CLINIC PROVIDER AGREEMENT

CLINIC: SETON HEALTHCARE CLINICS PHONE# (512) 715-3000

ADDRESS: PO BOX 1299	BURNET,	BURNET	78611
(BILLING ADDRESS)	(CITY)	(COUNTY)	(ZIP)

LOCATION: MULTIPLE

MEDICARE ID# 451365 MEDICIAD ID# 09415100-04

Contact person for accounts receivable: DON BRUNSON (512) 715 -3009

On behalf of all SETON HEALTHCARE SYSTEM, I agree to be a Mandated Provider for Burnet County Indigent Health Care Program (CIHCP). I understand that CIHCP service recipients are eligible for medically necessary health care services as outlined in Section 4 of the CIHCP Handbook. Clinic services are reimbursable by Burnet County as follows:

A) Clinic and physician services according to allowable CPT Code amounts set by the TDSHCP Handbook.
B) Laboratory and X-Ray services according to allowable CPT Code amounts set by the TDSHS CIHCP Handbook

Invoices (standard CMS-1500 Claim Forms) submitted to the Burnet County CIHCP will be restricted to medically necessary services as ordered by a duly licensed physician. The billed amount will be consistent with the amounts these clinics charge all other patients. Reimbursement will be at the TDDHS established amount, and will reflect any general and specific exclusion as outlined in the CIHCP Handbook. I accept the CIHCP reimbursement amount for CIHCP Mandatory services as payment in full; I understand that the recipient cannot be invoiced for any remaining balance. Invoices (standard CMS-1500 Claims Forms) will be sent monthly to **Burnet County CIHCP, 220 South Pierce Street , Burnet, Texas 78611**, and will include each CIHCP identification number, name and DOB of each recipient, and if applicable, the patient identification number assigned by the clinic. Invoices (standard CMS-1500 Claim Forms) should include detailed narrative descriptions of each billed procedure and all should be signed and dated. All invoices (standard CMS-1500 Claim Forms) received will be processed for payment within a 30-day time frame in which the bill is received unless there are circumstances reframing bill payment. (Pending eligibility for CIHCP, SSI determination etc.), invoices received

ninety-five (95) days after the date of service (or date of certification if prior coverage applies), will not be reimbursed.

I understand that either party may cancel this agreement with a thirty (30) day written notice, or sooner if both parties mutually agree. I understand that if I choose to cancel my participation as a CIHCP provider, that I should contact the CIHCP Director in writing of intent to cancel and that I will not refuse services for CICHP recipients until thirty (30) day from the date of written notification, or earlier if mutually agreeable. I further understand that the CICHP office will be responsible for notifying recipients of changes and/or cancellation to this agreement.

KAREN LITTERER

Hospital Administrator (please type)

Signature_____

Date _____

_____

CIHCP Director (please type)

Signature_____

Date_____

James Oakley

County Judge (please type)

Signature_____

Date 1-23-18