PEHP Health & Benefits | PROUDLY SERVING UTAH PUBLIC EMPLOYEES

560 East 200 South » Salt Lake City, UT » 84102-2004 » 801-366-7555 or 800-765-7347 » www.pehp.org

Thank you for your request for an application packet for membership on the Public Employees Health (PEHP) Provider Networks.

In order to consider this request for membership, please return the following information via email to providersubmissions@pehp.org

SUBMIT FORM TO PEHP

- ☐ Completed application (see attached)
- ☐ Copy of signed and dated Release Form (see attached)
- ☐ Copy of Certificate of Liability Insurance (declaration sheet with limits clearly listed, date insurance was effective, and expiration date)
- ☐ Copy of 147C IRS Form (W9 forms not accepted)
- ☐ Copy of Board Certification Certificate (if applicable)
- ☐ Copy of Drug Enforcement Agency (DEA) certificate (if applicable)

If you have any questions, please contact us at 801-366-7555 or email providersubmissions@pehp.org.

Sincerely,
PEHP Provider Specialist Representative

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Instructions for Completing the Individual Provider Credentialing Application

Thank you for requesting an application packet for membership in the Public Employees Health Plan (PEHP) Provider Panel. Please return the completed application with the requested information within 45 days. After 45 days, the contracting process will be suspended, and reapplying may be necessary. The credentialing process can take up to one month to complete and does not guarantee inclusion on any PEHP panel.

The information on the Application must be complete and accurate. An incomplete Application may delay processing or result in a denial of membership.

- Type or legibly complete the Application in black or blue ink.
- Submit completed Application as well as any requested addenda. If a Section of the Application does not apply to you, write N/A in the first box of that Section.
- Attach copies of the following documents when the application is submitted:
  - ☐ Evidence of Professional Liability Policy or Certification (declaration sheet with limits clearly listed, date insurance was effective, and expiration date)
  - ☐ Copy of 147C IRS Form (W9 forms not accepted)
  - ☐ Board Certification (if applicable)
  - ☐ DEA Certificate (if applicable)

You will only be required to fill out the section that pertains to you. For example, if you are a medical provider, you will only fill out the Medical Provider Section. You will not need to complete the BCBA or Dental sections. If you are unclear on which section you need to fill out, please get in touch with us at 801-366-7555, or email providersubmissions@pehp.org.

Non-Covered Service

Services and Benefits covered by PEHP are limited by the Master Policy, this contract, and other plan documents. By signing this agreement, you may offer noncovered services to a PEHP member but only as follows:

- You may not bill PEHP for services that you knew or should have known were not covered by PEHP
- You must Inform PEHP members at the time of service of the status of and out-of-pocket costs for any non-covered service
- You must repay PEHP for any non-covered service billed to and paid by PEHP in error, together with a penalty of 25% or $100, whichever is greater

Violation of any provision above may result in the termination of this agreement.

PEHP Fee Schedules

You must complete the application process, which includes signing the contract agreement, before gaining access to PEHP's proprietary fee schedule. Once your application is approved, you will have online access to the fee schedule and contract. Signing the contract does not obligate you to PEHP's fee schedule for any predetermined period of time. You can terminate the contract with 30 days written notice at any time.

Note: All medical claims must be sent via EDI (Electronic Data Interchange.) Please indicate your clearinghouse or UHIN information on the application. This is a requirement in order for the application to be complete. Furthermore, we require all providers to set up EFT (Electronic Funds Transfer) services to receive payments. You will receive a user name and password later in the application process that you can use to log in to our website and set up these services.

If you have any questions, please contact a PEHP Provider Specialist at 801-366-7555 or 800-765-7347.

Table of Contents

INSTRUCTIONS:
When filling out the Application, you will only be required to fill out the Section that pertains to you and your specialty. For example, if you are a medical provider, you will only fill out the Medical Provider Section. You will not need to complete the BCBA or Dental sections. If you are unclear on which section you need to fill out, please get in touch with us at 801-366-7555, or email providersubmissions@pehp.org

All providers are to review Section 4 regarding the Electronic Data Interchange (EDI) regarding requirements.

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PEHP Provider Credentialing Application

Section 1 – Individual Medical and Mental Health Provider

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on the original application, you will need to attach additional sheets and reference the question(s) being answered. Current copies of the following documents must be submitted with this application:

- Copy of 147C IRS Form
- DEA Certificate (if applicable)
- Board Certification (if applicable)
- Evidence of Professional Liability Certificate / Policy

I. IDENTIFYING PROVIDER INFORMATION			
Last Name:	First:		Middle:
List any other name under which you have been known			
Other Last Name:	Other First:		Other Middle:
Home Mailing Address:	City:		
	State:		Zip:
Home Phone Number:	E-mail Address:		
Birth Date: (mm/dd/yyyy)	Citizenship:		
Birth City:	Birth County:	Birth State:	Birth Country:
Social Security #:		Gender:	
Spouse Last Name:	Spouse First:		Spouse Middle:

II. PRACTICE INFORMATION			
If more than one office location, *make copies of pages 4 and 5 and complete Section II Practice Information for each.*			
Practice Name/Group Practice Name:		Primary Practice ☐	Other Office Practice ☐
NPI #:		Department:	
Tax ID #:		Name Affiliated with Tax ID #:	
Taxonomy Code:			
Practicing Specialties:		Subspecialties:	
Contact Name:			
Office Address:			
City:	State:		Zip:
Phone Number:		Fax Number:	

PRACTICE INFORMATION *(continued)*		
Billing Address: Same as Office Address ☐	Other ☐	
Contact Name:		
Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	
Do you participate in EDI (Electronic Data Interchange)? Y ☐ N ☐	**Clearinghouse Name-Required**:	
Trading Partner Number:		
Other Medical Interests in Practices, Research, etc.?	Please check all that apply: Solo Practice ☐ Group Practice ☐ Single Specialty ☐ Multispecialty ☐ Hospital Based ☐	
Do you intend to serve as primary care provider? Y ☐ N ☐	Do you intend to serve as a specialist? Y ☐ N ☐	
Do you employ any allied health professionals (e.g., nurse practitioner, physician assistants, psychologist, etc.? Y ☐ N ☐	Please list all types of allied health professionals employed:	
Allied Health Professionals (Attach additional sheets if necessary) Name: License #: Type of Provider:	Name: License #: Type of Provider:	
Is your practice limited to certain ages? Yes ☐ No ☐	Age Limitation:	
Office Hours	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Holidays		
Continuous care facility	Answering Service Phone #:	
Covering Physician Name:	Phone #:	
List Languages Fluently Spoken By Staff:	List Languages Fluently Spoken By Physician:	
If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. *(Attach a copy of your CLIA certificate or waiver if you have one.)*		
Billing Name:	Tax ID #:	
Type of Services Provided:		
Do you have a CLIA Certificate? Yes ☐ No ☐	Do you have a CLIA Waiver? Yes ☐ No ☐	
List CLIA Certificate #:	Expiration Date:	

III.	**PREMEDICAL EDUCATION** ***(Attach additional sheets if necessary)***		
College or University Name:		Degree Received:	Grad Year:
Mailing Address:		City:	
		State:	Zip:

IV.	**MEDICAL/PROFESSIONAL EDUCATION** ***(Attach additional sheets if necessary)***		
Medical School:	Degree Received:		Grad Year:
Mailing Address:		City:	
		State:	Zip:
Medical/Professional School:	Degree Received:		Grad Year:
Mailing Address:		City:	
		State:	Zip:

V.	**POSTGRADUATE TRAINING AND EXPERIENCE**	
	INTERNSHIP/PGYI ***(Attach additional sheets if necessary)***	
Institution:	Program Director:	
Mailing Address:	City:	
	State:	Zip:
Type of Internship:		
From (mm/yy):	To (mm/yy):	
Did you successfully complete the program? Yes ☐ No ☐ *(If "No" please explain on separate sheet)*.		

