Facility and Ancillary Application

Thank you for your interest in Superior HealthPlan. Please use this checklist to ensure you have all necessary contract and credentialing items to avoid processing delays.

Documents contained in this packet must be completed fully and returned:

- ☐ Fully completed **Facility and Ancillary Credentialing Application**.
- ☐ Signed and dated **Participating Provider Agreement**. Return entire original contract. Do not populate any effective dates. (Not required for re-credentialing.)
- ☐ Signed and dated **W9** with IRS registered legal business name and billing address information. Use only one TIN or SSN. This legal name must match the name on the Participating Provider Agreement.
- ☐ Read **Participation Provider Conflict of Interest and Healthcare Entity Financial Interest Policy and Disclosure Statement** in its entirety.
  - ☐ Complete and return page 4 and ensure you have selected either "Yes" or "No".
  - ☐ Complete and return page 5 and ensure you have selected either "Yes" or "No".
  - ☐ Complete and return page 8 only if you are disclosing a prior contract or business relationship with Superior HealthPlan.
  - ☐ Complete and return page 11 and ensure you have selected either "Do" or "Do not".
  - ☐ Complete and return page 12 and ensure you have selected either as "Yes" or "No".
  - ☐ Complete and return page 13 and ensure you have selected either as "Yes" or "No".

Documents you will need to provide:

- ☐ Copy of the Federal, State and/or Local License.
- ☐ Copy of Accreditation Certificate(s).
  - ☐ If not accredited, please provide one of the following:
    - Copy of the State Site Survey.
    - Cover letter from Centers for Medicare and Medicaid Services (CMS) stating facility is in substantial compliance.
    - Copy of CMS letter certifying/recertifying facility (if deficiencies were cited).
- ☐ Copy of other applicable State/Federal Licensures (i.e. Clinical Laboratory Improvement Amendments [CLIA], Bureau of Radiation Control, Pharmacy, Mammogram Certificate, Laser Certificate, Drug Enforcement Agency [DEA])
- ☐ Copy of Certificate of Insurance.
- ☐ Copy of Texas Medicaid and Healthcare Partnership (TMHP) Medicaid Letter (when applicable).
- ☐ Comprehensive Outpatient Rehabilitation Facility (CORF) providers must provide evidence of an Agreement with the Texas Heath and Human Services (HHS).

Important Notice: Failure to legibly complete all sections of this application and submit current copies of all required documentation will result in processing delays. Initial credentialing applications will be discontinued if requested information is not provided within 30 days of Superior's receipt of an application. Superior HealthPlan will obtain information from various outside sources (e.g., state licensing agencies, accreditation sources) to evaluate your application. You have the right to review any primary source information Superior collects during this process. However, this does not include references or recommendations or other information that is peer review protected.

Once all fields of this form are completed, please return this form, along with all other needed documents, to the following:

Credentialing Applications may be returned to:

- **Mail:** Superior HealthPlan
  ATTN: Contract Management
  7990 Interstate 10 West, Suite 300
  San Antonio, TX 78230
- **Email:** SHP.NetworkDevelopment@SuperiorHealthPlan.com

Re-Credentialing Applications may be returned to:

- **Mail:** Superior HealthPlan
  Credentialing Department
  5900 E. Ben White Blvd.
  Austin, TX 78741
- **Email:** Credentialing@SuperiorHealthPlan.com
- **Fax:** 1-866-702-4831

Contract steps:

Upon submitting this application, you will move to the intake/contracting step.

For any questions, please reach out to the Superior Provider Services department at 1-877-391-5921

Demographic Information

Legal Business Name: _____

Facility DBA Name: _____

Physical Address (must be a street address): _____

City: _____ State: _____ Zip: _____ County: _____

What are the location days and hours of operation? S M T W T F S

_____ to _____

Facility Phone: _____ Facility Fax: _____

Facility Email Address: _____ Facility Website: _____

Tax ID: _____ NPI: _____ Medicare Identification Number: _____

Facility TPI: _____ Specialty: _____ Sub-Specialty: _____

Primary Taxonomy: _____ Additional Taxonomy: _____

Are there additional NPI's used for claim submission purposes covered under the same facility licensure?
☐ Yes ☐ No (If **Yes**, complete information below.)

