HOSPITAL PROVIDER AGREEMENT

HOSPITAL: SETON HIGHLAND LAKES HOSPITAL PHONE# (512) 715-3000

BILLING ADDRESS: P.O. BOX 1299 BURNET TEXAS 78611

LOCATION: MULTIPLE

MEDICARE ID # 451365 MEDICARE ID# 09415100-04

Contact person for accounts receivable: Don Brunson (512) 715-3009

On behalf of Seton Highland Lakes Hospital, 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. Hospital care services are reimbursable by Burnet County as follows:

A) Inpatient services according to interim rate for outpatient services multiplied by the billed amount as outlined in Section 4 of the CIHCP Handbook.
B) Outpatient services according to the interim rate for outpatient services multiplied by the billed amount as outlined in Section 4 of the CIHCP Handbook.

Invoices (standard UB 04 claim form) 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 this hospital charges 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 UB 04 claim form) 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 UB 04 claim form) should include detailed narrative descriptions of each billed procedure and all should be signed and dated. All Invoices 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 CICP, SSI determination etc.) Invoices (standard UB 04 claim form) 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 is should contact the CICHP Director in writing of intent to cancel and that I will refuse services for CIHCP recipients until thirty (30) days 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

SIGNATURE_____

DATE:_____

_____
CIHCP DIRECTOR

SIGNATURE_____

DATE:_____

JAMES OAKLEY
COUNTY JUDGE

SIGNATURE 

DATE: 1-23-18