Bulldog Billing Medical Contracts, Credentialing, Claims, Consulting

Date: _____

To: _____(Client Name/Practice Name
Re: Patient Claims Submission Agreement

CLAIMS SUBMISSION & INSURANCE VERIFICATION/BENEFITS AGREEMENT

For Insurance Verification & Benefits Check ~ I will need the following information:

(All patient demographic & insurance data to be transmitted to me via secure fax # 760.859.3877, text to 760.310.4659 or secure email at veronica.bush@bulldogbilling.org)
*****FOR PATIENTS TO CONTACT ME: 949-344-4676 ~ askveronica.bdb@gmail.com***

- Copy of Insurance card (front/back)
- Copy of Patient's (&/or Legal Guardian) CDL or ID or a Copy of their Demographic/Registration Page

For the Claims Submission ~ I will need the following information:

(All patient demographic & insurance data to be transmitted to me via secure fax # 760.859.3877 or secure email at veronica.bush@bulldogbilling.org)

- Patient Demographics (minimally to include first & last name, address, phone, DOB & social security number)
- Copy of Insurance card (front/back)
- Copy of Patient's (&/or Legal Guardian) CDL or ID or a Copy of their Demographic/Registration Page
- Copy of authorization from insurance company, or at the very least, the authorization number, dates of coverage and procedures covered (for EAP or TESTING)
- For Testing: Authorization form with ALL clinical information completed (if applicable)
- REQUIRED & COMPLETE Billing Info to be provided on Day Sheet or Complete in EHR System: Date of Service, Correct Patient Names as per Insurance Card, CPT Codes, ICD-10 codes, Payments Taken
    - Any inconsistencies in the patient names, errors in DOS, CPT and ICD-10 Codes will need to corrected ON THE DAYSHEET PRIOR to being billed out.
    - Please note whether visit was VIDEO or IN PERSON

Payments: When you receive paper remittance (with or without actual payment) from the insurance company, please scan both the check (if there is one) and the supporting explanation of benefits and forward to me for posting/ balancing. All other electronic payments, I should be able to receive via the insurance company portals directly & will post as they come in. Also, if you could please relay to me, the EFT payments that are direct deposited to your checking account (i.e. insurance company, date of transaction & dollar amount deposited), I will be able to balance against the payments received. If you currently receive &/or reconcile payments via Insurance Co Portals, please provide me with the log-in information on the next page so I can do that for you.

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Bulldog Billing (its employees, consultants or subcontractors) does not engage in, nor will be party to any fraudulent billing practices. It is always the responsibility of the Provider to determine and submit the appropriate billing codes (CPT & ICD-10/DSM5) and charges for the services performed.

Please Initial _____ for your complete understanding of everything included.

I look forward to working with you!

_____
Provider Signature

Veronica Bush
Veronica Bush

_____
Printed Name

_____
Date

_____
Date

Start Date~ Please indicate preferred or planned date of service for Bulldog Billing to begin submitting claims for your Practice _____. ACTUAL date might vary depending on set up of software or completion of necessary documents.

ADDENDUMS TO AGREEMENT

Please Initial Acknowledgement: .

***This Agreement to remain in effect unless **mutually agreed upon** changes are made by either Provider (Client) or Bulldog Billing & a 30-day notice is given in writing to all involved parties. This 30-day notice would be considered invalid for just cause (ie conditions in signed Agreement are not met).

***BAA to be sent under separate cover for signatures.

***All PHI & HIPAA data covered under Bulldog Billing Cyber Insurance Policy.

Bulldog Billing fees for billing services rendered will be 6% & WILL NOW INCLUDE ALL PATIENT & INSURANCE MONIES RECEIVED, POSTED AND APPLIED during each monthly billing cycle.

***The commission on the portions paid by the patient is to cover my time checking, double-checking and verifying all eligibility, copays & deductibles upon your request. Additionally keeping track of who has paid for what dates of service and advising you when EOB's state the patient portions change is also included.

***Invoicing to the Client will be done on a monthly basis for all payments received and posted in the previous month & will be sent electronically to your email with options to pay via M/C, Discover, Visa, Amex, Zelle, PayPal or Venmo. Payment is due upon receipt of the emailed invoice & considered past due 7 days after receipt.

PO Box 2421 Orange CA 92859 ~ P: 760-310-4659 ~ F: 760-859-3877 ~ veronica.bush@bulldogbilling.org

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Your **signature** below (hand signed or typed) allows Bulldog Billing to use all information contained in this, and all additional submitted documents, for the express use of Credentialing/ Contracting & Insurance Billing for Provider &/or Group as discussed & agreed upon.

_____ _____

Provider/ Title Date

EHR/ Software Systems

_____

Client & Practice Name

***Do you currently have an EHR system that you're using for charting/ billing? YES ☐ NO ☐ If so, which one?_____

*****If you do & if I will be doing your billing (now or in the future), please provide me with an ADMINISTRATIVE (all functions) user ID/ password: _____User ID _____Password

*****If you do NOT, then I will set up an account for your Practice under Office Ally. There would of course be complete accessibility for you should you want it.

NOTE: Depending on your insurance panels that you are contracted with, Office Ally may charge a monthly fee of $35 for the billing/clearinghouse module. This would be the responsibility of the provider.

Please initial here _____ acknowledging the above.