Additional Facility NPI's: _____ Additional Specialties: _____

Is this location handicap accessible? ☐ Yes ☐ No

Do you perform Advanced Imaging Services (CT/CTA, MRI/MRA, PET scan)? ☐ Yes ☐ No

Mailing address same as above? ☐ Yes ☐ No (If **No**, complete information below.)

Mailing Address (must be an address): _____

City: _____ State: _____ Zip: _____ County: _____

Facility Phone: _____ Facility Fax: _____

PLEASE NOTE: SIGNED AND DATED W-9 MUST BE PROVIDED FOR BILLING ADDRESS

Ancillary Services

☐ Ambulatory Surgery Center

Are you a Medically Dependent Children Program Provider (MDCP)?
☐ Yes ☐ No

Are you a Prescribed Pediatric Extended Care Center (PPECC)?
☐ Yes ☐ No

☐ CORF/ORF:
- ☐ Physical Therapy (PT)
- ☐ Speech Therapy (ST)
- ☐ Occupational Therapy (OT)
- ☐ Cognitive Rehab Therapy (CRT)

☐ Durable Medical Equipment (DME)

Do you provide Pediatric Services?
☐ Yes ☐ No

If Yes, age range: _____

☐ Home Health Care:
☐ PT ☐ ST ☐ OT ☐ PDN
☐ Home Infusion

☐ Home Health Care with Long-Term Service and Support (LTSS):
☐ PT ☐ ST ☐ OT

☐ Home Infusion

☐ Infusion Center: Outpatient Chemotherapy/Infusion

Is this facility Medicare (CMS) certified (required to participate in Medicaid networks)?
☐ Yes ☐ No ☐ Pending
If Yes, provide current survey date:
____ / ____ / ____ and

CMS Certification Number (CCN):
_____

☐ Laboratory (only need to provide Facility Demographics and CLIA information)

☐ LTSS

☐ Outpatient Dialysis Center

☐ Therapy Services:
☐ PT ☐ ST ☐ OT ☐ CRT

☐ Urgent Care Center

☐ Other: _____

(Complete LTSS section on page 6, Counties Served on page 7.)

Licensure

(Attach a copy.)

License Number: _____ Effective Date: _____ Expiration Date: _____

Accreditation

(Attach a copy of the accreditation certification.)

☐ Yes - Entity Name: _____

☐ No - Complete the **Site Visit Requirement** section below.

Site Visit Requirement

1. Has the Texas Department of Health and Human Services (HHS) or a government agency delegated by HHS completed a post-licensing onsite survey within the past 36 months?

   ☐ Yes - Date of most recent full survey: _____

   ☐ No - Successful completion of a health plan onsite visit will be required to complete credentialing.

2. Were any deficiencies cited during the last survey? ☐ Yes ☐ No ☐ N/A (No recent survey)
   If **No**, submit verification of no deficiencies. If **Yes**, have all deficiencies been corrected?
   ☐ Yes - Provide evidence of acceptance by HHS of your corrective action plan.
   ☐ No - Submit your plan to correct all deficiencies.

Telehealth Services

☐ Telemedicine Services (delivering medical services through technology such as phone or video): ☐ Yes ☐ No

☐ Telemonitoring Services (patient monitoring remotely via specialized electronic devices): ☐ Yes ☐ No

Intellectual and Developmental Disabilities (IDD) Providers

Do you have experience in treating patients with IDD? ☐ Yes ☐ No

Essential Community Providers (ECP)

(Exchange/Commercial Only)

Are you considered an ECP as defined by CMS? ☐ Yes ☐ No

Minority Owned Business

Are you designated as a Minority Owned Business? ☐ Yes ☐ No

Insurance/Professional Liability Coverage

(Attach a copy of the Certificate of Insurance.)