VI.	**RESIDENCIES/FELLOWSHIPS** ***(Attach additional sheets if necessary)***		
Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates.			
Institution:		Program Director:	
Mailing Address:			
City:		State:	Zip:
Type of Training (e.g., residency, etc.):	Specialty:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? Yes ☐ No ☐ *(If "No," please explain on separate sheet.)*			
Institution:		Program Director:	
Mailing Address:			
City:		State:	Zip:
Type of Training (e.g., residency, etc.):	Specialty:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? Yes ☐ No ☐ *(If "No," please explain on separate sheet.)*			

VII. BOARD CERTIFICATION				
Include certifications by board(s) which are duly organized and recognized by: • The American Board of Medical Specialties • The American Osteopathic Association • A board or association with equivalent requirements approved by the State Medical Board • A board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty				
Name of Issuing Board	Specialty	Certificate Number	Year Certified/Recertified	Expiration Date (if any) (mm/yyyy)
Have you applied for board certification other than those indicated above? Yes ☐ No ☐				
If so, list board(s) and date(s):		Have you applied for certification and not passed the certification? Yes ☐ No ☐ *(If yes, please explain on separate attachment).*		
If not certified, describe your intent for certification, if any, and date of eligibility for certification.				

VIII. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.) *Attach additional sheets if necessary*.		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

IX. MEDICAL LICENSURE/REGISTRATIONS – CURRENT *(Attach copies of documents)*		
Utah Medical License #:	License Type:	Date issued (mm/dd/yy):
		Exp Date (mm/dd/yy):
Drug Enforcement Administration (DEA) Registration #:		Date issued (mm/dd/yy):
		Exp Date (mm/dd/yy):
National Provider Identifier (NPI):		
ECFMG # (applicable to foreign medical graduates):		Date issued (mm/dd/yy):
		Exp Date (mm/dd/yy):

X. ALL OTHER STATE MEDICAL LICENSES List ALL Medical Licenses Present or Previously Held (Attach additional sheets if necessary)			
State:	License #:	Lic Type:	Date issued (mm/dd/yy):
			Exp Date (mm/dd/yy):
State:	License #:	Lic Type:	Date issued (mm/dd/yy):
			Exp Date (mm/dd/yy):
State:	License #:	Lic Type:	Date issued (mm/dd/yy):
			Exp Date (mm/dd/yy):

XI. PROFESSIONAL LIABILITY – CURRENT *(Attach copies of* professional liability policy or certification face sheet*)*			
Current Insurance Carrier:	Policy #:		Original Effective Date:
Mailing Address:			
City:	State:		Zip:
Per claim amount: $	Aggregate amount: $		Expiration Date (mm/dd/yy):
Please list all of your professional liability carriers within the past seven years, other than the one listed above. If additional space is needed, please attach a separate page.			
Name of Carrier:	Aggregate amount: $		Expiration Date (mm/dd/yy):
Mailing Address:			
City:	Policy#:	From (mm/dd/yy):	To (mm/dd/yy):
Per claim amount: $			
Did you purchase tail coverage? Yes ☐ No ☐		State:	Zip:
Name of Carrier:	Aggregate amount: $		Expiration Date (mm/dd/yy):
Mailing Address:			
City:	Policy#:	From (mm/dd/yy):	To (mm/dd/yy):
Per claim amount: $			
Did you purchase tail coverage? Yes ☐ No ☐		State:	Zip:
Name of Carrier:	Aggregate amount: $		Expiration Date (mm/dd/yy):
Mailing Address:			
City:	Policy#:	From (mm/dd/yy):	To (mm/dd/yy):
Per claim amount: $			

XII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS		
Please list all institutions where you have current affiliations This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheets. Attach additional sheets if necessary		
Name of primary Admitting Hospital/Institution:		
Mailing Address of Primary Admitting Hospital:		
City:	State:	Zip:
Staff Status: (Active, provisional, courtesy, temp, etc.)	Department:	Appointment Date (mm/yy): From: To:
Name of Other Hospital/Institution:		
Mailing Address of Other Hospital/Institution:		
City:	State:	Zip:
Staff Status: (Active, provisional, courtesy, temp, etc.)	Department:	Appointment Date (mm/yy): From: To:

CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS *(Continued)*		
Name of Other Hospital/Institution:		
Mailing Address of Other Hospital/Institution:		
City:	State:	Zip:
Staff Status: (Active, provisional, courtesy, temp, etc.)	Department:	Appointment Date (mm/yy): From: To:
If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):		

XIII. PEER REFERENCES			
List three professional references from your specialty area, not including relatives, current partners, or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. **NOTE:** References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.			
Name of Reference:	Specialty:	Phone #:	
Mailing Address:		Suite #/Floor:	
City:	State:	Zip:	
Name of Reference:	Specialty:	Phone #:	
Mailing Address:		Suite #/Floor:	
City:	State:	Zip:	
Name of Reference:	Specialty:	Phone #:	
Mailing Address:		Suite #/Floor:	
City:	State:	Zip:	

Mental Health Individual Provider Sub-Specialties

To maintain accurate information for PEHP's online provider listing, please select the sub-specialties under which you would like to be identified.

Provider Name:

Sub-Specialty:

- ☐ ADD/ADHD
- ☐ Adjustment Disorder
- ☐ Anxiety Disorder
- ☐ Cognitive Disorder
- ☐ Dissociative Disorders
- ☐ Eating Disorder
- ☐ Impulse-Control Disorder
- ☐ Mood Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorders
- ☐ Sexual/Gender Identity Disorder
- ☐ Substance Abuse Related Disorders

Age of Patient you treat:

- ☐ Child (0-12)
- ☐ Adolescent (13-18)
- ☐ Adult (19+)

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Professional Authorization to Release Information Form

I hereby affirm that the information submitted in the Participating Provider Application and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I fully understand that any material misstatements, omissions, or false information I knowingly make may constitute cause for denial of my application for participation or termination of the provider agreement. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation and re-evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

I hereby give to PEHP the authority to consult with, and obtain from, any and all individuals and organizations who can provide information concerning my professional liability coverage and claims, information bearing on my professional competence, training, character, ethical qualifications, ability to work cooperatively with others, and any other information necessary to process this application, other than health status which must include a separate release for information. This release shall be valid until my application is accepted or denied.

After acceptance, access to information shall be governed by a participating provider agreement. I hereby release from any and all liability those individuals and organizations who provide or process information pertinent to this application in good faith and without malice. I understand and agree that acceptance of my application does not constitute acceptance as a participating provider until such time as I receive written notice of approval of the application from PEHP.

I signify my willingness to appear for reviews or onsite visits with regard to my application. Any information obtained in connection with this application shall be treated confidentially to maintain the applicant's right of privacy and shall ensure that the information is only available to personnel or agents of PEHP with a need to know such information. This requirement also applies to information related to third parties, including patients and peers..

Print Name Here: _____

Signature: _____ Date: _____

(Stamped Signature is Not Acceptable)

PROFESSIONAL LIABILITY QUESTIONNAIRE

1. Yes ☐ No ☐ In the past ten years, have any professional liability claims, malpractice claims, or letters of Intent to sue been filed against you?

   If yes, how many? _____ How many are pending? _____

2. Yes ☐ No ☐ In the past ten years, has any judgment been entered against you in any professional liability case?

3. Yes ☐ No ☐ In the past ten years, have you been denied professional liability insurance, has your policy been canceled, has your professional liability insurer refused your policy or placed limitation on the scope of your coverage, or has any professional liability carrier expressed any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage?

