treatment as specified on the Fee Schedule. Peer to peer approval of Treatment must be confirmed in writing, via mail or fax, by Manager.

(C) Records. To assist Manager in performing the utilization review of claims, Provider, at Provider's cost, shall diligently provide to Manager copies of all reports and records generated by Provider during the course of Treatment of the Participant as may be reasonably requested by Manager. Provider shall provide to Manager any other information that Manager may reasonably request to provide utilization review.

4.2 Claims Procedures.

(A) Acknowledgments. Provider acknowledges that:

(1) Plan Administer pays claims. Manager makes recommendations to the respective Plan Administrators as to the amount of payment of Provider's claims, and the respective Plans are responsible for payment or denial of payment of Provider's claims.

(2) Manager's utilization review of Provider's claims is a condition precedent to any payment to the Provider from the Plan. Failure to submit claims for payment to Manager will result in the delay or denial of payment to Provider.

(B) Claim Forms. All claims for payment by Provider shall be submitted on universal insurance claim form (UB-92 or HCFA 1500), or such other similar form as may be approved in advance by Manager.

(C) Time Limitations. All claims must be submitted to Manager for utilization review and approval within six (6) months of the date on which the claimed Treatment occurred. Within ten (10) business days from the receipt of the claim by Manager, Manager shall provide its recommendation to the respective Plan Administrator for payment or denial of the claim. This recommendation may be delayed in the event that Provider has failed to provide to Manager the records underlying the claim for payment in a timely manner.

(D) Preapproval. Manager shall approve for payment all claims for Treatment which have been precertified or concurrently approved by Manager in accordance with Articles 4.1(B)(1) & 4.1(B)(2) above. Manager shall make prompt recommendations for the payment of such claims to the Plan Administrator.

(E) Right of Appeal. In the event that Provider disagrees with Manager's determination and recommendation regarding the payment or denial of the claim, Provider may request an appeal of the recommendation in accordance with Article 5 below.

4.3 Fee Schedule.

(A) Provider agrees that all claims for payment for Treatment rendered will be submitted to Manager for approval for payment based upon the agreed Fee Schedule (Exhibit A). The Fee Schedule may be amended from time-to-time by mutual agreement between the parties.

(B) Provider agrees to accept all approved payments, together with any co-payment or deductible required by any Plan, as a full settlement and an accord and satisfaction for all Treatment rendered to the Participant. For any claim which is denied, in whole or in part, and not modified by appeal (reference Article 5 below), Provider shall be deemed to release and waive payment for any such claim, and agrees not to seek collection of such amounts from the Plan or Participant. In no event will the Provider attempt to obtain written negation of this section from the Patient or Patient's representative. (i.e. the Personal Financial Responsibility Form)

(C) In the event that any Plan requires a co-payment by the Participant, it is the Provider's responsibility to collect such co-payment. Provider must inform Participant in advance that Participant will be responsible for payment of the co-payment. In the event that any Plan requires the payment of a deductible by the Participant, it is the Provider's responsibility to collect such deductible payment. Provider must inform Participant in advance that Participant will be responsible for payment of the Treatment deductible

(D) In the event that Provider charges for appointment cancellation, Provider may seek to collect such charges from the Participant directly. Manager will not approve payment of cancellation fees from any Plan.

ARTICLE 5: APPEAL & ARBITRATION.

5.1 The following terms and conditions set forth Provider's exclusive rights for appealing any determination of Manager regarding the denial or reduction of any claim for payment hereunder. The parties hereby waive and exclude any right of application to any court of law or equity in connection with the denial of any claim for payment. In the event that either party fails to provide timely notice as required herein, the party shall be deemed to have waived its right to proceed with further appeal, and shall be bound by the last controlling determination with regard to payment of such claim.