Current Carrier Name (not agency): _____ Policy Number: _____

Street/PO Box: _____ City: _____ State: _____ Zip: _____

Effective Date: _____ Expiration Date: _____

Occurrence Amount: $ _____ Aggregate Amount: $ _____

MMP Directory Data Element Requirements

(MMP providers - Please complete page 5. A response is required in each section.)

1. Has the practitioner completed cultural competence training?

African American	☐ Yes	☐ No	Hispanic/Latino	☐ Yes	☐ No
Alaskan Native	☐ Yes	☐ No	Pacific Islander	☐ Yes	☐ No
American Indian	☐ Yes	☐ No	Other	☐ Yes	☐ No
Asian	☐ Yes	☐ No			

2. Does your location offer Non-English languages on site by qualified health-care interpreters?

American Sign Language (ASL)	☐ Yes	☐ No	Polish	☐ Yes	☐ No
Arabic	☐ Yes	☐ No	Portuguese	☐ Yes	☐ No
Cantonese	☐ Yes	☐ No	Russian	☐ Yes	☐ No
Haitian	☐ Yes	☐ No	Spanish	☐ Yes	☐ No
Hindi	☐ Yes	☐ No	Tagalog	☐ Yes	☐ No
Italian	☐ Yes	☐ No	Vietnamese	☐ Yes	☐ No
Japanese	☐ Yes	☐ No	Other	☐ Yes	☐ No
Korean	☐ Yes	☐ No			
Mandarin	☐ Yes	☐ No			

3. Do you supply translation services for written materials? ☐ Yes ☐ No

4. Please specify what accessible types of options you have for individuals with physical disabilities?

Parking spaces, curb ramps or loading zones at building entrance: ☐ Yes ☐ No
Doorways wide enough to ensure safepassage by individuals using mobility aids: ☐ Yes ☐ No
Wheelchair accessible restrooms with grab bars and accessible: ☐ Yes ☐ No
ASL signage and raised tactile text characters at office or elevator: ☐ Yes ☐ No
Medical equipment accessible to patients using mobility aids: ☐ Yes ☐ No
Exam rooms accessible to patients using mobility aids: ☐ Yes ☐ No

Other: _____

5. Does the practitioner have specialized training and experience in treating the following?

Physical disabilities	☐ Yes	☐ No
Intellectual and developmental disabilities	☐ Yes	☐ No
Chronic illness	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Serious mental illness	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No
Homelessness	☐ Yes	☐ No
Deafness or hard-of-hearing	☐ Yes	☐ No
Blindness or visual impairment	☐ Yes	☐ No
Co-occurring disorder	☐ Yes	☐ No

Other: _____

6. Is the practitioner's location an accessible public transportation route? ☐ Yes ☐ No

Long-Term Services and Supports Provider Demographic Information

(LTSS providers - Please complete pages 6 and 7.)

Provider Name: _____

DADS Contract ID(s) (Required): _____, _____, _____, _____, _____

NPI or LTSS/API Number: _____

Please select service type and specify Rate Enhanced Level (if applicable):

LTSS Service	Enhancement Level
☐ Adult Day Care (X1)	
☐ Primary Home Care/PAS (X2)	
☐ Transitional Assistant Services (TAS) (XY)	
☐ Financial Management Services (FMS) (XU)	
☐ Value Added (X3)	
☐ Assisted Living/Respite Care (X4)	
☐ Adult Foster Care (X5)	
☐ Emergency Response System (X6)	
☐ Nursing Facility (X7)	
☐ Home Delivered Meals (X8)	
☐ Adaptive Aides/Medical Equipment (X9)	
☐ Minor Home Modifications (XA)	
☐ Physical Therapy (XB)	
☐ Occupational Therapy (XC)	
☐ Speech Therapy (XD)	
☐ Employment Assistance Services (XE)	
☐ Habilitation (XH)	
☐ PAS for CFC only (XN)	
☐ Supported Employment (XS)	

Counties Served

(Please select each county where services can be provided, per each Service Delivery Area [SDA].)