If the answer to any question **1 through 3 is "Yes"**, include the nature of the case, the date, and a summary of the care given on the professional liability form provided. Please enclose a copy of the original complaint and the settlement award.

4. Yes ☐ No ☐ Has your license to practice medicine in any jurisdiction ever been suspended, revoked, or otherwise limited?

5. Yes ☐ No ☐ Have you ever been denied a license or the right to take an examination for licensing in any state, province, or country?

6. Yes ☐ No ☐ Have you ever been called before any licensing board for interrogation (concerning any violations of the laws or regulations pertaining to the profession for which you are applying), for unethical conduct, or for fees?

7. Yes ☐ No ☐ Has your license to prescribe or administer controlled substances ever been revoked or suspended?

8. Yes ☐ No ☐ Have you ever been convicted of a violation of any state or federally controlled substance act, drug, or narcotic law?

9. Yes ☐ No ☐ Have you ever been convicted of, or plead guilty to a felony?

10. Yes ☐ No ☐ Have you ever been refused membership on a hospital medical staff?

11. Yes ☐ No ☐ Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed?

12. Yes ☐ No ☐ Have you ever been suspended from receiving payment under the Medicare or Medicaid programs?

13. Yes ☐ No ☐ Has any action been taken against you, whether still pending or completed, by any governmental agency or law enforcement body for your alleged failure to comply with laws, statutes, regulations, or other legal requirements which may be applicable to the practice of your profession or to your rendering of service to patients?

14. Yes ☐ No ☐ Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?

If the answer to any question **4 through 14 is "Yes"**, please enclose a letter giving the date, jurisdiction, and nature of the charges and judgment, as well as the action taken.

PROFESSIONAL LIABILITY QUESTIONNAIRE *(Continued)*

15. Yes ☐ No ☐ Have you ever had treatment, are you presently undergoing treatment, or have you ever been recommended for treatment for narcotics, sedatives, or other drug dependencies or addictions?

16. Yes ☐ No ☐ Have you ever had treatment, are you presently undergoing treatment, or have you ever been recommended for treatment for alcohol abuse or addiction?

17. Yes ☐ No ☐ Have you ever had treatment, are you presently undergoing treatment, or have you ever been recommended for treatment for psychiatric therapy for emotional illness?

18. Yes ☐ No ☐ Are you aware or have you been advised that you have any temporary or permanent physical or mental condition or impairment which, by its nature or as a result of its treatment, might interfere with your ability to practice your profession with reasonable skill and safety?

If the answer to any question **15 through 18 is "Yes"**, please enclose a letter giving details of your use, condition, or addiction and include the name and address of the treating professional and/or institution.

19. Yes ☐ No ☐ **If I am a Physician Assistant**, requesting to be credentialed without physician supervision, I attest that I have completed 10,000 hours of post-graduate clinical practice experience, and at least 4,000 of those hours in the specialty I am requesting to be contracted for.

PROFESSIONAL LIABILITY INFORMATION FORM

Provider Name: _____

Tax ID Number: _____ **NPI Number**: _____

For each malpractice action/case that the provider has been involved in during the past ten years, please print or type in detail the answers to each of the following questions. If more than one action/case exists, please copy this sheet for a separate response for each action/case. ***Full disclosure of the information requested below is necessary for completion of the credentialing process.*** All information will be kept confidential.

Date of Occurrence: _____ **Carrier Involved**: _____

What is the status of the action/case?

☐ Pending ☐ Settled Out of Court ☐ Found for Plaintiff

☐ Dropped ☐ Dismissed ☐ Found for Defendant

If damages where paid, either by settlement or court award, what was the amount?

Paid on provider's behalf: $ _____ Paid by all parties: _____

What is/was provider's status?

☐ Primary Defendant ☐ Co-Defendant ☐ Other

In the space below (attach additional pages if needed), provide detailed information of the following:

A. What was the alleged harm to the patient?

_____

_____

_____

B. What was provider alleged to have done incorrectly or failed to have done correctly?

_____

_____

_____

C. Provide any other details pertinent to the action/case.

_____

_____

_____

D. Identify any other parties who are named in the action/case.

_____

_____

_____

E. Provide the name and Phone number of the attorney who represented the provider in the action/case.

_____

Provider Signature: _____ **Date**: _____

ELECTRONIC DATA INTERCHANGE (EDI) INFORMATION FOR ALL PROVIDERS

All providers are required to submit claims electronically. PEHP currently accepts claims through the Utah Health Information Network (UHIN); through a number of clearinghouses that submit through UHIN; or providers can set up and submit individual claims through the PEHP Provider Portal.

Providers who wish to submit claims themselves and not through a clearinghouse:

- Providers will need to contact UHIN and establish a Trading Partner Number. The Trading Partner Number will be used for all payers that accept claims through UHIN. To enroll with UHIN please call **801-466-7705.**
- Once the Trading Partner Number has been established, please contact the EDI department at PEHP, **801-366-7544 or 800-753-7818,** to arrange testing. We will need your Trading Partner Number, tax ID, contact name, phone number and NPI.

Adding a New Provider to a Practice:

When a new provider is added to the practice, please contact the EDI Department to add the new provider to the correct trading partner to avoid claim rejections. Please contact the EDI department by phone, **801-366-7544 or 800-753-7818** or E-Mail **edi.helpdesk@pehp.org**. They will need to know the Trading Partner Number as well as the provider's NPI.

PEHP currently supports the following transactions:

- **Health Care Claim**: PEHP accepts Dental, Professional, and Institutional claims. PEHP will return a Functional Acknowledgement (997) report and a Front-End Acknowledgement (277fe) report.

- **Health Care Eligibility and Benefit Inquiry**: Real time or batch eligibility and benefit requests. Currently available through the UHINT tool, may also be available through your practice management system.
- **Health Care Claims Status Inquiry**: Real time or batch status reports on claims that were previously submitted. Currently available through the UHINT tool, may also be available through your practice management system.
- **Health Care Claim Payment and Remittance Advice**: Providers will have the option of receiving an Electronic Provider Remittance (835) or printing a paper remittance from our website. Either option allows provider to sign up for Electronic Funds Transfer.

Electronic Funds Transfer:

PEHP will send an electronic provider remittance to the provider and send the funds to the provider's bank. Providers will also have the option of viewing their remittance on the PEHP website. Only providers who receive electronic remittance are eligible for electronic funds transfer.

PUBLIC EMPLOYEES
MEDICAL PROVIDER AGREEMENT

THE PUBLIC EMPLOYEES MEDICAL PROVIDER AGREEMENT is entered into as of _____ day of _____, 20__ between **PUBLIC EMPLOYEES HEALTH PROGRAM**, herein after PEHP, a program of the Utah State Retirement Board, an independent state agency and _____ herein after "PROVIDER".

SECTION 1
DEFINITIONS AND STANDARDS

1.1 **ALLOWABLE MEDICAL EXPENSE**. Any necessary, reasonable and customary expense covered by the Plan(s).

1.2 **COORDINATION OF BENEFITS**. PEHP's group Plans contain a non-profit provision to coordinate with other group plans under which a Member is covered so that the total benefits available will not exceed 100% of the Allowable Medical Expenses.

1.3 **COPAYMENT**. The portion of the cost of Covered Services that a Member is obligated to pay under the Plan(s), including deductibles, coinsurance, and Copayments. A Copayment may be either a fixed dollar amount or a percentage of the Allowable Medical Expense. The payment by a Member for non-Covered Services is not considered a Copayment and, therefore, does not apply to yearly out-of-pocket limits.

1.4 **COVERED SERVICES**. Health care services and supplies as defined under PEHP's Master Policy(ies) that are eligible for reimbursement or Payment under a Plan. PEHP'S Master Policy(ies) can be obtained online at www.pehp.org.

