



Document Checklist

Dear Doctors,

Please be sure that all of the following documents are included and returned via email, fax or mail. We have supplied you with copies of everything that needs to be filled out. Please also provide copies of your Medical License, Board Certificate and CV.

- PEER REVIEWER APPLICATION/Contract – Please fill out completely
(Includes the COI Declaration)**
- W-9 Tax form – completed and signed**
- Copy of current professional license for each state where licensed**
- Curriculum Vitae**
- Board Certification Certificate(s) – required if an M.D., D.O., or DPM**
- Copy of professional liability Insurance**
- HIPPA Business Associate Addendum**
- Signature Card**
- Independent Contractor Agreement**
- Verification of Training**



PEER REVIEWER APPLICATION

Provider's Name: _____ Birthdate: _____

Practice Name and Business Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address _____ Office contact: _____

Best way to contact you: (email / fax / phone / other) _____

Tax ID# _____ Medical Lic# _____ STATE _____

Specialty _____ Medical Lic# _____ STATE _____

Board Certified by: _____ Medical Lic# _____ STATE _____

The following items must be sent attached to this application:

- W-9 Tax form – completed and signed
- Copy of current professional license for each state where licensed
- Curriculum Vitae - this document should be current and include job history.
- Board Certification Certificate(s) – required for MD, DO, DDS, DMD or DPM
- Copy of liability Insurance
- HIPPA Business Associate Agreement
- Reviewer Verification of Training Statement
- Reviewer Conflict of Interest Declaration - found on page 2-3 of this document

I attest that I have fulfilled the applicable State(s) CME requirement(s) and will continue to do so while I am a contractor to The P&S Network, Inc.. Yes / No

By signing this document, I, attest that the foregoing information is true and accurate. I further agree to abide by the following Peer Review Policy and Procedure Requirements. I understand and acknowledge that the Peer Review Policy and Procedure Requirements are necessary and must be strictly adhered to in order for me to be able to properly and timely provide peer review services for The P&S Network, Inc. ("P&S"). I understand and agree that the peer review services I will be providing are time sensitive in nature, and, if I accept a peer review case, the delivery or dictation of final report must be completed by the date requested. I further acknowledge and agree that P&S reserves the right to revise the Peer Review Policy and Procedure Requirements from time to time, as needed, and will abide by such revised Peer Review Policy and Procedure Requirements upon receipt of the same.

Provider's Signature

Printed Name

Date



**REVIEWER CONFLICT OF INTEREST
DECLARATION**

THE P&S NETWORK INC. needs the following information regarding conflict of interest as required by federal and state laws/regulations and URAC accreditation standards. Such conflicts are material professional or business relationships with certain entities that could affect your objectivity when you review cases. This information is necessary so that we do not refer cases for which you have a conflict of interest.

Please complete the following. If you need additional space, please attach another page and reference the item.

- 1. **CONTRACTS with PAYERS.** List any payers such as utilization review agents, insurer/workers comp carriers, health or workers comp plans, managed care entities, with whom you have contracts. Please name the payer and describe the service(s) you provide this entity(ies):

- 2. **OWNERSHIP INTEREST.** List any payers (see list above) where you have an ownership interest (of 5% or more or \$100,000 or above, whichever is less). Please provide the name of the entity(ties):

- 3. **OFFICER, DIRECTOR, or MANAGER.** List any such positions you hold with a payer (see list above). This includes the following positions: Medical Director at any level of a department, Manager, Supervisor, Board member, or member of a sub-committee of a Board. Please provide the position title, name of the entity(ies), and whether it is voluntary or compensated.