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PRACTICE NAME: _____

Practice Address/ Service Location: _____

_____

Business Phone: _____

Mailing Address: _____

_____

Home Address: _____

_____

Contact Phone #: _____

Email Address: _____

_____

_____

PLEASE ATTACH THE FOLLOWING DOCUMENTS AS WELL:

☐ **IRS TAX ID LETTER (CP575)**

☐ **VOIDED CHECK~ BUSINESS ACCOUNT (for insurance payments)**

☐ **STATE LICENSE**

☐ **DEA LICENSE (if applicable)**

☐ **NPI~ TYPE I (individual)**

☐ **NPI~ TYPE II (group- if applicable)**

_____ _____

Thank you for your cooperation with all of documentation collection! I look forward to working with you on your new adventure! ~~Veronica

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veronica.bush@bulldogbilling.org

BUSINESS ASSOCIATE AGREEMENT (HIPAA)

This Privacy Agreement ("Agreement"), is effective upon signing this Agreement and is entered into by and between _____Bulldog Billing_____ ("Covered Entity") and _____ (the "Business Associate").

I. Term. This Agreement shall remain in effect for the duration of this Agreement and shall apply to all of the Services and/or Supplies delivered by the Business Associate pursuant to this Agreement.

II. HIPAA Assurances. In the event Business Associate creates, receives, maintains, or otherwise is exposed to personally identifiable or aggregate patient or other medical information defined as Protected Health Information ("PHI") in the Health Insurance Portability and Accountability Act of 1996 or its relevant regulations ("HIPAA") and otherwise meets the definition of Business Associate as defined in the HIPAA Privacy Standards (45 CFR Parts 160 and 164), Business Associate shall:

(a) Recognize that HITECH (the Health Information Technology for Economic and Clinical Health Act of 2009) and the regulations thereunder (including 45 C.F.R. Sections 164.308, 164.310, 164.312, and 164.316), apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity;
(b) Not use or further disclose the PHI, except as permitted by law;
(c) Not use or further disclose the PHI in a manner that had the Covered Entity done so, would violate the requirements of HIPAA;
(d) Use appropriate safeguards (including implementing administrative, physical, and technical safeguards for electronic PHI) to protect the confidentiality, integrity, and availability of and to prevent the use or disclosure of the PHI other than as provided for by this Agreement;
(e) Comply with each applicable requirements of 45 C.F.R. Part 162 if the Business Associate conducts Standard Transactions for or on behalf of the Covered Entity;
(f) Report promptly to the Covered Entity any security incident or other use or disclosure of PHI not provided for by this Agreement of which Business Associate becomes aware;
(g) Ensure that any subcontractors or agents who receive or are exposed to PHI (whether in electronic or other format) are explained the Business Associate obligations under this paragraph and agree to the same restrictions and conditions;
(h) Make available PHI in accordance with the individual's rights as required under the HIPAA regulations;
(i) Account for PHI disclosures for up to the past six (6) years as requested by Covered Entity, which shall include: (i) dates of disclosure, (ii) names of the

entities or persons who received the PHI, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose and basis of such disclosure;
(j) Make its internal practices, books, and records that relate to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for purposes of determining Customer's compliance with HIPAA; and
(k) Incorporate any amendments or corrections to PHI when notified by Customer or enter into a Business Associate Agreement or other necessary Agreements to comply with HIPAA.

III. Termination Upon Breach of Provisions. Notwithstanding any other provision of this Agreement, Covered Entity may immediately terminate this Agreement if it determines that Business Associate breaches any term in this Agreement. Alternatively, Covered Entity may give written notice to Business Associate in the event of a breach and give Business Associate five (5) business days to cure such breach. Covered Entity shall also have the option to immediately stop all further disclosures of PHI to Business Associate if Covered Entity reasonably determines that Business Associate has breached its obligations under this Agreement. In the event that termination of this Agreement and the Agreement is not feasible, Business Associate hereby acknowledges that the Covered Entity shall be required to report the breach to the Secretary of the U.S. Department of Health and Human Services, notwithstanding any other provision of this Agreement or Agreement to the contrary.

IV. Return or Destruction of Protected Health Information upon Termination. Upon the termination of this Agreement, unless otherwise directed by Covered Entity, Business Associate shall either return or destroy all PHI received from the Covered Entity or created or received by Business Associate on behalf of the Covered Entity in which Business Associate maintains in any form. Business Associate shall not retain any copies of such PHI. Notwithstanding the foregoing, in the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible upon termination of this Agreement, Business Associate shall provide to Covered Entity notification of the condition that makes return or destruction infeasible. To the extent that it is not feasible for Business Associate to return or destroy such PHI, the terms and provisions of this Agreement shall survive such termination or expiration and such PHI shall be used or disclosed solely as permitted by law for so long as Business Associate maintains such Protected Health Information.

V. No Third Party Beneficiaries. The parties agree that the terms of this Agreement shall apply only to themselves and are not for the benefit of any third party beneficiaries.

VI. De-Identified Data. Notwithstanding the provisions of this Agreement, Business Associate and its subcontractors may disclose non-personally identifiable information provided that the disclosed information does not include a key or other mechanism that would enable the information to be identified.

VII. Amendment. Business Associate and Covered Entity agree to amend this Agreement to the extent necessary to allow either party to comply with the Privacy

Standards, the Standards for Electronic Transactions, the Security Standards, or other relevant state or federal laws or regulations created or amended to protect the privacy of patient information. All such amendments shall be made in a writing signed by both parties.

VIII. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the then most current version of HIPAA and the HIPAA privacy regulations.

IX. Definitions. Capitalized terms used in this Agreement shall have the meanings assigned to them as outlined in HIPAA and its related regulations.

X. Survival. The obligations imposed by this Agreement shall survive any expiration or termination of this Agreement.

COVERED ENTITY

Signature Veronica Bush Date _____

Print Name Veronica Bush Title: Owner

BUSINESS ASSOCIATE

Signature _____ Date _____

Print Name _____ Title: _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person ▶**	**Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*