1.5 **ELECTRONIC TRADING PARTNER AGREEMENT**. An agreement in relation to the interchange of data by use of the myPEHP Provider website.

1.6 **ELIGIBILITY**. Verification by PEHP that the individual is qualified to receive Covered Services and is recognized by PEHP as a Member.

1.7 **FEE SCHEDULE(S)**. A schedule of allowable fees established by PEHP and accepted by PROVIDER.

1.8 **MASTER POLICY(IES)**. A complete and detailed overview of the benefits for the various PEHP medical Plans.

1.9 **MEDICALLY NECESSARY**. As provided in the Master Policy and as may be amended - Any covered healthcare services, supplies or treatment provided for an illness or injury which is consistent with the Member's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of a Member or Provider. However, such healthcare services must be appropriate with regard to standards of good medical practice in the state of Utah and could not have been omitted without adversely affecting the Member's condition or the quality of medical care the Member received as determined by established medical review mechanisms, within the scope of the Provider's licensure, and/or consistent with and included in policies established and recognized by PEHP. Any medical condition, treatment, service, equipment, etc. specifically excluded in the Master Policy is not a Covered Service regardless of Medical Necessity.

1.10 **MEDICAL REVIEW COMMITTEE**. A committee which may consist of the Medical Director, Claims Managers, Claims Supervisors or other appropriate PEHP personnel. Based on established criteria, this committee has the authority to review, and approve or deny claims for Covered Services.

1.11 **MEMBER(S)**. A person who is eligible to receive Covered Services under a Plan included in this Agreement.

1.12 **PARTICIPATING PROVIDER**. A health care provider contracted with PEHP to provide health care services to Member in accordance with the Plan(s).

1.13 **PAYMENT**. A monetary amount established in the Fee Schedule(s) that PEHP pays to PROVIDER for Covered Services to Member.

1.14 **PLAN(S)**. The benefit program(s) administered by PEHP that are covered under this Agreement.

1.15 **PRE-AUTHORIZATION.** As defined in the Master Policy and as may be amended – The process, prior to service, that the Member and the PROVIDER must complete in order to obtain authorization for specific benefits of the Master Policy which may be subject to limitations and to receive maximum benefits for hospitalization,surgical procedures,durable medical equipment, pharmaceutical medication products,or other services as required. Preauthorization does not guarantee payment should a Member's coverage terminate,should there be a change in benefits, should benefit limits be used by submissions of claims in the interim, or should actual circumstances of the case be different than originally submitted. Unless otherwise stated, pre-authorizations are valid for 12 months from the date of the authorization, even if treatment has not been completed.

1.16 **PRE-NOTIFICATION**. The process a Member must follow in order to notify PEHP of an impending hospital admission.

1.17 **SUBSCRIBER**. An employee of the State of Utah, its political subdivisions or educational institutions who is eligible for and has elected coverage under the Group Insurance Program of Title 49, Chapter 20, of the Utah Code Annotated.

SECTION 2
PROVIDER RESPONSIBILITIES

2.1 Individual Participating Providers agree to maintain hospital privileges at a participating hospital.

2.2 PROVIDER agrees to render Medically Necessary Covered Services to the Member within the scope of PROVIDER's qualifications and consistent with generally accepted standards of medical practice.

2.3 PROVIDER agrees to obtain Pre-Authorization/Pre-Notification on all applicable services prior to rendering services. Pre-Authorization/Pre-Notification requirements can be obtained online at www.pehp.org. PROVIDER agrees to not knowingly refer Members to out-of-network providers or knowingly perform/ authorize medically unnecessary services. Failure to obtain Pre-Authorization/Pre-Notification for services when required, even if those services are medically necessary, may result in PEHP applying out-of-network Member benefits to the Payment.

2.4 PROVIDER agrees to collect the applicable Copayments and accept as Payment in full the fees set forth in the Fee Schedule(s). Payment may be subject to Coordination of Benefits and Medicare provisions and PROVIDER agrees to follow all Coordination of Benefits and Medicare billing procedures.

2.5 PROVIDER agrees not to bill the Member for Covered Services or for any charges not specifically allowed by the Plan(s) for, or related to Covered Services. The types of charges for which PROVIDER cannot bill the Member include but are not limited to, service and interest charges (except those related to the collection of the Copayment or to the collection of charges for non-Covered Services) and/or unjustified after-hours charges. Unjustified after-hours charges are considered charges for those services rendered during PROVIDER's posted office hours. Not withstanding the above, PROVIDER may bill the Member for non-Covered Services.

2.6 PROVIDER and PEHP agree to make appropriate and good faith adjustments to claims when incorrect Payments are made and/or when additional Payments may be appropriate. PROVIDER and PEHP further agree that they are entitled to adjustments for up to twelve (12) months following the adjudication of a claim. For claims involving Coordination of Benefits, PROVIDER and PEHP are entitled to adjustments for up to fifteen (15) months following the adjudication of such claims. PROVIDER shall be given written notification of any overpayment adjustments. PEHP shall not offset overpayment amounts against any current or future payments unless PROVIDER has not refunded the overpayment within thirty(30) days of the notification.

2.7 PROVIDER agrees to submit all claims (including secondary claims under Coordination of Benefits) for the Member, by electronic data interchange unless claims are allowed to be submitted by mail through the process outlined on pehp.org. If submitting by mail is allowed, PROVIDER must submit mail claims on a CMS-1500 or UB-04 form (whichever is applicable) or the most current Federally mandated form. PROVIDER must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards as indicated in the Federal Register for electronic submission of claims. PROVIDER agrees to accept all remittance advice on an electronic format and all Payment via electronic funds transfer. Starting January 1, 2023, if Provider does not submit claims or receive remittance advice and Payment electronically, PEHP may deduct an appropriate administrative fee from paid claims in an amount outlined on www.pehp.org.

2.8 When submitting claims for the Member, PROVIDER agrees to use appropriate procedure and diagnostic codes that most closely identify services rendered to the Member, as defined by the standards of CMS code levels I-III, CPT guidelines, the appropriate corresponding ICD-9, ICD-10, or the most currently mandated Federal diagnosis or procedure codes, or as indicated on the Fee Schedule. PROVIDER acknowledges that claims submitted to PEHP will be subject to PEHP's code auditing product which evaluates code combinations during the processing of claims. PEHP's code auditing determinations are based on nationally recognized and accepted medical coding guidelines and sources. PROVIDER agrees to refrain from using any coding scheme that would tend to increase the amount of reimbursement beyond PEHP's Allowable Medical Expense. At the sole discretion of PEHP, any improper, illegal, unprofessional or inflationary coding which misrepresents, distorts, falsely reflects or adversely increases the benefits, may result in termination of this Agreement.

2.9 PROVIDER agrees to maintain medical records of the Member and preserve them for such time periods as are required by applicable law, regulations, and practices. Such medical records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of patient records. PROVIDER, upon request, shall release such records to PEHP, subject to such confidentiality requirements.

2.10 PROVIDER agrees that during PROVIDER's regular business hours and upon request, PEHP or PEHP's designated representative(s) shall have access to inspect, review and obtain copies of such records

(Section 2.9). When records are requested by PEHP in an on-site audit, PROVIDER shall produce copies of any such records for which PEHP shall reimburse PROVIDER no more than 10¢ per page, not to exceed $20. However, in no event shall PEHP reimburse PROVIDER for copying records which are requested for Payment of a claim.

2.11 PROVIDER agrees that during regular business hours and upon reasonable notice, PEHP shall be permitted to conduct on-site evaluations and inspections of PROVIDER's place of business and/or service locations.