5.2 Provider specifically acknowledges that the scope of any appeal will include a review of all Treatment rendered by Provider to the Participant to determine whether such Treatment was therapeutically necessary, regardless of whether the Treatment was precertified or concurrently approved by Manager. In the event that upon reconsideration any prior approved Treatment is deemed by the appeal umpire to not have been therapeutically necessary, the appeal umpire may direct the Manager to modify its recommendation to the Plan Administrator relating to the payment for such Treatment. Prior approved Treatment shall not be retrospectively denied based on the appeal process unless it is demonstrated that the information provided at the time of initial certification was grossly inaccurate, willfully misleading or that pertinent information was withheld from the reviewer.

5.3 Appeal. In the event that Provider disagrees with Manager's denial of any claim for payment for Treatment rendered, Provider shall have the right to appeal the denial in accordance with the following procedure:

(A) First Level Appeal

(1) Time Limitation. Within thirty (30) days following the notification of denial of any claim for payment, Provider shall provide written notification to Manager, identifying the disputed claim and stating that Provider desires to appeal the denial of the claim. The notice shall also contain a brief explanation of the reason underlying Provider's appeal of the claim.

(2) Review. Upon receipt of Provider's notice, Manager shall perform a first level appeal of the Treatment underlying the claim for payment. Within ten (10) days from receipt of Provider's notice, Manager shall notify Provider of the results of the first level appeal. In the event that the recommendation to the Plan Administrator is modified as a result of the first level appeal, the Plan Administrator will be promptly notified of any modification.

(B) Second Level Appeal. In the event that Provider disputes the results of the first level appeal, Provider may request a second level appeal of the claim for payment to be performed by an independent mental health care professional ("Referee") to be designated by Manager.

(1) Time Limitation. Within ten (10) days following the notification of the results of the first level appeal, Provider shall provide written notice to Manager requesting the second level appeal.

(2) Referee. The Referee shall be selected from Manager's list of independent mental health care professionals who perform appeal services.

(3) Review Procedure. Subject to availability, the Referee shall promptly review all records and reports underlying Provider's claims for services. The parties may submit written statements for consideration supporting their respective positions. The Referee shall make a binding determination on the therapeutic necessity of the Treatment subject of the claim. Said determination shall be mailed to the parties. In the event that the Referee deems that the all or a portion of the disputed Treatment was therapeutically necessary for the care of the Participant, the Referee shall instruct the Manager to modify its recommendation to the Plan Administrator for payment of that portion of the Treatment deemed by the Referee to be therapeutically necessary. Unless further appealed, the Referee's determination shall be final and binding.

5.4 Arbitration. In the event that Provider disagrees with the Referee's decision, said Provider may request that the claim be submitted to binding arbitration in accordance with the following procedure.

(A) Time Limitation. Provider shall provide written notice to Manager within ten (10) days following receipt of the Referee's determination requesting that the claim be submitted to binding arbitration.

(B) Arbitrator. The arbitration proceedings shall be conducted before one (1) neutral arbitrator ("Arbitrator"). The Arbitrator shall be selected from a nationally recognized mental health care management or utilization review organization mutually agreeable to both parties. Said Arbitrator must be affiliated, either directly or indirectly, with the organization, and have obtained an academic degree at least equivalent to a doctorate. In the event that the parties are unable to agree on a mental health care management or utilization review organization, the Referee shall designate such an organization to select the Arbitrator.

(C) Arbitration Procedure. Provider shall have the burden of showing that the Treatment subject to the claim was therapeutically necessary for the care of the Participant. Each party may present any evidence to the Arbitrator for consideration and review, including records and written affidavits, statements or testimony. The Arbitrator may, at the Arbitrator's discretion, communicate via telephone conference with both parties to solicit further information. Provided, the Arbitrator may not communicate with either party individually without the prior consent of the other party.

(D) Arbitration Decision. Following the review of all submitted evidence, the Arbitrator shall make a written determination regarding the therapeutic necessity of the Treatment which is the subject of the disputed claim. In the event that the Arbitrator deems that all or a portion of the disputed Treatment was therapeutically necessary for the care of the

Participant, the Arbitrator shall instruct the Manager to modify its recommendation to the Plan Administrator for payment of that portion of the Treatment deemed by the Arbitrator to be therapeutically necessary.