Statewide ☐

Bexar SDA

- Atacosa ☐
- Bandera ☐
- Bexar ☐
- Comal ☐
- Guadalupe ☐
- Kendall ☐
- Medina ☐
- Wilson ☐

Dallas SDA

- Collin ☐
- Dallas ☐
- Ellis ☐
- Hunt ☐
- Kaufman ☐
- Navarro ☐
- Rockwall ☐

El Paso SDA

- El Paso ☐
- Hudspeth ☐

Harris SDA

- Austin ☐
- Brazoria ☐
- Galveston ☐
- Harris ☐
- Fort Bend ☐
- Matagorda ☐
- Montgomery ☐
- Waller ☐
- Wharton ☐

Nueces SDA

- Aransas ☐
- Bee ☐
- Brooks ☐
- Calhoun ☐
- Goliad ☐
- Jim Wells ☐
- Karnes ☐
- Kenedy ☐
- Kleberg ☐
- Live Oak ☐
- Nueces ☐
- San Patricio ☐
- Refugio ☐
- Victoria ☐

Hidalgo SDA

- Cameron ☐
- Duval ☐
- Hidalgo ☐
- Jim Hogg ☐
- Maverick ☐
- McMullen ☐
- Starr ☐
- Webb ☐
- Willacy ☐
- Zapata ☐

Jefferson SDA

- Chambers ☐
- Hardin ☐
- Jasper ☐
- Jefferson ☐
- Liberty ☐
- Newton ☐
- San Jacinto ☐
- Orange ☐
- Polk ☐
- Tyler ☐
- Walker ☐

Jefferson SDA

- Carson ☐
- Crosby ☐
- Deaf Smith ☐
- Floyd ☐
- Garza ☐
- Hale ☐
- Hockley ☐
- Hutchinson ☐
- Lamb ☐
- Lubbock ☐
- Lynn ☐
- Potter ☐
- Randall ☐
- Swisher ☐
- Terry ☐

Tarrant SDA

- Denton ☐
- Hood ☐
- Johnson ☐
- Parker ☐
- Tarrant ☐
- Wise ☐

MRSA Central SDA

- Bell ☐
- Blanco ☐
- Bosque ☐
- Brazos ☐
- Burleson ☐
- Colorado ☐
- Comanche ☐
- Coryell ☐
- DeWitt ☐
- Erath ☐
- Falls ☐
- Freestone ☐
- Gillespie ☐
- Gonzalez ☐
- Grimes ☐
- Hamilton ☐
- Hill ☐
- Jackson ☐
- Lampasas ☐
- Lavaca ☐
- Leon ☐
- Limestone ☐
- Llano ☐
- Madison ☐
- McLennan ☐
- Milam ☐
- Mills ☐
- Robertson ☐
- San Saba ☐
- Somervell ☐
- Washington ☐

Travis SDA

- Bastrop ☐
- Burnet ☐
- Caldwell ☐
- Fayette ☐
- Hays ☐
- Lee ☐
- Travis ☐
- Williamson ☐

