



Preferred Mental Health Management

Application

Please return to: **PMHM**
7309 E. 21st St. North,
Suite 110
Wichita, KS 67206

Phone: 1-800-776-6793 Fax: 316-262-5723
Email: ProviderRelations@PMHM.com
PMHM's Website: www.PMHM.com

IMPORTANT! This is your invitation to join one of the nation's largest behavioral networks serving more than one million members. **Please give this questionnaire your prompt attention and respond within the next 30 days. Failure to include all requested information may result in the application being denied.**

FULL NAME _____ DOB ____/____/____
 SS# _____ MEDICARE# _____ NPI# _____
 DEA# _____ Exp Date ____/____/____ TAX ID # _____
 EMAIL _____ WEBSITE: _____
 Licensed/Certified as: _____ (ex. M.D./Ph.D./LSCSW, LCDC, etc.)

| PHYSICAL ADDRESS | MAILING ADDRESS |
|--|-----------------|
| CLINIC NAME | |
| ADDRESS | ADDRESS |
| CITY | CITY |
| STATE/ZIP | STATE/ZIP |
| PHONE # FAX # | |
| COUNTY | |
| ADDITIONAL ADDRESSES – ADD SEPARATE PAGE | |

MALPRACTICE INFO: Company Name _____
 Per Occurrence \$ _____ / Aggregate \$ _____ Exp. Date: _____

LICENSE INFO: License #(s); state(s); years licensed; exp. date

| License # | State | # Years Licensed | Exp. Date |
|-----------|-------|------------------|-----------|
| (1) _____ | _____ | _____ | _____ |
| (2) _____ | _____ | _____ | _____ |
| (3) _____ | _____ | _____ | _____ |

DOCUMENTS REQUIRED:

- ___ Copy of current malpractice liability declaration page with effective date and amount of coverage
- ___ Copy of DEA license (if applicable)
- ___ Copy of license
- ___ Curriculum Vitae

Where are your patients usually hospitalized?

(Please include name, address, phone, and type of affiliation with hospital for each.)

- (1) _____
- _____
- (2) _____
- _____

If you are not a psychiatrist, please list the name and telephone number of a psychiatrist colleague with whom you would collaborate for medication or inpatient treatment:

_____ Phone: _____

Answer Y or N to the following (if yes, explain on separate sheet):

- Yes No Has your practice information changed since you were last credentialed? Date changed: _____
- Yes No Are you willing to accept new patients? Yes No Do you provide 24 hour coverage?
- Yes No Is your license currently encumbered?
- Yes No Have you had a complaint filed against your license or been subject to investigation or disciplinary review by your state licensing board, county, state or professional society?
- Yes No Have you had any malpractice suits filed against you, including any settled out of court in the past 5 years?
- Yes No Have you been excluded from receiving payments from Medicare/Medicaid?
- Yes No Have you been suspended or expelled from a PPO, HMO or IPA since?
- Yes No Have you been convicted of a felony crime or a moral crime?
- Yes No Has your employment as a provider been terminated or have you had your privileges reduced due to substandard care, incompetence or misconduct?
- Yes No Are you currently addicted to alcohol, narcotics or other drugs?
- Yes No Do you currently have a physical, emotional or other difficulties which hinder your ability to perform the functions of your profession?

What languages do you speak fluently?

- | | |
|----------------|---------------------------|
| A.S.L. _____ | Russian _____ |
| Chinese _____ | Spanish _____ |
| French _____ | Vietnamese _____ |
| German _____ | Yiddish _____ |
| Hebrew _____ | Other (please list) _____ |
| Italian _____ | _____ |
| Japanese _____ | _____ |

What ages do you treat?

- | |
|------------------|
| 0-5 yrs. _____ |
| 6-12 yrs. _____ |
| 13-17 yrs. _____ |
| 18-64 yrs. _____ |
| 65+ _____ |

What type of therapy do you provide?

- Individual _____ Group _____ Couples _____ Family _____

What are your treatment specialties? (Number up to 5, with 1 being primary.)

- | | | |
|---------------------------|--------------------|----------------------------------|
| Behavior _____ | Modification _____ | Hypnosis _____ |
| Behavioral _____ | Medicine _____ | Medication Management _____ |
| Biofeedback _____ | _____ | Neuropsychological Testing _____ |
| Cognitive _____ | Therapy _____ | Pain Management _____ |
| CISD _____ | _____ | Psychological Testing _____ |
| ECT _____ | _____ | Stress Management _____ |
| Other (please list) _____ | _____ | |

In which of the following areas do you consider yourself to have expertise?

(Number up to 5, with 1 being primary.)