(F) Costs and Expenses. In the event of Arbitration, the non-prevailing party shall bear all costs and ancillary expenses of the arbitration proceedings, including, but not limited to, the professional fees of the Arbitrator and the mental health care management or utilization review organization. The parties shall bear their own out-of-pocket costs incurred in relation to the arbitration, including attorneys' fees.

(G) Binding Effect. The parties hereby exclude any right of application or appeal to any court, to the extent that they may validly so agree, and in particular in connection with any question of law arising during the course of the arbitration or out of the determination of the Arbitrator.

ARTICLE 6: PREFERRED PROVIDER NETWORK LEASE AGREEMENTS

6.1 Manager may enter into health service agreements with a variety of types of entities which may include preferred provider organizations, insurers, employers, third party payers, health maintenance organizations, capitated and non-capitated health plans, among others. Through these agreements Manager or its agent agrees to refer certain Participants to Provider.

Whereas, Provider desires to participate as an independent practitioner on the PMHM preferred provider panel or network and to provide services for members covered in the above-mentioned Health Plans and to receive compensation for such rendering of services;

Both Manager and Provider agree that the goal of their relationship under this agreement is to provide safe, effective treatment for Members covered through Health Plans contracting with PMHM and/or its subsidiaries/clients.

6.2 Unless legally or ethically prohibited from doing so, Provider agrees to accept all such referrals, and render Treatment to any such Participant as Provider deems to be prudent and therapeutically necessary.

6.3 Under these agreements, Manager will not be responsible for utilization review, review of therapeutic necessity recommendations regarding payment, or appeals. Such agreements may include utilization review by other parties or may be solely a preferred Provider arrangement.

Provider is responsible for compliance with any utilization review requirements, appeals procedures, and other administrative requirements which may be effected by these agreements.

6.4 Manager may be responsible for claims review under network lease agreements. In such circumstances, Manager’s function will be limited to repricing claims in accordance with the Fee Schedule. Claims may be reviewed and repriced by other parties under network lease agreements.

6.5 Manager will make good faith efforts to assure that appropriate identification documents and procedural instructions are distributed to Participants. Manager will make good faith efforts to assure that applicable utilization review, appeals and other administrative procedures are made available to Provider.

ARTICLE 7: QUALITY ASSURANCE AND IMPROVEMENT

7.1 Provider agrees to cooperate and comply with reasonable Quality Assurance and Improvement activities and standards undertaken by Manager.

7.2 Provider agrees to provide appropriate data reasonably requested by Manager to demonstrate, measure and validate Quality Assurance and Improvement actions.

7.3 Provider shall allow Manager reasonable access to records, in conformity with state and federal confidentiality laws and regulations.

7.4 Manager may conduct periodic site visits with reasonable notice to Provider.

ARTICLE 8: TERM AND TERMINATION

8.1 This Agreement will become effective as of the date it was initially signed by Manager and shall automatically renew annually for additional one year (1) year terms unless otherwise terminated as provided herein.

8.2 This Agreement may be terminated as follows:

(A) To terminate this agreement, Provider must give notice to Manager ninety (90) days prior to the end of the automatic renewal sent in writing to Manager by certified mail, return receipt requested, of its intent to terminate this Agreement. Once this notification has been received, Manager has ninety (90) days from the date of notification to terminate Provider. During this time, Provider agrees to continue to treat patients / members at the agreed upon PMHM rates.

(B) Manager may immediately terminate this Agreement by providing written notice to Provider upon the occurrence of any of the following events:

(1) Provider loses any necessary licensure required by federal or state law in order to provide Treatment to Participants;

(2) Provider fails to abide by Manager's systems of utilization review and case management;

(3) Provider submits a false or fraudulent claim for payment;

(4) A state regulatory board or professional ethics committee finds that Provider or any of its employees, agents or independent contractors have engaged in any unethical or improper conduct or has placed or imposed limits or supervision on the areas of Treatment which the Provider can render; or

(5) Provider violates any provisions set forth within this contract.

8.3.1 Provider shall have an affirmative obligation to report to Manager the occurrence of any of the events described in Article 8.1(B) above.