MRSA West SDA

- Andrews ☐
- Archer ☐
- Armstrong ☐
- Bailey ☐
- Baylor ☐
- Borden ☐
- Brewster ☐
- Briscoe ☐
- Brown ☐
- Callahan ☐
- Castro ☐
- Childress ☐
- Clay ☐
- Cochran ☐
- Coke ☐
- Coleman ☐
- Collingsworth ☐
- Concho ☐
- Cottle ☐
- Crane ☐
- Crockett ☐
- Culberson ☐
- Dallam ☐
- Dawson ☐
- Dickens ☐
- Dimmit ☐
- Donley ☐
- Eastland ☐
- Ector ☐
- Edwards ☐
- Fisher ☐
- Foard ☐
- Frio ☐
- Gaines ☐
- Glasscock ☐
- Gray ☐
- Hall ☐
- Hansford ☐
- Hardeman ☐
- Hartley ☐
- Haskell ☐
- Hemphill ☐
- Howard ☐
- Irion ☐
- Jack ☐
- Jeff Davis ☐
- Jones ☐
- Kent ☐
- Kerr ☐
- Kimble ☐
- King ☐
- Kinney ☐
- Knox ☐
- La Salle ☐
- Lipscomb ☐
- Loving ☐
- Martin ☐
- Mason ☐
- McCulloch ☐
- Menard ☐
- Midland ☐
- Mitchell ☐
- Moore ☐
- Motley ☐
- Nolan ☐
- Ochiltree ☐
- Oldham ☐
- Palo ☐
- Pinto ☐
- Parmer ☐
- Pecos ☐
- Presidio ☐
- Reagan ☐
- Real ☐
- Reeves ☐
- Roberts ☐
- Runnels ☐
- Schleicher ☐
- Scurry ☐
- Shackelford ☐
- Sherman ☐
- Stephens ☐
- Sterling ☐
- Stonewall ☐
- Sutton ☐
- Taylor ☐
- Terrell ☐
- Throckmorton ☐
- Tom Green ☐
- Upton ☐
- Uvalde ☐
- Val Verde ☐
- Ward ☐
- Wheeler ☐
- Wichita ☐
- Wilbarger ☐
- Winkler ☐
- Yoakum ☐
- Young ☐
- Zavala ☐

Application Attestation

- **Every question on this page must be answered.**
- **Please provide a detailed explanation on a separate sheet for any question(s) answered Yes.**
- **Modifications to the wording or format of this page will invalidate this attestation.**

1. Has this facility, under any current or former name or business entity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of health-care item or service?

   ☐ Yes ☐ No

2. Has this facility, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked, suspended or been issued a conditional license? This includes the surrender of such license while a formal disciplinary proceeding was pending before a state licensing authority.

   ☐ Yes ☐ No

3. Has this facility, under any current or former name or business identity, ever had accreditation revoked or suspended?

   ☐ Yes ☐ No

4. Has this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by a federal or state health-care program, or any disbarment from participation in any federal executive branch procurement or non-procurement program?

   ☐ Yes ☐ No

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire application are true, accurate and complete to the best of my knowledge.

I fully understand that any falsification of participating providers is cause for summary dismissal from Superior HealthPlan. I understand that acceptance of this application does not constitute approval or acceptance of participating status with Superior HealthPlan, and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is received.

_____ _____

Printed Name of Authorized Representative | Title of Authorized Representative

_____ _____

Signature of Authorized Representative | Date Signed

Credentialing Contact Information

Contact Name: _____ Contact Title: _____

Phone: _____ Fax: _____

Email: _____

Participating Provider Conflict of Interest, Health Care Entity Financial Interest Policy and Disclosure Statements

It is the policy of Superior HealthPlan, Inc. (Superior) that no provider participating in Superior's network shall use his or her position as a contracted provider, or knowledge gained in such position, in such a way that creates conflicts of interest (COI) with Superior, its parent company, an affiliate, subsidiary, or related corporation. The term COI refers to any situation or position in which personal interests (of the provider or a "related party")[1] conflict with organizational interests, affecting an individual's ability to make impartial decisions. Training and education are provided to promote COI awareness among all of Superior's providers. Superior also offers numerous avenues for providers to ask questions and receive information about identifying and disclosing COI.

Providers are responsible for disclosing actual, potential, or perceived COI on this form at the time they apply to join or to be recredentialed to remain in Superior's network. They are also responsible for promptly disclosing COI that may arise later, after they have joined Superior's network.

Process for Disclosing Actual, Potential or Perceived Conflicts Of Interest

1. All questions about, and disclosures of, COI should be directed to the Provider's local Superior ProviderServices Representative.
2. Identify COI by consulting with the Superior's Provider Services staff or referring to the examples listed in Attachment A to this Policy.
3. Disclose actual, potential, or perceived COI before taking any action that may appear to be influenced by the conflict.
4. Avoid participating in the activity in question until Superior determines whether a COI exists.
5. If a Conflict of Interest is determined to be real, Superior's Compliance Director will document and report the decision to the provider involved.