- 4. **RELATIONSHIPS with FIDUCIARIES.** List any relationship you have with any group health/workers comp plan administrator or plan fiduciary. Please describe the relationship and the name of the entity(ies):

-
-
5. RELATIONSHIPS with PROVIDERS. List any relationships you have with health care provider medical groups, independent practice associations (IPAs), or other provider groups who make recommendations on medical treatment for patients. Please note that being a participating provider for a group health/workers comp plan does not necessarily create a conflict of interest, as long as you are not benefiting financially from the arrangement.
Please describe the relationship and name of the entity(ies).
-
-

6. RELATIONSHIPS with FACILITIES: Provide the name of the facility(ies) where you have staff and/or other clinical privileges. Please indicate the relationship.
-
-

7. DEVELOPER or MANUFACTURER. List any drugs, devices, and procedures that you were involved in developing or manufacturing. Please be specific and indicate your role. Please note that having such an association, does not present a conflict of interest as long as you are not financially benefiting from the sale/use of the above.
-
-

I, ATTEST by my signature below that the above information is correct.

SIGNATURE

PRINT NAME

DATE

If there are questions, please contact Matt Zimand at 323-556-0555 ext 108



An important note about the credentialing process:

P &S Network has been accredited by URAC since 2006. Our renewal is coming up and URAC has implemented several new rules and regulations. One of these new regulations requires that P &S Network produce two additional documents with every peer review. Samples of these documents can be found at the end of this letter.

The first document is called "*Reviewer Conflict of Interest*." This document is to make sure that you have no conflicts regarding the referral in question. Please familiarize yourself with the document. It is included in the email and will accompany all referrals starting May 1, 2012. We will create this document with your signature on it automatically at the same time we create the Peer Review Report. This way you do not need to take additional time to sign it and send it back to us each time.

If you do have a conflict, please contact the Administrator via email as soon as possible so that she can re-assign the case. Again, in order to expedite matters and to minimize additional work for you, we will assume you have no conflicts if we do not hear from you, and we will proceed with you as the reviewing physician.

The second new document is called "*Reviewer Attestation: Credentials, Knowledge, Experience*." The purpose of this document is to ensure that you have the required credentials to perform the assigned referral. Please familiarize yourself with this document. The procedure for this document will be the same as with the COI. If you feel that you are not qualified to perform the review, please email the administrator that sent you the referral as soon as possible. If we do not hear from you, we will assume that you have accepted the file and P&S will create the document, with your signature attached.

In addition to the new requirements for individual reviews as detailed above, URAC has made several changes to their standards. We have put together these changes in the attached document called "*Reviewer Verification of Training Statement*." Please read and sign the aforementioned documents, and return them via fax at (323)556-0556 or email matt@physiciansandsurgeons.net, or using the provided self-addressed stamped envelope.

Thank you,

Avrom Gart, MD
Medical Director



REVIEWER CONFLICT OF INTEREST

Internal and External Reviews

(Signature required prior to each case reviewed)

THE P&S NETWORK (P&S) Inc. is required by federal and state laws/regulations and URAC accreditation standards to assign reviewers who do not have a conflict of interest (COI) with the case referred. Please confirm the following with respect to this case and notify us promptly if you feel you have a possible COI.

Please clarify all 'YES' answers using the space at the end of this document.

I AGREE DO NOT AGREE The compensation I receive for this review is not in any way dependent on my decision for this case.

I AGREE DO NOT AGREE To the best of my knowledge, I was not involved in the specific episode of care prior to referral of this case for review.

I ATTEST to the following regarding a material professional, familial, or financial conflict of interest with any of the following:

YES NO The referring entity such as a contract with or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the utilization review agent, the insurer, health maintenance organization, other managed care entity, payor or any other party to this case.

YES NO The insurance issuer/workers' comp carrier or group health/workers' comp plan that is the subject of this review. I do not have a contract to provide utilization reviews to enrollees of the health/workers' compensation benefit plan that is the subject of this review.

YES NO The covered person whose treatment is the subject of this review or the covered person's authorized representative.

YES NO Any officer, director or management employee of the insurance issuer/workers' comp carrier that is the subject of this review. I am not a Medical Director at any level of any department, Manager, Supervisor, Board Member, or member of a board sub-committee for an insurance/workers' compensation carrier that is the subject of this case.

YES NO Any group health/workers' comp plan administrator, plan fiduciary, or plan Employee.

YES NO The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of this review.