- | | |
|------------------------------------|------------------------------|
| Adjustment to illness/injury _____ | Gay/Lesbian Issues _____ |
| Anger Problems _____ | Grief _____ |
| AIDS/ARC _____ | Learning Disabilities _____ |
| Alcohol/Substance abuse _____ | Life Transition Issues _____ |
| Anxiety Disorders _____ | Mood Disorders _____ |
| Attention Deficit Disorders _____ | Psychotic Disorders _____ |
| Developmental Disorders _____ | PTSD _____ |
| Eating Disorders _____ | Sexual Problems _____ |

Other (please list) _____

What cities/towns are within a reasonable distance of your office? _____

Is your office handicapped-accessible? Yes _____ No _____

What are your regular office hours for patient service? _____

What arrangements do you have for out-of-hours coverage? _____

What is the typical length of time between scheduling and first appointment? _____

What arrangements can be made for emergency appointments? _____

Can you be available for crisis intervention? Yes _____ No _____

Evenings Yes _____ No _____ Weekends Yes _____ No _____

Release of Information/Agreement:

I hereby authorize PMHM to contact appropriate third parties to verify information regarding my participation in the PMHM program. PMHM is authorized to receive and inspect all documents pertaining to my licensure, training, experience, current competence and health status.

Such contact may include, but not be limited to, hospitals, licensing entities, medical and specialty organizations, insurance carriers, courts of law, state and foreign jurisdictions and employers. I agree to release of information from malpractice carriers regarding claims, suits and settlements and information contained in utilization and quality compilations, including but not limited to, health care institutions with which I have been or am currently affiliated. In the event of an adverse determination, PMHM will notify me of the basis of the determination.

In submitting this application, I release from liability any party providing information to PMHM in good faith concerning my application or affiliation with the corporation. This release applies to PMHM and its agents and employees regarding consideration of this or any other application I may file, or any proceeding for reappointment, reduction, suspension, de-participation or review of professional services I may provide in affiliation with the corporation.

I agree to promptly notify PMHM of any change to information in my application. All information will be treated as confidential by PMHM and will not be re-disclosed to any other party without my express written consent.

RELEASE AND DISCLOSURE/ATTESTATION

Please release to Preferred Mental Health Management LLC (PMHM) representatives the following information: verification of all details regarding my educational background and state licensure (disciplinary actions, suspensions or any curtailment of my professional activities) and release all information regarding my malpractice insurance (coverage verification, certificate of insurance or declaration page showing all applicable endorsements and sub-endorsements and claims history). I release all persons providing such information from any liability for doing so. I hereby certify that the information in this application is complete and accurate.

SIGNATURE _____ DATE _____

PRINTED NAME _____

OFFICE ADDRESS _____ CITY/ STATE/ZIP _____

**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 Administrator 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 Provider shall have an affirmative obligation to report to Manager the occurrence of any of the events described in Article 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
401 E. Douglas, Suite 505
Wichita, Kansas 67202
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

By _____

Print Name _____

Title _____

Date _____

PROVIDER

By _____

Print Name _____

Title _____

Date _____

Exhibit A

FEE INFORMATION FOR PSYCHOLOGISTS

| | |
|--|-------|
| Intake Evaluation (90791) | 80.00 |
| Individual Psychotherapy 45-50 min. (90834) | 75.00 |
| Individual Psychotherapy 20-30 min. (90832) | 40.00 |
| Group Therapy 2-3 hours (90853) | 30.00 |
| Psychological Testing (96101) | 75.00 |
| Family Therapy (90847) | 75.00 |
| Psychotherapy pt & fam w/e&m 30 min. (90833) | 40.00 |
| Psychotherapy pt & fam w/e&m 50 min (90836) | 66.00 |

FEE INFORMATION FOR SOCIAL WORKERS

| | |
|--|-------|
| Intake Evaluation (90791) | 65.00 |
| Individual Psychotherapy 45-50 min. (90834) | 60.00 |
| Individual Psychotherapy 20-30 min. (90832) | 35.00 |
| Group Therapy 2-3 hours (90853) | 30.00 |
| Family Therapy (90847) | 60.00 |
| Psychotherapy pt & fam w/e&m 30 min. (90833) | 30.00 |
| Psychotherapy pt & fam w/e&m 50 min (90836) | 45.00 |

FEE INFORMATION FOR CERTIFIED DRUG\ALCOHOL COUNSELOR

| | |
|--|-------|
| Intake Evaluation (90791) | 50.00 |
| Individual Psychotherapy 45-50 min. (90834) | 50.00 |
| Individual Psychotherapy 20-30 min. (90832) | 30.00 |
| Group Therapy 2-3 hours (90853) | 25.00 |
| Family Therapy (90847) | 50.00 |
| Psychotherapy pt & fam w/e&m 30 min. (90833) | 30.00 |
| Psychotherapy pt & fam w/e&m 50 min (90836) | 45.00 |