[1] A "related party" is defined as a provider's spouse, parents, step parents, children, step- children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, same or opposite sex domestic partner.

Health Care Entity Financial Interest Disclosures

It is also the policy of Superior HealthPlan that all providers participating in its network shall disclose to Superior any and all Financial Interests, including "Controlling Interests,"[2] such providers or any of their related parties may have in a "Health Care Entity."

For purposes of this policy and the disclosure required herein, a "Health Care Entity" is defined to mean any provider of health care services, in whatever form that provider may be organized (to include but not be limited to a corporation, a partnership, a professional association, a limited liability company, or a professional corporation) and no matter what type of services the provider may provide or be licensed to provide (to include but not be limited to, therapy services, hospital services, pharmacy services, laboratory services, radiology services, physician services, home health services, etc.).

Providers are responsible for disclosing any such Financial Interest on this form at the time they apply to join or to be recredentialed to remain in Superior's network. They are also responsible for promptly disclosing any such Financial Interest that may arise later, after they have joined Superior's network.

Providers who have questions about whether an interest or relationship they have with a Health Care Entity or other provider constitutes a Financial Interest that should be disclosed to Superior should contact their local Provider Services Representative to discuss.

Examples of Health Care Entity Financial Interests that should be disclosed pursuant to this policy include:

1. A physician applying to join or being recredentialed in Superior's network owns an interest in a pharmacy;
2. The spouse of a provider joining or being recredentialed in Superior's network owns a therapy services company;
3. A provider joining or being recredentialed in Superior's network owns an interest in a hospital or owns a company that leases facility space to a hospital; or
4. A physician being contracted/credentialed or recredentialed by Superior has a Financial Interest in aHealth Care Entity that provides a "Designated Health Service" (clinical laboratory services; physical,occupational, or speech pathology services; radiation therapy services and supplies; radiology andcertain other imaging services; durable medical equipment services and supplies; prosthetics andorthotics services, and prosthetic devices and supplies; parenteral and enteral nutrients, equipment and supplies; home health services; outpatient prescription drug services; inpatient and outpatient hospitalservices; and/or nuclear medicine).

[2] A "Financial Interest" refers to any ownership interest you have in any corporation (whether for profit or nonprofit), limited liability company, partnership or other business organization other than beneficial ownership in a publicly traded company of less than 5%. A "Controlling Interest" shall include an interest by which you have the power to vote for the election of directors, managers or other management of a person or entity or the power to direct or cause the direction of the management or policies of a person or entity. A "Financial Interest" also refers to a financial arrangement you may have with the Health Care Entity, such as an employment agreement, services contract, consulting arrangement, lease or equipment-sharing agreement.

Conflict of Interest Disclosure Statement

I, _____ , hereby declare that I (or a related party) **Do** ☐ **Do not** ☐ have an actual, potential or perceived Conflict of Interest that I wish to disclose to Superior HealthPlan, Inc.

Such disclosure must include, , the legal name of the entity involved, its business address, its federal tax ID number, its principal line(s) of business, and the provider's ownership interest (by percentage) and/or management role (including title) with the entity.

If I checked "do" above, the following is a summary of my disclosure, including all material facts and the above-listed items of information (use additional paper as necessary):

Legal name of the entity involved: _____

Business address: _____

_____

Federal tax ID number: _____

Provider's ownership interest (e.g., type and percentage): _____

_____

Entity's principal line(s) of business: _____

_____

Signed: _____

Name: _____

Title: _____

Date: _____

Financial Interest Disclosure Statement

Name: _____ **Filing Period:**

Title: _____ Annual _____ Interim

FINANCIAL INTEREST

1. **Do you or a related party (see definition above) have a direct or indirect ownership or investment interest in any entity* (see definition below)?**

   ☐ **Yes** ☐ **No**

2. **Do you or a related party have a compensation arrangement with any entity*?**

   ☐ **Yes** ☐ **No**

*An entity is any provider, supplier, or business that provides any form of healthcare services or products.