YES NO The facility at which the recommended health care service or treatment would be

YES NO The facility at which the recommended health care service or treatment would be provided such as staff privileges at a facility where the recommended health care service or treatment would be provided if the insurance issuer's or group health plan's previous non-certification is reversed.

YES NO The developer or manufacturer of the principle drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review.

If you answered yes to any of the questions above, please explain, including the entity names involved.

I, therefore, ATTEST by my signature below that the above information is correct and I do not have a conflict of interest for this case. If I become aware of such a conflict during my review, I will immediately:

- Recuse myself from the case and notify P&S of my recusal; and
- Return any and all case files, information, and/or documents to P&S.

Case ID #: _____ Date: _____

Signature of Reviewer: _____

Printed Name: _____ Date: _____

**Please fax this back to P&S prior to accepting the case: Fax: 323-556-0556.
If you have any questions, please contact Matt Zimand at 323-556-0555 ext. 108.



REVIEWER ATTESTATION: CREDENTIALS, KNOWLEDGE, EXPERIENCE

(Internal and External Reviews)

(Signature required prior to each assigned review)

I, _____, attest that as a reviewer for this case:

- I have a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, and my license or certification is current and unrestricted.
- I have current, relevant experience and/or knowledge to render a determination for this case.
- I have at least five (5) years of accumulative full-time equivalent experience [37.5-40 hours or more per week] providing direct clinical care to patients over the length of my career.

Total number of months in direct clinical care over total career: _____

- I have experience providing direct clinical care to patients within the past three (3) years.

Dates in direct clinical care: **[today's date-3 yrs]** to **[today's date]**

Case ID #: _____ Date: _____

Signature of Reviewer: _____

Printed Name: _____ Date: _____

**Please fax this back to P&S prior to accepting the case: Fax: 323-556-0555
If there are questions, please contact Matt Zimand at 323-556-0555 ext 108



HIPAA BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (“Addendum”) is entered into by and between The P&S Network, Inc., acting on behalf of itself and its current and future affiliates (collectively, “P&S”) and _____, M.D. (“Business Associate”) and hereby supplements, amends, and is made a part of any and all HIPAA Related Agreements. The term “HIPAA Related Agreements” means any and all agreements (in effect as of the date of full execution of this Addendum (“Effective Date”) or entered into any time thereafter) by and between P&S and Business Associate under which Business Associate has created or received and/or may create or receive Protected Health Information (as defined below) from or on behalf of P&S.

Recitals

A. P&S and Business Associate are parties to the HIPAA Related Agreements pursuant to which Business Associate provides certain services to P&S, and, in connection with those services, P&S discloses to Business Associate certain protected health information as defined at 45 CFR § 160.103 (the “Protected Health Information”) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA,” found at Public Law 104-191), and certain regulations promulgated by the U.S. Department of Health and Human Services to implement certain provisions of HIPAA (the “HIPAA Privacy Rule,” 45 CFR Part 160 and 45 CFR Part 164, subparts “A” and “E” and the “HIPAA Security Rule,” 45 CFR Part 160 and 45 CFR Part 164, subparts “A” and “C,” collectively, the “HIPAA Regulations”).

B. P&S is a “covered entity,” as that term is defined in the HIPAA Privacy Rule. Business Associate, as recipient of Protected Health Information from P&S under the HIPAA Related Agreements, is a “business associate” of P&S, as that term is defined in the HIPAA Privacy Rule.

C. Pursuant to the HIPAA Privacy Rule, all business associates of P&S, as a condition of doing business with P&S, must agree in writing to certain mandatory provisions regarding, among other things, the use and disclosure of Protected Health Information. The parties agree that the obligations specified herein shall commence upon the Effective Date.

IN CONSIDERATION OF THE FOREGOING, and the mutual promises and covenants contain herein, the parties agree as follows:

Agreement

1. **Definitions.** Unless otherwise provided in this Addendum, capitalized terms have the

same meaning as set forth in the HIPAA Privacy Rule.

2. Applicability. This Addendum shall be applicable to Protected Health Information (i) received by Business Associate from P&S pursuant to the HIPAA Related Agreements or (ii) created or received by Business Associate on behalf of P&S pursuant to the HIPAA Related Agreements.