ARTICLE 9: INDEMNIFICATION

9.1 It is acknowledged by the parties that Manager shall incur no liability as a result of any claims arising out of or in any way related to the Treatment or non-Treatment of any Participant by Provider. Provider shall defend, indemnify against liability and hold harmless Manager, its officers, employees and agents from any and all claims, demands, litigation, and expenses of all kinds, including attorney fees, which may result or arise from any malpractice or negligence caused or alleged to be caused by Provider, Provider's employees or agents while acting within the scope of their duties under this agreement.

9.2 Manager shall indemnify for loss the Provider, Provider's employees and agents from any and all liabilities or judgments which may result or arise from any negligence directly caused or alleged to be directly caused by Manager, its officers, employees or agents as a result of actions taken or not taken by Manager in the administration of the Plan as provided herein.

9.3 The indemnity and hold harmless obligations set forth in this Article 9 will survive the termination of this Agreement.

ARTICLE 10: REPRESENTATIONS AND WARRANTIES.

10.1 Manager and Provider both represent and warrant that each provision of this Agreement is legal, valid, binding and enforceable as to said party, and that each has completed all necessary corporate and business formalities in order to enter into this Agreement.

10.2 Provider represent and warrants that it will not discriminate against any Participant on the basis of race, color, sex, age, religion, national origin or disability.

10.3 During the term hereof, Provider shall carry and maintain professional liability insurance providing for coverage in the amount of not less than $1,000,000.00 per claim and $3,000,000.00 in the aggregate or such alternate greater amount as state laws and regulations require.

10.4 Provider shall maintain all required and appropriate licenses, certifications, and accreditations. Provider grants permission for Manager to contact primary source organizations to verify licenses, certification and accreditation status or other information required for inclusion in Manager's PPO.

ARTICLE 11: NOTICES

11.1 With the exception of notification of termination, any formal notice between the parties required or permitted under this agreement shall be deemed sufficiently given if said notice is personally delivered, delivered by US Mail, sent by registered or certified mail; or by email or fax, to the party to who said notice is to be given. With the exception of notification of termination, notices delivered in person, by US Mail, email or fax shall be deemed to be served effective as of the date the notice is delivered or sent, as applicable. Notices sent by registered or certified mail shall be deemed to be served seventy-two (72) hours after the date said notice is postmarked to the addressee, postage prepaid. Until changed by written notice given by one party to the other, the addresses and numbers of the parties shall be as follows:

(A) Manager:

Preferred Mental Health Management LLC
Attn: Provider Relations
7309 E 21st St North, Ste 110
Wichita, Kansas 67206
Phone: (316) 262-0444
Fax: (316) 262-5723

(B) Provider: ______________________________________

Attn:__________________________________

____

____
Phone: (______) _______-_______________
Fax: (______) _______-_________________

11.2 All future addendums to this Agreement shall be deemed to be in effect within 30 days after the effective date listed on the addendum to Provider. If Provider wishes to decline the addendum, he or she should send Manager notification via certified mail, return receipt requested, within 30 days of the effective date on the addendum.

ARTICLE 12: MISCELLANEOUS

12.1 This Agreement shall be governed by the laws of the State of Kansas as effective and in force on the Commencement Date. Any legal proceeding relating to this Agreement shall be brought exclusively in the Eighteenth Judicial District Court, Wichita, Sedgwick County, Kansas, U.S.A., or in the United States District Court for the District of Kansas at Wichita, Kansas, U.S.A., and both parties hereto consent to the jurisdiction of said courts.

12.2 The agreement does not supersede the Provider's obligation to abide by Federal, State or Local laws.

12.3 Except as provided in this agreement, in the event of termination of this agreement each party will remain liable for any obligation or liabilities arising from activities carried on by such party or its agents or employees during the period this agreement is in effect.

12.4 The failure of either party to insist upon the strict performance of any of the terms or conditions of this Agreement or to exercise any option, right or remedy herein contained, shall not be construed as a waiver or as a relinquishment for the future of such term, provision, option, right or remedy, but the same shall continue and remain in full force and effect. No waiver by either party of any term or provision hereof shall be deemed to have been made unless expressed in writing and signed by such party.