2.12 In performing the services herein specified, PROVIDER is acting as an independent contractor and shall not be considered as an agent or employee of PEHP. It is agreed and acknowledged by the parties that, as an independent contractor, PROVIDER retains sole and absolute discretion and judgment in the manner and means of providing health care services here under. In no event shall this Agreement be construed as establishing a partnership or joint venture or similar relationship between the parties hereto, and nothing herein contained shall be construed to authorize either party to act as agent for the other. PROVIDER shall be liable for PROVIDER's own debts, obligations, acts and omissions, including the payment of all required withholding ,social security and other taxes and benefits due in connection with any compensation received under this Agreement.

2.13 PROVIDER agrees to file a claim for Covered Services directly to PEHP within twelve (12) months from the date of service. PROVIDER further understands and agrees that claims received by PEHP twelve (12) months or more after the date of service are not eligible for Payment and charges for those Covered Services may not be billed to the Member. When PEHP is the secondary payor, it is the Member's responsibility to ensure that the PROVIDER submits claims to PEHP no later than fifteen (15) months from the date of service.

2.14 PROVIDER, on his/her own behalf and on behalf of all persons providing health care of any type (such persons shall be included in the definition of PROVIDER for purposes of these representations and warranties), hereby represents and warrants to PEHP as follows:

(1) No malpractice actions or pending proceeding shave taken place in the past ten (10) years, which involve PROVIDER and have not been disclosed to PEHP;

(2) No malpractice settlements, judgments or arbitration proceedings have taken place in the past five (5) years, which involve PROVIDER and have not been disclosed to PEHP;

(3) No revocation, restriction or suspension of PROVIDER's license has taken place which has not been disclosed to PEHP;

(4) No suspension of PROVIDER's Medicare or Medicaid privileges has taken place which has not been disclosed to PEHP;

(5) PROVIDER's professional liability insurance has not been canceled in the past five (5) years;

(6) PROVIDER has not been the subject of any state, federal or other jurisdictional licensing investigations or actions that have not been disclosed to PEHP;

(7) PROVIDER has not been convicted of any felony or misdemeanor involving moral or ethical turpitude;

(8) PROVIDER holds a current Drug Enforcement Agency Narcotic Registration Certificate, where applicable;

(9) No revocation, restriction or suspension of PROVIDER's Drug Enforcement Agency Narcotic Registration Certificate has taken place that has not been disclosed to PEHP.

Provider's failure to notify PEHP of any of the above may, at PEHP's sole discretion, result in the termination of this Agreement or the termination of the PROVIDER. If PEHP determines in good faith that the health, safety or welfare of PEHP's Members would be jeopardized by the continuation of the PROVIDER, PEHP may immediately terminate PROVIDER from this Agreement or at PEHP's option suspend PROVIDER from this Agreement until PEHP is satisfied that PROVIDER has remedied the situation.

2.15 If, during the period of this Agreement, there are changes in the status of any of the warranties listed in Section 2.14, PROVIDER agrees to immediately notify PEHP.

2.16 PROVIDER agrees to carry general and professional liability insurance at PROVIDER's expense in an amount of not less than one million dollars ($1,000,000) per occurrence with a three million dollar ($3,000,000) aggregate per year. PROVIDER shall allow PEHP access to insurance carrier data and information on PROVIDER's medical malpractice history including the number,type,nature and disposition of claims filed against PROVIDER. If PROVIDER is or becomes uninsured at any time during the period of this Agreement, PROVIDER shall immediately inform PEHP, in writing, of this fact. Failure to maintain the required insurance amounts under this provision shall result in termination of this Agreement.

2.17 PROVIDER agrees to be solely liable for any and all malpractice or professional negligence actions based on PROVIDER's acts or omissions.

2.18 PROVIDER acknowledges this Agreement pertains to PROVIDER's services only and may not be sold, transferred, extended to, assigned, or delegated by PROVIDER without prior written consent.

2.19 This Agreement supersedes any prior or contemporaneous agreement entered into between PROVIDER and PEHP.

2.20 PROVIDER acknowledges that PROVIDER has a credentialing and recredentialing process for the individual Participating Providers that complies with National Council on Quality Assurance ("NCQA") standards. PROVIDER shall continue to administer such a credentialing and recredentialing process for the term of this Agreement.

2.20.1 If any existing individual Participating Provider is found to be in violation of NCQA standards, PROVIDER shall notify PEHP of such violation in writing within fifteen business days. At the sole discretion of PEHP, the individual Participating Provider may be immediately suspended from PEHP's panel upon notification, and shall not be reinstated until PEHP receives written verification from PROVIDER that the violation has been corrected. Any liability a rising out of any failure to discover and/or disclose violations shall be the sole responsibility of PROVIDER.

2.20.2 PROVIDER shall maintain all records necessary for PEHP to monitor the effectiveness and compliance of the credentialing and recredentialing processes. During regular business hours and upon reasonable notice, PEHP or PEHP's representative shall have the right to audit and/or review all such records.

2.20.3 If PEHP discovers compliance problems or has concerns about the credentialing or recredentialing process, PEHP shall make such issues known to PROVIDER and the parties shall agree to discuss and use reasonable efforts to resolve such issues.

2.20.4 PEHP shall have the right, upon thirty (30) days written notice to PROVIDER, to revoke and assume responsibility for some or all of the credentialing process delegated to PROVIDER.

2.20.5 PROVIDER agrees to notify PEHP within fifteen (15) days of any additions or deletions of individual Participating Providers.

_____ (The foregoing initials reflect acknowledgment of 2.20.)
(Initials)

2.21 Participating Provider status will not be guaranteed if PROVIDER changes geographical location(s). PROVIDER may need to reapply for continued participation with PEHP.

2.22 At PEHP's discretion, PEHP may apply the terms of this Agreement to any individual provider who benefits from this Agreement and seeks payment for covered health care services rendered to a Member in any setting, location, or circumstance until [if] PROVIDER [fails to give] gives PEHP actual notice to terminate this Agreement or its application to the PROVIDER.

SECTION 3
PEHP RESPONSIBILITIES

3.1 PEHP hereby agrees to adjudicate claims from PROVIDER within thirty (30) days based on receipt of all pertinent, applicable and necessary documents for review and explanation.

3.2 PEHP shall perform administrative responsibilities, benefit Payment operations, accounting functions and other related functions necessary to implement and operate the Plan(s) in the most cost-effective and efficient manner.

3.3 PEHP shall, upon request of PROVIDER, verify and provide Member Eligibility and Plan coverage. Such verification maybe relied upon by the PROVIDER except in the case of fraud or abuse of benefits by the Member.

3.4 PEHP shall update and provide Members with current informational and educational materials related to benefits, provider panels and other pertinent information.

3.5 Requests for additional benefits or adjustments for previously processed (paid or rejected) claims must be presented in writing to the Medical Review Committee within 180 days of adjudication of claim. All requests should include documentation supporting the request for reconsideration. Any further disputes can be addressed through PEHP's Appeal Process.

SECTION 4
TERM and TERMINATION

4.1 **TERM.** Performance obligations assumed under this Agreement shall commence on the date first written above and shall continue until otherwise terminated as provided herein.

4.2 **IMMEDIATE TERMINATION.** PROVIDER shall be automatically terminated if any license, or certificate, which is required to be maintained, is revoked, suspended or placed on probation, including any stay of execution of the revocation or suspension.

4.3 **TERMINATION**. Either party shall have the right to terminate this Agreement without cause upon thirty (30) days, advance written notice by certified mail.

SECTION 5
GENERAL PROVISIONS

5.1 **AMENDMENT OF TERMS**. This Agreement may be amended by PEHP upon giving thirty (30) days written notification of such proposed amendment. The continued participation in the Plan(s) by PROVIDER without written objection within the thirty (30) day period shall constitute PROVIDER approval.