3. Scope of Use of Protected Health Information. Business Associate shall not use or disclose Protected Health Information for any purpose other than:

- (i) As permitted or required by the HIPAA Related Agreements (including this Addendum); and
- (ii) As otherwise required by law.

4. Safeguards for the Protection of Protected Health Information. Business Associate shall implement and use appropriate safeguards, including but not limited any and all such safeguards directed by P&S, to ensure that Protected Health Information is not used or disclosed by Business Associate, or by any subcontractors, affiliates, or business associates of Business Associate, except as provided in the HIPAA Related Agreements (including this Addendum).

5. Reporting of Unauthorized Uses or Disclosures. Business Associate shall promptly report to P&S any use or disclosure of Protected Health Information by Business Associate or its subcontractors of which Business Associate becomes aware that is not provided for or permitted in the HIPAA Related Agreements (including this Addendum). Business Associate shall permit P&S reasonable access to Business Associate's employees and records (including electronic records) as reasonably necessary to investigate any such report.

6. Use of Subcontractors. To the extent that any HIPAA Related Agreement expressly permits Business Associate to use subcontractors and/or agents to perform its obligations under such HIPAA Related Agreement or to otherwise delegate performance of its obligations (if at all), Business Associate shall cause each such subcontractor, agent or delegatee to sign and shall ensure their compliance with an agreement with Business Associate containing the same provisions and conditions related to the protection and confidentiality of Protected Health Information as those that apply to Business Associate under the applicable HIPAA Related Agreements (including this Addendum).

7. Authorized Access to Protected Health Information. To the extent that Business Associate maintains Protected Health Information in a Designated Record Set, at the request of P&S, Business Associate shall provide P&S (or an Individual as directed by P&S) access to such Protected Health Information in a Designated Record Set in the time and manner reasonably designated by P&S in order for P&S to meet the requirements imposed on P&S by 45 CFR § 164.524.

8. Amendment of Protected Health Information. To the extent that Business Associate maintains Protected Health Information in a Designated Record Set, Business Associate shall make any amendment(s) to Protected Health Information in a Designated Record Set that P&S directs or agrees to pursuant to 45 CFR § 164.526, and in the time and manner reasonably

designated by P&S.

9. Accounting of Disclosures of Protected Health Information. Business Associate shall keep records of all disclosures of Protected Health Information made by Business Associate (the “Disclosure Accounting”) on an ongoing basis for a period of at least six (6) years (or such longer period as may be required by the HIPAA Related Agreements or by applicable law), except for disclosures:

- (i) To carry out Treatment, Payment, or Health Care Operations, as provided in 45 CFR § 164.502;
- (ii) To individuals of Protected Health Information about them as provided in 45 CFR § 164.502;
- (iii) That are otherwise excluded from the HIPAA Privacy Rule disclosure accounting requirements by the provisions set forth at 45 CFR § 164.528(a)(1), subsection (iii) through (ix); or
- (iii) That occurred prior to April 14, 2003.

At a minimum, the Disclosure Accounting shall contain:

- (a) The date of the disclosure;
- (b) The name of the entity or person to whom or which the Protected Health Information was provided and, if known, the address of such entity or person;
- (c) A brief description of the Protected Health Information disclosed; and
- (d) A brief statement of the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure or, in lieu of such statement, a copy of the Individual’s written authorization or request for disclosure pursuant to the HIPAA Privacy Rule.

Business Associate shall provide the Disclosure Accounting to P&S (or to an Individual, if so directed by P&S) within sixty (60) days of receiving a written request therefor from P&S.

10. Right to Audit. Upon the request of P&S and/or the Secretary of the Department of Health and Human Services, Business Associate shall make its practices, books and records related to Protected Health Information available to P&S and/or the Secretary of the Department of Health and Human Services for the purpose of determining P&S’ compliance with the HIPAA Regulations and/or Business Associate’s compliance with this Addendum.