12.5 The descriptive headings of the provisions of this Agreement are formulated and used for convenience only and shall not be deemed to affect the meaning and construction of any such provision.

12.6 Manager shall have the right to assign this Agreement, either in whole or in part to another party. Provider shall have the right to assign the agreement with the written permission of Manager.

12.7 This Agreement shall be binding upon and inure to the benefit of the parties hereto and their permitted successors and assigns.

12.8 If any provision in this Agreement shall be held invalid, illegal or unenforceable in any jurisdiction, the validity, legality and enforceability of the remaining provisions of this Agreement shall not be impaired thereby, nor shall the validity, legality or enforceability of any such defective provisions be in any way affected or impaired in any other jurisdiction.

12.9 The parties hereto intend by this Agreement to effect the appointment of Provider as an independent contractor of Manager under the terms and conditions contained herein. No other relationship is intended to be created between the parties hereto except for that of independent contractor, and nothing herein shall be construed so as to give either party any rights as an agent, employee, joint venturer or partner in the business of the other party or entitle either party to control in any manner the conduct of the other party's business, other than as specified herein.

12.10.a This Agreement constitutes the entire agreement between the parties with respect to their relationship. There are no verbal understandings, agreements, representations or warranties between the parties which are not expressly set forth herein. This Agreement supersedes all prior agreements and understandings between the parties, both written and oral.

12.10.b Manager has the right to make exceptions to the provider's credential requirement on a case by case basis.

12.10.c The Provider must provide in writing, notification if there is a merger, acquisition, buyout, change in name or tax ID within 10 days of finalization of such change.

IN WITNESS WHEREOF, Manager and Provider have caused this Agreement to be executed by their duly authorized representatives as of the day first above written.

PREFERRED MENTAL HEALTH MANAGEMENT LLC	**PROVIDER**
By____________________________________	By ____________________________________
Print Name____________________________	Print Name____________________________
Title__________________________________	Title__________________________________
Date__________________________________	Date__________________________________

Exhibit A

PLEASE SEE NOTE BELOW BEFORE COMPLETING RATES

SUBSTANCE ABUSE	Facility's Estimated Usual Rate	Facility's Proposed Per Diem Rate*	PMHM's Customary Rate
Adult Detoxification	________	________	$300-350
Adolescent Detoxification	________	________	$300-350
Adult Inpatient	________	________	$300
Adolescent Inpatient	________	________	$300
Adult Day Hospital (partial)	________	________	$175
Adolescent Day Hospital (partial)	________	________	$175
Adult Structured Outpatient Program	________	________	$75/day
Adolescent Structured Outpatient Program	________	________	$75/day

Average length of stay:____

Do the above discounted fees include doctor's attending charges? ☐ Yes ☐ No

PSYCHIATRIC	Facility's Estimated Usual Rate	Facility's Proposed Per Diem Rate*	PMHM's Customary Rate
Adult Inpatient	________	________	$350-400
Adolescent Inpatient	________	________	$350-400
Adult Day Hospital (partial)	________	________	$175
Adolescent Day Hospital (partial)	________	________	$175
Adult Structured Outpatient Program	________	________	$75/day
Adolescent Structured Outpatient Program	________	________	$75/day

Average length of stay:____

Do the above discounted fees include doctor's attending charges? ☐ Yes ☐ No

***PMHM negotiates an all inclusive per diem rate with its facilities. This rate includes room and board and all usual therapies, labs and testing.**

IMPORTANT NOTE: "PMHM's Customary Rate" represents the average rate which PMHM obtains from the majority of its national facility networks. This customary rate is provided to give you a general idea of the rates PMHM obtains. We understand, however, that managed care rates vary somewhat depending on geographic location. PMHM accepts your facility's discounted rates offered above as the most competitive rates your facility offers. For PMHM to process your application, you must provide us with a proposed rate. Please list your facility's <u>bottom dollar</u> rate.