5.2 **DISPUTE RESOLUTION**. PROVIDER and PEHP agree to make reasonable efforts to resolve controversies that might arise under this Agreement. If there is a dispute between the parties to this Agreement, the parties agree to be subject to Utah Code Ann. §49-11-613 and §63-46b-1 et. seq., the Utah Administrative Procedures Act.

5.3 **GOVERNING LAW**. This Agreement shall be governed by and construed in accordance with the laws of the State of Utah, without application of any principles of choice of laws.

5.4 **NOTICES**. All notices and other communications required to be in writing shall be deemed to have been given either at the time of delivery if delivered personally or by an independent contract carrier, or twenty-four (24) hours after the time of postmark if mailed Express Mail, postage prepaid, return receipt requested, or three (3) days after the time of postmark if mailed registered or certified mail, postage prepaid, return receipt requested, and in each case addressed as follows:

PEHP: **560 East 200 South**
Salt Lake City, Utah 84102-2004
Attention: Provider Relations

PROVIDER: _____
_____
_____

5.5 **PRIVACY**. PEHP and PROVIDER acknowledge that each is a “covered entity” under the Health Insurance Portability and Accountability Act (HIPAA). Each party represents and warrants to the other that it is or will be in compliance with privacy provisions of HIPAA as found at 45 CFR parts 160 and 164:

Standards for Privacy of Individually Identifiable Health Information, commonly known as the “Final Privacy Rule”. Each party shall indemnify and hold the other party harmless from any liability, costs, awards, judgments, penalties or fees (including reasonable attorney’s fees) arising out of a breach of its obligations under the Final Privacy Rule or future obligations placed on the parties under HIPAA.

5.6 **INDEMNIFICATION.** PEHP agrees to indemnify PROVIDER from and against any claims or other liability, including attorney fees, based upon PEHP’s failure to comply with its obligations under this Agreement. PROVIDER agrees to indemnify PEHP from and against any claims or other liability based upon the PROVIDER’s failure to comply with its obligations under this Agreement.

5.7 **FORCE MAJEURE**. Neither Party will be liable for delay or damages if prevented from fulfilling its obligations by reason of Force Majeure causes, including but not limited to acts of God, acts of war (whether declared or undeclared), terrorism, or any other cause beyond the control of such Party. In case of Force Majeure, the Party’s performance obligations will be extended by a reasonable period of time corresponding to the delay caused by the Force Majeure. The Party experiencing the Force Majeure will

inform the other Party in writing within fifteen (15) days after a factor event of Force Majeure has been recognized to have occurred.

SECTION 6
BENEFIT PROGRAMS

6.1 This agreement shall be applicable to all PEHP Plans and networks listed in any Attachment I, Fee Schedules.

6.2 This Agreement incorporates the PEHP Master Policy found at www.pehp.org and the applicable benefit summaries to determine Covered Services. While reasonable care has been taken to prevent any conflicts between documents, any conflict between this Agreement and the PEHP Master Policy or applicable benefit summaries shall be resolved by first giving precedence to the PEHP Master Policy and its applicable benefit summaries and then to this Agreement.

IN WITNESS WHEREOF, the undersigned have affixed their signatures to this Agreement on their own behalf or on behalf of the party named below pursuant to authority and resolution of its Governing Board. The parties have executed this Agreement to be effective as of the date first written above.

PROVIDER

_____ _____

Signature **Date**

_____

Print Name

_____

Title

PUBLIC EMPLOYEES HEALTH PROGRAM

_____ _____

Director, Clinical Management **Date**

Fill in information below: (Attach additional sheet if necessary.)

Provider Name/ Degree Physical Location(s) Telephone # Fax # E-mail Address	Billing Office Name Billing Address Telephone # Fax # E-mail Address	Tax Identification # Tax Name National Provider Identifier (NPI)	Specialty Type and DEA #

ATTACHMENT I

PEHP ELECTRONIC TRADING PARTNER AGREEMENT

The provisions of this Agreement are intended to govern the rules of conduct and methods of operation between the Public Employees Health Program (herein after referred to as PEHP) and PROVIDER who has entered in to an independent contractor arrangement with PEHP, in relation to the interchange of data by use of the myPEHP Provider website.

The myPEHP Provider website provides a means by which PROVIDERS may inquire about Plan coverage; Member eligibility, claims inquiry, Payment status, and other information or services that may be added or deleted from time to time (hereinafter referred to as services).

This agreement also takes into account that PEHP, a health plan, and said PROVIDERS are "covered entities" as defined by 45 CFR parts 160 and 164, Standards of Privacy of Individually Identifiable Health Information, and as such, are individually responsible for compliance with the provisions therein.

Therefore, in consideration of the mutual promises and covenants contained herein, the sufficiency of which is acknowledged, the parties agree as follows:

1. SERVICES

1.1 Availability. This Agreement applies to the services described, as modified and supplemented from time to time. Unless otherwise indicated in the related description, the myPEHP Provider website is available to PROVIDERS twenty-four (24) hours a day, seven (7) days a week. PEHP may temporarily suspend access and services at its discretion.

2.1 PROVIDER Responsibility for Use. PROVIDER will use the myPEHP Provider website in a manner consistent with applicable laws. PROVIDER is solely responsible for all use of PROVIDER's myPEHP Provider website account and for any violation of the terms of this Agreement by anyone using PROVIDER's account. For purposes of this Agreement, PROVIDER's "**use**" (a) means (i) use by PROVIDER's employees, agents or contractors who have obtained PROVIDER's signature in their employment or engagement, (ii)use by PROVIDER's employees, agents or contractors, who following their separation from employment or engagement from PROVIDER were enabled by the use of PROVIDER's signature obtained in their employment or engagement, (iii) use by any person who obtains PROVIDER's signature because of PROVIDER's negligence, and (iv) use by any person who obtains PROVIDER's signature from any person described in (i), (ii) or (iii) above and (b) specifically excludes the unauthorized use of PROVIDER's myPEHP Provider website account by any person who is not described in (i)–(iv) above or who accesses or uses PROVIDER's signature without authorization from same.

3. CONFIDENTIALITY, PRIVACY AND SECURITY

3.1 Use and Disclosure of Protected Health Information. The following provisions apply specifically to the possession, use and disclosure of Protected Health Information obtained by means of a transaction and is intended to document each party's assurances that it will appropriately use and safeguard such data.

(a) Definition."**Protected Health Information**" or "**PHI**" shall have the broadest meaning given under applicable laws and generally refers to individually identifiable health information transmitted or maintained in any form or medium.

(b) Standard. PEHP will not (and will require that its directors, officers, employees, contractors and agents do not) use or disclose PHI obtained from PROVIDER in any manner that would constitute a violation of law if so used or disclosed by PROVIDER. PEHP may use PHI (i) for PEHP's proper management and administrative services or (ii) to carry out PEHP's legal responsibilities.