11. Future Confidentiality of Protected Health Information. Upon the expiration or earlier termination of any HIPAA Related Agreement for any reason, Business Associate shall return to P&S, or, at P&S’ direction, delete, purge and destroy, all Protected Health Information (in any form, recorded on any medium, or stored in any storage system) that was created or obtained pursuant to that terminated HIPAA Related Agreement (and that Business Associate does not need to maintain to perform its obligations under any then-existing HIPAA Related Agreement) and shall retain no copies of such information. If Business Associate destroys Protected Health Information, an officer of Business Associate shall certify such destruction to P&S in writing. If such return or destruction is not feasible, Business Associate shall extend the protections of this Addendum to the information and shall limit further uses

and disclosures to those purposes that make the return or destruction of the information infeasible.

12. Termination in Event of Breach. In the event that Business Associate violates any material term of any HIPAA Related Agreement (including this Addendum), P&S may terminate the HIPAA Related Agreement immediately by providing written notice of such termination to Business Associate.

13. Indemnification. Business Associate agrees that it shall be financially responsible for, and agrees that it shall defend, indemnify, and hold harmless, P&S (including its corporate affiliates and each of its and their shareholders, affiliates, officers, directors, employees, agents, attorneys, successors, successors-in-interest, and assigns) from and against any and all claims, causes of action, suits, litigation, proceedings, complaints, demands, charges, liens, disputes, obligations, damages, losses, debts, indebtedness, liabilities, costs (including settlement costs and costs of investigation), expenses and fees (including reasonable attorneys' fees) arising out of or in connection with Business Associate's actions and omissions involving Protected Health Information relating to enrollees, subscribers, insureds, customers, or patients of P&S. The provisions of this Section 13 shall survive the expiration or earlier termination of this Addendum.

14. Amendments. The parties shall negotiate in good faith any amendments to this Addendum or a replacement of this Addendum to the extent necessary in order to maintain compliance with applicable laws and regulations.

15. Effect on HIPAA Related Agreements. Except as amended herein, all terms of all of the HIPAA Related Agreements shall remain in full force and effect.

16. Construction. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies with HIPAA and the HIPAA Regulations.

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Addendum to be executed as of the Effective Date.

P&S:

THE P&S NETWORK, INC.
a California corporation

By: _____

Title: _____

Business Associate:



INDEPENDENT CONTRACTOR AGREEMENT

THIS AGREEMENT is made this ___ day of _____, 20___, between _____ ("Contractor"), and P&S Network, Inc. ("Company").

The parties stipulate as follows:

- a. Company is a corporation engaged in the business of providing Quality IRO and Utilization Review Services for the insurance industry.
- b. Contractor is a licensed physician that is Board Certified.
- c. Company desires to contract with Contractor, and Contractor agrees to perform the services described herein upon the terms and conditions set forth in this Agreement.

IN CONSIDERATION of the mutual promises set forth below, Contractor and Company hereby agree as follows:

1. Nature of Agreement:

1.1. Independent Contractor Status. It is the express intention of the parties that Contractor be an independent contractor and not an employee or agent of the Company in performing the services specified by this Agreement. Therefore, nothing in this Agreement shall be interpreted or construed in any way as creating or establishing an employment relationship between the Company and Contractor or any employee or agent of Contractor. The parties expressly acknowledge that Contractor is not now, and shall not become or be considered, an employee or agent of the Company for insurance, benefits, payroll, state or federal tax purposes, or for any other purpose.

1.2 Cancellation of Prior Offers. Any and all prior arrangements, understandings, and contracts, or offers or representations with respect thereto, are hereby canceled and void in all their terms and conditions.

2. Term and Termination:

2.1 Term. This Agreement will become effective upon execution on the above date.

2.2 Termination.

2.2.1 Written Notice. Either party may terminate this Agreement at any time, without cause, by giving 30 days written notice of termination to the other party. Such right of termination shall be in addition to, and not in lieu of, any other remedy to which the terminating party may be entitled.

2.2.2 Breach. Should either party default in the performance of this Agreement or materially breach any of its provisions, the non-breaching party may terminate this Agreement by giving written notification to the breaching party. Termination shall be effective immediately on receipt of the notice, or five days from mailing of the notice, whichever occurs first. For the purpose of this section, material breach of this Agreement shall include but not be limited to the following:

- a. Nonpayment of compensation by Company after 60 days written demand for payment.

