HEALTH WEST PROVIDER AGREEMENT

PROVIDER NAME: ______________________________________**ATTN:** __________________________

ADDRESS: ____

CITY: ___________________________________**STATE:** ____________________**ZIP:** _________________

PHONE #: ____________________________________**FAX#:** _____________________________________

EMAIL: ____________________________@_________________ **EFFECTIVE DATE:** _____/_____/_____

TAX ID #:______________________________________**MAIN NPI#:**_________________________________

CAQH#____**OTHER CREDENTIAL #**______________________

This letter of Agreement is between HEALTH WEST, LLC, for all of its members and employers, or other clients, collectively known as "CLIENT" and the Provider listed above and includes all of the physicians, nurse practitioners, and other healthcare services and providers offered at your place of business, collectively known as "PROVIDER". In exchange for good and valuable services both parties enter into this Agreement as of the effective date listed above and agree to the following terms;

Provider Responsibilities:

1. To accept the agreed upon allowed amount in Attachment A or the schedule on file with Health West.
2. Only balance bill the member for Copays, Deductible and Coinsurance as listed on the EOP/EOB.
3. Submit clean claims to the appropriate EDI or other address provided within 6 months of services.
4. Notify Client of any changes to address, phone number, tax id, or participating providers.
5. Assist the member with pre-authorization or medical management as needed or requested by Client.
6. Contact Health West with questions about Fee Schedules, adding or deleting providers, etc..
7. Notify Health West in a timely manner of any and all legal action against any provider in your practice.
8. Maintain all credentialing records and provide the CAQH# or other proof of credentialling to Health West.
9. Assist with any information needed such as medical records, etc.. in order to pay the claim properly.
10. Perform all of your duties in accordance with State or Federal Law where applicable.

Health West Responsibilities:

1. Bind Client to pay clean claims according to the Fee Schedule and The Plan Document within 30 days of receipt of a clean claim.
2. Bind Client to pay 90% of all clean claims within 30 days of receipt of clean claims or requested information.
3. Assist with any claim problems, appeals, or questions, on behalf of PROVIDER OR CLIENT.
4. Provide a means of verifying eligibility, benefits, claims status and other questions.
5. Provide you with the EDI#, PO Box or other mailing address for claims and a customer service phone #.
6. Perform all duties in accordance with State and Federal Law where applicable.

This Agreement covers all services performed at your locations and for all providers at your clinic locations, facility or Hospital. This Agreement renews every year and may be terminated by either party with a 90-day notice. We include all providers under this Agreement as long as they are billing under the Tax ID#(s) provided. This Agreement consists of 1) Attachment A - Sample Fee schedule, 2) Attachment B - Application page and 3) Attachment C - Your list of participating providers. You may request a full fee schedule from Health West.

HEALTH WEST PROVIDER AGREEMENT

You may fax this signed form and all information to: (888) 316-8572
You may email this signed form and all information to: providers@healthwestonline.com
You may contact Health West at: (888) 316-1933 X 115
Address for Notice: PO BOX 885, Bountiful, UT 84010

Please confirm your acceptance of the terms outlined in this Agreement by signing below:

Provider:	**Health West:**
Name: ___________________________	**Name:** ___________________________
Title: ___________________________	**Title:** ___________________________
Company Address: ___________________	**Address:** P.O. Box 885
Company City, State, Zip: ______________	**City, State, Zip:** Bountiful, UT 84010
Signature: _________________________	**Signature**: _________________________
Date: ___________________________	**Date:** ___________________________

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Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Other (see instructions) ▶

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

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 the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

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).

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 on page 4.

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

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

HEALTH WEST PROVIDER AGREEMENT

Attachment A – Fee Schedule

All /Hospital/Facility Services are effective on the date of this Agreement will be reimbursed as follows:
All Services provided will be reimbursed at Fee Schedule: **HW0102** (Sample Fee Schedule below)
A full fee schedule will be provided to you via email

CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE
DEFAULT	60%	29806	1296.12	54150	162	73610	38.23	87081	10.57	94640	18.11
11000	56.19	29807	1330.73	57288	926.58	73620	32.82	87086	13.23	94762	26.69
11100	103.99	29822	709.97	57454	183.7	73630	38.04	87804	15.29	95004	6.48
11301	115.48	29824	843.94	57460	380.9	76700	138	87880	12.88	95810	1020.28
11302	136.05	29826	685.51	58150	1164.6	76770	131.85	88305	105.92	95811	1166.13
11306	117.97	29827	1455.37	58260	997.3	76801	167.99	90378	1493.57	95860	129.39
11307	138.79	29828	936.85	58262	1064.4	76805	173.37	90465	27.05	95861	205.94
11311	111.57	29848	550.62	58300	98.92	76811	274.97	90466	15.3	96372	27.04
11312	154.9	29877	738.99	58301	118.53	76816	120.7	90468	26.46	97001	79.07
11401	149.36	29879	816.2	58563	2444.92	76830	131.08	90471	18.44	97001	75.68
11402	100.41	29880	859.88	58303	2303.21	70830	190.28	90472	10.80	97014	13.50
11603	300.43	29881	783.63	58570	963.48	76942	136.07	90473	26.08	97033	31.82
11604	314.27	29888	1288.58	58571	1078.62	77080	113.47	90633	39.44	97035	12.67
11642	281.22	30140	445.08	58611	95.82	80048	13.68	90636	109.91	97110	31.59
11643	327.08	30520	636.12	58661	769.89	80050	34.92	90648	30.18	97112	32.63
11721	46.69	31231	209.39	58662	882.04	80053	13.59	90649	161.42	97140	29.12
11730	107.84	31237	368.78	59025	55.13	80061	19.08	90657	10.43	97802	35.04
11750	222.41	31255	539.07	59400	2463.49	80076	13.23	90658	15.19	99202	82.63
12001	137.85	31267	403.79	59410	1169.15	81000	5.3	90660	27.04	99203	127.83
12011	160.31	31276	680.34	59425	470.76	81001	5.3	90669	94.62	99204	185.69
12032	303.03	31287	293.74	59510	2674.86	81002	3.97	90680	85.41	99205	225.49
12052	293.62	31575	135.17	59514	1249.72	82043	7.31	90696	41.19	99211	27.13
13132	512.2	36415	4.43	59515	1336.89	82274	20.28	90700	27.68	99212	48.05
13736	1368.46	38510	716.11	59610	2297.8	82550	8.31	90707	63.72	99213	74.11
17000	83.71	42330	280.05	59820	400.06	82570	6.65	90715	34.01	99214	114.38
17003	11.46	42440	622.91	61795	376.73	82728	17.54	90716	104.85	99215	162.84
17004	219.4	42820	404.52	64718	709.09	82947	6.17	90723	73.4	99242	103.34
17110	113.51	42821	412.6	66821	340.92	82948	4.14	90734	104.69	99243	151.64
17262	203.95	42826	339.53	66984	903.63	83002	23.95	91110	1280.3	99245	276.92
19120	589.82	43235	390.82	67210	764.15	83036	12.3	92002	56.44	99381	108.46
19361	1596.63	43239	493.98	68761	173.01	83540	8.31	92004	164.07	99382	113.47
20550	75.02	43249	1039.45	69210	57.22	83550	11.16	92012	84.04	99383	144.7
20610	89.21	43262	556.17	69436	204.8	84133	23.19	92014	124.9	99384	134.07
20680	673.81	43264	590.93	69631	980.43	84403	33.16	92015	23.32	99385	130.2
20924	631.65	44377	409.95	70486	301.11	84436	8.87	92083	92.47	99386	154.05
21930	534.77	45378	568.99	71020	40.62	84439	11.26	92135	55.41	99391	97.49
23410	1074.68	45380	666.5	72110	62.92	84443	14.53	92235	134.4	99392	104.26
23440	934.29	45384	654.04	73010	35.27	84550	5.76	92543	29.47	99394	115.18
25075	492.95	45385	747.71	73030	39.97	85025	9.61	92557	55.1	99395	121.8
25447	965.45	47562	953.78	73110	40.7	85027	10.57	92567	23.34	99396	131.02
25600	331.72	47563	1062.42	73130	37.4	85610	5.08	92568	20.69	99397	168.27
26055	803.14	49505	669.66	73140	34.7	85651	5.74	93000	31.19	99460	99.12
27130	1815.05	49561	1142.53	73510	43.19	86308	8.37	93880	300.49	99462	42.09
27447	2026.39	49568	363.21	73562	41.6	86430	7.31	93971	199.96	A4590	35.74
28285	532.41	49587	633.56	73564	46.86	86677	18.79	94010	43.96	11000	56.19

HEALTH WEST PROVIDER AGREEMENT

Attachment B

Participating Provider Application and check List

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You may fill out one application for your clinic/practice and attach a detailed list of all providers and locations where they practice. Please return

Date: ____________________

____
NAME OF CLINIC/OFFICE(s) attach List

____
Location Address (attach list)

____
Billing address (if different from office address)

____
Main Address

____
Billing City State Zip Code

____
City State Zip Code

____
Billing Phone# Fax#

____
Phone # Fax #

____________________@____________________
Billing e-mail Address

____
Provider Contact Name

____
Contact e-mail if different

SECTION I
Please list ALL locations or provide a separate sheet that includes all locations.

Fed. Tax ID #: ____________________ NPI#:____________________

State License #: ____________________ Expiration Date: ____________________

DEA #: ____________________ Expiration Date: ____________________

CAQH #: ____________________

I do hereby certify that all providers in this clinic or practice are completely up to date and current on all licensing required by State and Federal Law and that the office keeps and maintains up to date records of all provider licensing, DEA and other requirements per State and Federal Law and I am willing to provide any and all information to Health West for verification purposes upon request. I will notify Health West of any material changes in provider licensing, legal actions, adverse insurance sanctions or cancelation that may affect their license or standing to practice medicine or other healthcare services within thirty (30) days of receipt.

____
Responsible Party Signature

____
Date

Attachment C

Please attached a list of all physicians and other healthcare providers that admit to your facility so that we may contact them to become participating. Please include all Tax ID #'s if different from the main one and all NPI #'s. You can email this information in a spread sheet. All updates and additions may be sent by email or fax.

Attachment D

Sample Logo's for member Identification Cards: