CLINIC PROVIDER AGREEMENT

Clinic: LONE STAR CIRCLE OF CARE Phone # 877-800-5722

Address: 205 E University Avenue, Suite 200 Georgetown Texas 78626-6814

Location: Multiple

Medicaid ID # 1560575-03 NPI ID#1639129331

Contact person for Accounts Receivable:_____

On behalf of all Lone Star Circle of Care Clinics and affiliated Physicians, 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 CICHP Handbook. Clinic services are reimbursable by Burnet County as follows:

A) Clinic and physician services according to allowable CPT Code amounts set by the TDSHS CIHCP 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. Reimbursements will be at the TDDHS established amount, and will reflect any general and specific exclusion as outlined in the CIHCP Handbook. I accept the CICHP reimbursement amount for CICHP Mandatory Services as payment in full: I understand that the recipient cannot be invoiced for any remaining balance. Invoices (standard CMS-1500 Claim Forms) will be sent monthly to Burnet County IHC, 220 S. Pierce Street, Burnet, Texas 78611, and will include each CICHP 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 CICHP, SSI determination etc.). The County will only pay for services provided to current Burnet County IHC clients on date of service. Invoices received ninety-five 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 CICHP Director in writing of intent to cancel and that I will not refuse services for CICHP 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

Clinic Administrator: _____
Print Name

Signature: _____ Date: _____

James Oakley: J. Oakley Date: 1-3-2020
Burnet County Judge

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