- b. Failure of Contractor or any employee or agent of Contractor to perform the services described in Paragraph 3.1 satisfactorily.
- c. Failure of Contractor to maintain a current and valid medical license and Board Certification.

2.2.3 Insolvency, Sale, Death. This Agreement terminates automatically on the occurrence of any of the following events: (a) bankruptcy or insolvency of either party; (b) sale of the business of either party; or (c) incapacity or death of Contractor.

3. Services of Contractor:

3.1 Services. Contractor agrees to perform utilization review services for Company ("Services"). Said Services shall be performed on an as requested basis.

3.2 Methods. Contractor and any employee or agent of Contractor will determine the method, details, and means of performing the Services with respect to performing the services.

4. Services of Company:

4.1 Liability. Company agrees to maintain a policy of Errors and Omissions Insurance in the minimum amount of \$1,000,000 per occurrence and an aggregate amount of \$3,000,000.

5. Compensation:

5.1. Contractor's Fee. In consideration for the foregoing Services, Company agrees to pay Contractor per compensation agreement.

5.2. Expenses. Unless otherwise agreed to by the Company, Contractor shall be solely and fully responsible for all costs and expenses incident to the performance of the Services performed by the Contractor, including without limitation: all costs of equipment provided by Contractor; all fees, fines, licenses, insurance or taxes required of or imposed against Contractor, all transportation, lodging and food costs incident to performance of services under this Agreement, and all other costs of doing business. The Company shall not be held responsible for any expenses incurred by Contractor.

6. Obligations of Contractor:

5.1 Material, Equipment, and Supplies. Contractor will supply all materials, equipment, and supplies required to perform the Services pursuant to this Agreement.

5.2 Assignment. Neither this Agreement nor any duties or obligations imposed under this Agreement may be assigned by Contractor to a subcontractor.

5.3 State and Federal Taxes. Contractor shall pay, when and as due, any and all state and federal taxes incurred as a result of Contractor's compensation, including estimated taxes. Contractor indemnifies Company for any claims, losses, costs, fees, liabilities, damages, or injuries suffered by Company arising out of Contractor's breach of this section.

5.4 Confidentiality.

5.4.1 Confidentiality. Contractor acknowledges the confidential nature of the information acquired while providing Services under this Agreement. Contractor expressly understands and agrees that such information constitutes confidential information, including but not limited to, any client information, the Company business information and trade secrets, work product materials, and any other privileged materials. Contractor agrees that he shall not use or disclose such confidential information for any purpose other than in the performance of the services under this Agreement and at the direction of the Company's Board of Directors/Administrator.

5.4.2 Misappropriation. Contractor understands, acknowledges, and agrees that all information concerning clients of the Company, including said clients' names, addresses, contact persons, and other client profile information, were developed and maintained by the Company and constitute confidential, proprietary, and/or trade secret information to which Contractor may have access during the term of this Agreement.

5.4.3 Agreement Not To Disclose Or Use Trade Secrets. During the term of this Agreement, Contractor will have access to and become acquainted with information of a confidential, proprietary or secret nature which is or may be either applicable to, or related in any way to, the present or future business of Company, the research and development or investigation of Company, or the business of any customer of Company. For example, trade secret information includes, but is not limited to, specially developed methods or designs, computer programs, application programs, computer disks, devices, secret inventions, marketing strategy, processes and compilations of information, records, specifications and information concerning customers or vendors. Contractors shall not disclose any of the above-mentioned trade secrets or confidential information, directly or indirectly, or use them in any way, either during the term of this Agreement or at any time thereafter, except as required in the course of this Agreement with Company. Contractor will abide by Company's policies and regulations, as established from time to time for the protection of its trade secret and confidential information.

5.5 Licensing/Certification. At all times during the period of this Agreement, Contractor shall maintain a current medical license and board certification. Contractor will notify the Company immediately should there be a change in license or board certification status.

6 General Provisions:

6.1 Notices. Any notices required or convenient to be given under this Agreement shall be in writing, and any such written notice shall be deemed to have been duly given on the earlier of (a) the date that such notice is received or (b) the date that it is mailed via either registered or certified mail, return receipt requested, postage prepaid, to the parties at the addresses below:

P&S Network, Inc.
8484 Wilshire Boulevard, Suite 620
Beverly Hills, CA 90211

Contractor Address:

Any party may change such party's address by giving notice of such change. Failure to give any notice in a manner provided in this subsection shall not defeat the effectiveness of any written notice that is actually and timely received.

6.2 Complete Agreement. This Agreement sets forth the final, complete, and exclusive statement of the parties' agreement concerning the professional services arrangement, and any prior agreements or representations relating thereto are merged herein, completely superseded hereby, and of no force or effect.

6.3 Interpretation of Agreement. This Agreement shall not be strictly construed against or in favor of any party hereto, without regard to which party, or such party's counsel drafted the Agreement. This Agreement shall be construed and governed by the laws of the State of California.

6.3.1 Fair Reading. This Agreement is the result of negotiations between the parties and shall not be construed strictly against or in favor of any party hereto.

6.3.2 Headings. The headings of sections and subsections are for the convenience of the reader only and shall not be used to construe the meaning of any provision of this Agreement.

6.4 Severability. In the event that any provision of this Agreement, or any portion thereof, is found to be invalid or unenforceable, such determination shall not affect the validity or enforcement of any other provision, or any other valid subprovisions, of this Agreement.

6.5 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one agreement; provided, however, that this Agreement shall be of no force or effect until one such executed counterparts is delivered to each of the parties hereto.

7 **Right to consult with counsel.**

Each party represents that they have read this Agreement and that they are fully aware of and understand its contents. The parties further represent that they have had an opportunity to consult with legal counsel and has either done so or has waived such right.

Each party, having read, understood, and agreed to be bound by the terms and conditions of this Agreement, do hereby execute said Agreement by affixing their signatures hereto.

Dated: _____ By: _____

Name: _____ **Contractor**
P&S NETWORK, INC.

Dated: _____ By: _____

Its: _____



Reviewer Verification of Training Statement

- I have received a summary of the URAC Standards (see attached) that apply to peer review.

- I understand that my professional review must be compliant with URAC standards as well as all State and Federal laws that may apply.

- I have had the opportunity to ask questions of The P&S Network, Inc. regarding the URAC Standards and applicable State law as they apply to peer review.

SIGNATURE: _____

PRINT NAME: _____

Please fax this page back to The P&S Network, Inc. at: (323)556-0556

or

Email to: matt@physiciansandsurgeons.net

If you have questions, please contact: Matt Zimand at Ph: 1-323-556-0555 ext. 108.

P&S REQUIREMENTS

Reference: URAC STANDARDS FOR PEER REVIEW – ver 5.0

IR – 1, 3- The P&S Credentialing Program

P&S is required to verify your credentials* and experience through a credentialing program. This program:

- a. Verifies your credentials prior to contract, and thereafter no later than the scheduled expiration for those credentials that expire.
- b. Requires you to notify P&S immediately of an adverse change in your license or Board status.
- c. Requires P&S to implement corrective action if there are adverse changes on your license or Board Certification.

IR - 2 - Reviewer Credentialing Verification

P&S verifies the following information from you:

- a. Current license
- b. Current board certification (or other certification as applicable)
- c. History of sanctions and/or disciplinary actions as reported to the state office where you are licensed or as obtained from the OIG (Office of Inspector General) if the state office does not provide such information
- d. Your professional experience (from your C.V. or resume)
- e. Direct patient care experience: total length of time and dates of experience

IR – 4 – Reviewer Qualifications

All reviewers must have the following to be accepted on the P&S panel of reviewers:

- a. current, non-restricted licensure or certification as required for clinical practice in a state of the United States;
- b. at least five (5) years full-time equivalent experience providing direct clinical care to patients. For certain requests, such as an external review or if required by our client contract, you will also be required to have direct care experience in the previous three (3) years prior to the case.
- c. At a minimum, are a clinical peer; **and**
- d. a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review