(c) Obligations Regarding PHI. PEHP and PROVIDER each agree, for the benefit of each other and additionally for the benefit of the providers to whom PEHP or PROVIDER maybe a "business associate" under the Health Insurance Portability and Accountability Act ("**HIPAA**") of 1996 and rules or regulations promulgated therein that:

(i) both parties will not use or further disclose PHI in a manner that would violate the requirements of applicable laws, if so used or disclosed by the originator of the transaction;

(ii) both parties will not use or further disclose PHI other than (A) as permitted or required by this Agreement or supplemental agreements now or hereafter existing which govern either party's business relationship or arrangement with other providers or (B) as required by law;

(iii) both parties will implement appropriate safeguards to prevent use or disclosure of PHI, other than as provided by this Agreement (including the security procedures specified in the 45 CFR Parts 160 and164);

(iv) both parties will have a written policy to prevent the improper use or disclosure of PHI, including a procedure for notifying appropriate persons of the improper use or disclosure of PHI of which either party becomes aware;

(v) PROVIDER will promptly report to PEHP (or, in the case of PEHP, to the affected PROVIDER) any instances of which either party becomes aware that the confidentiality of PHI has been breached;

(vi) PROVIDER will promptly report to PEHP (or, in the case of PEHP, to the affected PROVIDER) any use or disclosure of PHI received or sent in a transaction of which either party becomes aware and which is not provided for by this Agreement;

(vii) both parties will require that any third party, including agents and contractors agree to the same restrictions and conditions that apply to the PROVIDER with respect to such information, including those in this Section 3.1(c);

(viii) both parties will make PHI available for amendment, to provide an accounting of disclosures or to comply with other requirements of applicable laws;

(ix) both parties will make their internal practices, books and records relating to the use and disclosure of PHI available for purposes of determining their compliance with applicable laws pertaining to PHI; and

(x) at termination of this Agreement, PROVIDER will return or destroy all PHI received in a transaction that is still maintained in any form and will retain no copies of such information or, if such return or destruction is not feasible, extend the protections of this Agreement and this Section 3.1 to the information and limit further use and disclosure to those purposes that make the return or destruction of the information not feasible.

(d) Breach. If PEHP or PROVIDER breaches a material obligation under this Section 3.1, or is in violation of the requirements of applicable laws respecting PHI, the non-breaching party in its sole discretion may take, but is not obligated to take, reasonable steps to cure the breach or terminate this Agreement or, if termination is not feasible, report the breach or violation to the Utah state and federal governmental authorities having jurisdiction.

(e) Incorporation of Additional Requirements; Construction. The requirements of applicable law pertaining to PHI, to the extent not adequately provided for in this Section 3.1 or elsewhere in this Agreement, are hereby incorporated by reference and shall become a part of this Agreement. This Agreement and Section 3.1 shall be construed as broadly as necessary to implement and comply with applicable privacy laws, including HIPAA. Section 3.1 is intended to document the assurances and other requirements respecting the use and disclosure of PHI that must be obtained by "covered entities" from contracting parties who are "business associates" under HIPAA and it will be modified as appropriate from time to time to comply with HIPAA.

3.2 Interception of Transactions. To the maximum extent permitted by law, PEHP is not liable for the interception by improper means or the theft by persons (other than PEHP employees, agents or contractors) of transactions carried on the myPEHP Provider website.

3.3 Signatures. Access to the myPEHP Provider website and use of services require an electronic identification, which may consist of user names, passwords, symbols or codes ("**signatures**"). PROVIDER SHALL MAINTAIN THE CONFIDENTIALITY AND CONTROL THE USE OF PROVIDER'S SIGNATURE. SUCH SIGNATURES SHALL BE DEEMED "CONFIDENTIAL INFORMATION" UNDER SECTION 3.1 OF THIS AGREEMENT.

Recipients of transactions will maintain the confidentiality of the signatures of other Providers affixed to or contained in such transactions.

3.4 Governmental Entities. PROVIDERS that are Utah governmental entities may be subject to the Government Records Access and Management Act (Utah Code Annot. (1953), §§ 63-2-101 *et seq.*, as amended, "**GRAMA**"). Under GRAMA, certain records within a governmental entity's possession or control may be subject to public disclosure. Not withstanding anything to the contrary in this Agreement, a PROVIDER that is a Utah governmental entity subject to GRAMA may disclose information to the extent required by GRAMA or as otherwise required by law.

4. AUDIT

4.1 PEHP will make its practices, books and records (excluding stored transactions, confidential information and PHI) relating to the safeguarding, protection, use and disclosure of PHI and confidential information available on reasonable advance notice for inspection by PROVIDER for purposes of determining compliance with Section 3.1. PEHP will, at the request of PROVIDER, make available an accounting of PEHP's further disclosures of PHI and confidential information disclosed by PROVIDER. In addition, if PEHP has reasonable cause to believe that PROVIDER use of the myPEHP Provider website is not in compliance with this Agreement or 45 CFR Parts 160 & 164, PEHP may audit stored transactions for compliance, *provided that* PEHP first notifies PROVIDER of the audit and gives PROVIDER the opportunity to have a representative present. Any audit shall be conducted so as not to cause the improper disclosure or use of transactions or their content.

5. CONTRACTORS

5.1 PEHP may perform their obligations under this Agreement directly or through contractors. PEHP shall cause its contractors to comply with the obligations, restrictions and conditions applicable to PEHP regarding the contents of transactions, confidential information, security and privacy contained in Section 3. Not withstanding that PEHP may contract certain communication and support services, PEHP shall remain primarily responsible for the performance of such services.

6. INTERNET (ISP) ACCESS AND OTHER PROVIDER RESOURCES

6.1 PROVIDER, at PROVIDER's own expense, will provide and maintain the hardware, software, equipment and services necessary to effectively and reliably access the myPEHP Provider website. PROVIDER will also format, transmit and receive transactions complying with the standards and use of other services. An Internet service provider and Internet browser that support the use of 128 byte SSL encryption is necessary. The PROVIDER's web browser must be enabled to accept "cookies".

7. COMPLIANCE WITH LAW

7.1 Generally. PEHP and PROVIDER will each comply with laws applicable to this Agreement to the use of the myPEHP Provider website, other services and the content of transactions. This Agreement will be interpreted, to the maximum extent possible, so as to be consistent with such laws.

7.2 No Agency. PEHP provides specific myPEHP Provider services to PROVIDERS, but does not act for PROVIDERS as a general matter. PEHP is not responsible for the content of transactions.

8. STORAGE AND RETENTION

8.1 PROVIDER is solely responsible for providing and maintaining data backup and retention adequate for PROVIDER's needs, for maintaining adequate source records (which maybe electronic) relating t transactions and for complying with applicable law relating to the storage, maintenance and retention of such record.

9. LIMITED WARRANTY; DISCLAIMERS

9.1 PEHP warrants that it will use its best efforts to correctly provide services of the myPEHP Provider website in a timely manner. PEHP MAKES NO OTHER WARRANTIES, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE REGARDING THE SERVICES OR RESOURCES PROVIDED BY IT OR THE USE OF SERVICES NOT COMPLYING WITH APPLICABLE LAW. PEHP DISCLAIMS LIABILITY (RELATING TO PEHP'S OR PROVIDER'S CONNECTION TO THE INTERNET OR THE INTERNET SERVICE PROVIDER) FOR THE FAILURE OF PROVIDERS TO COMPLY WITH THIS AGREEMENT (INCLUDING ANY FAILURE TO COMPLY WITH APPLICABLE LAWS, RULES OR

REGULATIONS RELATING TO THE SECURITY OR PRIVACY OF PHI OR FOR THE CONTENT AND USE OF SAID SERVICES). PEHP DOES NOT WARRANT UNINTERRUPTED OR ERROR-FREE OPERATION, COMPATIBILITY WITH ANY PARTICULAR HARDWARE OR SOFTWARE, OR INTER-CONNECTIBILITY WITH OTHER NETWORKS OR SERVICES.

10. LIMITATION OF LIABILITY

10.1 Regardless of whether any remedy set forth herein fails in its essential purpose or otherwise, neither PROVIDER nor PEHP will be liable to the other for lost profits or data, or any special, incidental, indirect, exemplary or consequential damages arising from, or as a result of, any delay, omission or error in the transmission or receipt of any transactions or use of other services or other claims arising out of this Agreement, even if advised in advance of the possibility of such damages.

