AMENDMENT

to

HOSPITAL PROVIDER AGREEMENT

between

Baylor Scott & White Medical Center – Marble Falls

and

Burnet County

May it be known that **Baylor Scott & White Medical Center – Marble Falls**, hereafter referred to as "Hospital", and **Burnet County** on behalf of the Burnet County Indigent Health Care Program hereafter referred to as "CIHCP", mutually agree to amend the 2018 Hospital Provider Agreement as follows:

> "This Agreement provides for health care services to low income individuals who are not entitled to benefits under Title XVIII of the Social Security Act or eligible for assistance under the State plan under this title."

This Amendment is effective immediately upon the date of last signature.

Baylor Scott & White Medical Center – Marble Falls

By: _____

Printed Name: Timothy Ols

Title: President, Hill Country

Date of Signature: 3/7/2024

Burnet County

By: _____

Printed Name: James Oakley

Title: Burnet County Judge

Date of Signature: 3-8-24

HOSPITAL PROVIDER AGREEMENT

Hospital: BAYLOR SCOTT & WHITE CLINICS Phone# (830) 201-8000

Billing Address: 810 W. HWY 71 MARBLE FALLS, TEXAS 78654

Location: Multiple

Medicare ID# 670108 Medicaid ID#: 3537128-01 Traditional Services
3537128-02 ASC Services

Contact person for accounts receivable: Sharon Choate (830) 201-8647

On behalf of Baylor Scott & White Hospital, I agree to be a Mandated Provider for Burnet County Indigent Health Care Program (CIHCP). I understand that CHICP 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 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 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 S. Pierce St., 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 CIHCP, 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 wither party may cancel this agreement with a thirty (30) day written notice, or sooner if both parties mutual 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) days from the date of written notification, or earlier if mutually agreeable. I further understand that the CIHCP office will be responsible for notifying recipients of changes and/or cancellation to this agreement.

TIM OLS
HOSPITAL ADMINISTRATOR

SIGNATURE: _____

DATE: 2/8/18

CIHCP DIRECTOR

SIGNATURE_____

DATE: _____

JAMES OAKLEY, COUNTY JUDGE

SIGNATURE: _____

DATE: 1/23/2018

HOSPITAL PROVIDER AGREEMENT

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SIGNATURE: _____

DATE: 2/8/18

CIHCP DIRECTOR

SIGNATURE_____

DATE: _____

JAMES OAKLEY, COUNTY JUDGE

SIGNATURE: _____

DATE: 1/23/2018