IR – 8, 9, 10 and Core 33 – Attestations Required: Reviewer Conflict of Interest, Experience, Credentials, Financial Incentives

- a. As part of the credentialing application, you will be required to declare any perceived conflicts of interest you may have with respect to ownership/control with payors or benefit plans, etc. P&S will use this information to avoid sending you cases for which such conflicts of interest may exist.
- b. At the time a case is sent to you, you will be required to sign attestations confirming your knowledge, experience, and lack of a conflict of interest for that particular case. You are also required to confirm that you will not accept compensation that is in any way dependent on your decision on the case. If there are issues, you are required to inform P&S promptly and return all case materials if requested by P&S.

IR 17 – Performance Monitoring

The Medical Director as well as our clients conduct random audits of report quality and will

inform you of the results and offer additional training if needed. New reviewers also receive more intense auditing until performance is acceptable.

IR –21 – Additional Information

P&S is required to accept any additional information that may assist in providing a review decision(s). The information may be provided by the covered person or attending provider. For such cases, P&S provides a copy of the information to the insurance issuer/workers' comp carrier or group health/workers' comp plan and offers them an opportunity to terminate the review process. Once the party responds with a written request, P&S will advise you to stop review of the case.

IR – 22, 23 – Timeframes for Review

Timeframes can be set by the client, Federal or State regulations, or accreditation standards. P&S will inform you at the time you are available to take the case, what turn-around-time is expected for your review. Unless otherwise required, timeframes vary according to the type of review:

- a. Expedited case: must be completed as soon as possible but in no event more than 72 hours after P&S receives the case.
- b. Non-Expedited case: must be completed within 45 calendar days after P&S receives the case.

The above timeframes are inclusive of P&S sending out your report so the timeframe expected of you will be shorter than the above.

IR – 24 to 27 – Report Content

You will be sent the appropriate report template to complete for the referred case. Templates are determined based on the client, regulations, and/or type of review (medical necessity/appropriateness, investigational, legal case). You are required to complete each section of the template and according to the quality standards of P&S so that our clients may receive a quality report within the required timeframe. P&S staff will assist and provide support to you as needed.

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CORE - 38 - Consumer Safety Mechanism

P&S expects that you will notify us immediately if you discover an immediate threat to the health and safety of the patient such as use of medications the patient is known to have a contraindication or allergy to, etc. If you would like to see the policy and procedure on this, please contact P&S.

CORE – 15, 16 – Confidentiality/Security of Individually-Identifiable Health Information

As a HIPAA Business Associate (B.A.) to P&S, we require you to sign the B.A. agreement at time of contract which details how the patient's confidential health information is to be protected during your handling of the case. In addition, the B.A. agreement includes breach notification requirements as required by the HITECH law. ** By safeguarding all case-related materials in your possession you will prevent inadvertent leaks of this material to others who do not have a right to this information.

*Credentials: license, Board or other certification

** HITECH: "Health Information Technology for Economic and Clinical Health Act of 2009."

The P&S Network, Inc.
444 S. San Vicente Blvd., Suite 703
Los Angeles, CA 90048



Tel: (310) 423-9988
Fax: (310) 423-9980

Signature Card:

Please sign below so we can keep your signature on file. Please sign in the middle of the box without touching any lines.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. You must enter your individual name as shown on your social security card. You may enter your business, trade, or "doing business as" name on the **business name** line.

Other entities. Enter your business name as shown on required Federal tax documents. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or "doing business as" name on the business name line.

Part I—Taxpayer Identification Number (TIN)

You must enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, using your EIN may result in unnecessary notices to the requester.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at www.irs.gov.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester. Other payments are subject to backup withholding.

Note: Writing "Applied For" means that you have already applied for a TIN OR that you intend to apply for one soon.

Part II—For Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester a completed Form W-8 (certification of foreign status).

Part III—Certification

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to

persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name, but you may also enter your business or "doing business as" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