11. INDEMNIFICATION

11.1 By PEHP. PEHP will defend PROVIDER against claims that the use of services by PROVIDER infringes on any patents, copyrights or trademarks or that the use of services is a misappropriation of trade secrets, and will pay (a) all costs, damages and attorney's fees finally awarded against PROVIDER as a result of such claims and (b) any settlement of such claims, provided that PROVIDER notifies PEHP in writing promptly upon discovery of such claims and fully cooperates giving PEHP complete authority and control in the defense and settlement of such claims. PEHP will have no liability or obligation for claims based on (i) use of services not in compliance with applicable standards or (ii) the content of transaction. THIS SECTION 11.1 STATES PEHP'S ENTIRE OBLIGATION FOR BREACH OF THE FOREGOING NON-INFRINGEMENT WARRANTY.

11.2 By PROVIDER. Except for claims arising out of PEHP's breach of this Agreement or PEHP's negligent acts, omissions or willful misconduct, PROVIDER agrees to indemnify, defend and hold harmless PEHP, its employees, directors, agents and contractors for, from, and against all damages and costs, including reasonable attorneys fees, that result from (i) the claims of third parties arising out of (a) PROVIDER's use of the myPEHP Provider website and services, including PROVIDER's connection to the Internet or (b)the content and use of the myPEHP Provider website by PROVIDER, (ii) the Payment of health insurance claims and (iii) the compliance by PROVIDER with applicable laws (including those relating to the security and privacy of PHI), provided that PEHP notifies PROVIDER in writing promptly upon discovery of any such third party claims and fully cooperates giving PROVIDER complete authority and control in the defense and settlement of such claims. For purposes of this Section 11.2, PROVIDER's "**use**" of the myPEHP Provider website and services (a) means (i) use by PROVIDER's employees, agents or contractors who have obtained PROVIDER's signature in their employment or engagement, (ii) use by PROVIDER's employees, agents and contractors who following their separation from employment or engagement by PROVIDER were enabled by the use of PROVIDER's signature obtained in their employment or engagement, (iii)use by any person who obtains PROVIDER's signature because of PROVIDER's negligence, and (iv) use by any person who obtains PROVIDER's signature from any person described in (i), (ii) or (iii) above and (b)specifically excludes the unauthorized use of PROVIDER's myPEHP website account by any person who is not described in (i) - (iv) above or who accesses or uses PROVIDER's signature without authorization from same.

12. LIMITATION OF ACTION

12.1 No action, regardless of form, arising out of this Agreement may be brought by either party more than two years after the cause of action has arisen, or in the area of nonpayment, more than two years from the date of last Payment.

13. TERMINATION

13.1 By Either Party. This Agreement will remain in effect until terminated by either party with not less than thirty (30) days prior notice to the other party.

13.2 By PEHP for Cause. PEHP may terminate this Agreement (a) if PROVIDER fails to comply with any of

its material terms or conditions, and fails to cure such non-compliance within thirty (30) days of notice, or (b) if PROVIDER uses or attempts to use the myPEHP Provider website services for any fraudulent or illegal purpose or (c) fails to comply with the standards of 45 CFR Parts 160 &164 and fails to cure such non-compliance within thirty (30) days of notice. PEHP may immediately suspend PROVIDER's access to the myPEHP Provider website and services, with or without terminating this Agreement, (i) if PROVIDER uses or attempts to use the myPEHP Provider website or services for any fraudulent or illegal purpose or (ii) PROVIDER fails to comply with 45 CFR Parts 160 & 164.

13.3 Obligations on Termination. Upon termination for areas on other than stated in Section 13.2 (i)and (ii), PEHP and PROVIDER will agree on a reasonable time, not to exceed thirty (30) days, within which PROVIDER may pursue alternatives to the services. During this time period, PROVIDER may continue to use the myPEHP Provider website and services in accordance with this Agreement, and the parties shall be subject to this Agreement for such time period. The effective date of termination will be the date on which PROVIDER ceases to use the myPEHP Provider website and services or thirty (30)days following notice of termination, whichever first occurs. PROVIDER will, within thirty (30) days of the effective date of termination, turnover to PEHP or, if agreed by PEHP, certify the destruction of all property belonging to or provided by PEHP.

14. MODIFICATION

14.1 The terms and conditions of this Agreement cannot be modified or waived except (a) by a writing signed by the parties hereto or (b) by PEHP giving PROVIDER thirty (30) days advance written notice of changes, in which case PROVIDER's use of services after the thirty (30) day notice period will constitute PROVIDER's acceptance of the modification or waiver stated in the notice.

15. APPEALS

15.1 Any action arising out of this Agreement shall be a legal right under Title 49 of the Utah Code Annotated and such action shall be subject to the appeals procedure as set forth in Utah Code Annotated Section 49-11-613.

16. GENERAL PROVISIONS

16.1 Assignment. Neither PEHP nor PROVIDER may transfer or assign its rights or obligations under this Agreement without the prior written consent of the other, except for a transfer or assignment to a parent, a subsidiary, an affiliate, an entity with which it is merged or consolidated, or the purchaser of all or substantially all of its assets, provided such transferee assumes all its obligations under this Agreement.

16.2 Attorney's Fees. The prevailing party in any legal action concerning this Agreement is entitled to recover its reasonable attorney's fees and costs following a final judgment.

16.3 Construction; Severability. To the maximum extent possible, this Agreement and its provisions will be interpreted consistently with applicable law. Any provision of this Agreement that is determined to be invalid or unenforceable will be ineffective to the extent of such determination without invalidating the remaining provisions of this Agreement or affecting the validity or enforceability of such remaining provisions. The words "law" or "laws" shall have the broadest meaning in the context used, and will generally refer to Utah state and federal laws, rules and regulations.

16.4 Entire Agreement. This Agreement contains the parties' entire agreement respecting the subject matter hereof, supersedes and replaces all prior agreements between PEHP and PROVIDER pertaining to the provision of services, and may be modified only as provided herein or by a signed written document. THIS AGREEMENT MAY NOT BE CONTRADICTED BY EVIDENCE OF ANY ALLEGED ORAL AGREEMENT. ALL PRIOR ORAL DISCUSSIONS ARE MERGED IN THIS AGREEMENT. No course of dealing or failure or delay in exercising any right, privilege, remedy or option will operate as a waiver of any right, privilege, remedy or option under this Agreement.

16.5 Excusable Delays. No party will be liable for any failure to perform its obligations hereunder, where such failure results from any act of God or other cause beyond such party's reasonable control (including, without

limitation, any mechanical, electronic or communications failure).

16.6 Governing Law. This Agreement is governed by the laws of Utah, excluding laws pertaining to choice of law.

16.7 Headings. Section headings are for convenience and will not affect the construction or interpretation of any provisions of this Agreement.

16.8 Notice. All notices hereunder will be by e-mail (excluding notices under Sections 3.1(c), 3.1(d), 13, 14 and 16) or in writing sent by United States certified mail, postage prepaid, to the address of the other party which is set forth in this Agreement, or to such other addresses as the party will designate in writing. Any notice will be deemed to be effective upon delivery. Notice may be waived by mutual written consent of the parties.

16.9 Ownership. PROVIDER has no rights of ownership or other property rights in any standards, services or other materials furnished by PEHP in connection with this Agreement.

16.10 Survival. The provisions of Sections 3, 7.2, 9, 10, 11, 15 and 16 will survive the termination of this Agreement.

16.11 Third Party Rights. Nothing in this Agreement is intended to confer any rights or remedies on any persons other than the parties hereto and their respective successors and assigns, nor is anything in this Agreement intended to relieve or discharge the obligation or liability of any third parties to any party to this Agreement, nor will any provision give any third party any right of subrogation or action against any party to this Agreement.

EXECUTED this _____ day of _____ , 20__

PROVIDER

_____

Print Name (if applicable attach group roster)

_____

Tax Identification Number(s) (TIN) (If applicable, list multiple TIN's)

_____

NPI

_____

Provider Signature

PUBLIC EMPLOYEES HEALTH PROGRAM

_____

Director, Clinical Management

_____

Date