Disclosure of Interest

If you answered YES to any of the above questions, please explain in detail the financial interest or relationship being reported (use separate sheet as needed). Please include the legal name of entity, business address, Federal tax ID number, ownership interest amount, and entity's line of business:

CERTIFICATION

To the best of my knowledge and belief, I hereby certify that the information provided above accurately and completely describes all financial and other interests, which are required to be reported. If any situation should arise in the future which may involve me in a conflict of interest, I will promptly provide a new Disclosure Statement to Superior Health Plan, Inc.

Signature: _____ Date: _____

Typed/Printed Name: _____

Disclosure of Private Equity Ownership or Prior Contracts or Business with Superior HealthPlan

Does a Private Equity Firm have ownership in any of your Home Health, Rehabilitation, Nursing or Hospice Facilities? ☐ **Yes** ☐ **No**

Have You or any Affiliate ever held (prior to now) a provider contract or done other Business with Superior HealthPlan or any of its Affiliates? ☐ **Yes** ☐ **No**

If yes, please identify the name of such entity and its relationship to You below. As used above, the capitalized terms are defined as follows:

"You" means the individual, partnership, corporation or other entity that is entering into a provider agreement with Superior HealthPlan, Inc.

"Affiliate" means an entity that is related by ownership (of any amount) or control (by sharing the same officers or directors) to You or to Superior HealthPlan

"Business" means holding a contract for provider services, vendor services or other services with Superior HealthPlan or an Affiliate of Superior HealthPlan.

If You answered "yes" above, please provide the following information (use additional paper as necessary):

Legal name of the entity with a Prior Contract or Other Business: _____

_____

Business address of such entity: _____

_____

Federal tax ID number of such entity: _____

Entity's relationship to You: _____

_____

Signed: _____

Name: _____

Title: _____

Date: _____

Examples of Areas for Potential Conflicts of Interest

Including but not limited to:

1. Contracts or transactions between Superior and the provider or a related party (other than the participating provider agreement).
2. Contracts or transactions between Superior and any other profit or nonprofit company, corporation,firm, association, or entity of which the provider or a related party is a director, partner, officer,consultant or other unspecified affiliate.
3. Contracts or transactions between Superior and any other corporation, firm, association, or entity inwhich the provider or a related party has some financial interest, other than an interest in securitiespublicly traded on a national exchange with a market value of less than $25,000, regional or localsecurities in which the ownership interest does not exceed five percent (5%) of those securitiesoutstanding, or securities in which the ownership interest is a time or demand deposit in a financialinstitution or an insurance policy.
4. Contracts or transactions to which Superior is a party, where the provider or a related party stands to profit individually and thus encourages Superior to purchase certain goods or services.
5. Contracts or transactions involving a business or other entity that competes with Superior's activities,where the provider or a related party has any ownership, directorship, or other similar interest in thecompeting business or entity.

   NOTE: This example is not to be construed to mean, and does not mean, that providers may notcontract with Superior's competitors to be participating providers in those competitors' networks. Thisexample is in no way meant to be interpreted as an "exclusivity provision."
6. To buy, sell or lease any kind of property, facilities or equipment from or to Superior or to anycompany, firm or individual who is or is seeking to become a contractor, supplier or customer ofSuperior, without first making disclosure of such transaction.
7. Any occasion to accept commissions, a share or other payments, loans, services, personal travel or gifts or entertainment of excessive value, from any individual or entity doing, or seeking to dobusiness with Superior.

COI and Disclosure Questionnaire

If you answered "Do" on page 11, "yes" on page 12, OR "yes" on page 13, please complete this questionnaire.

1. What type of services are provided at the conflicted entity you described above? (see definition ofentity below)

2. Are you authorized to perform services at the conflicted entity?

   _____

3. Do you currently perform services at the conflicted entity?

   _____

4. What percentage of your services are performed at the conflicted entity?

   _____

5. Please describe the billing arrangement at the conflicted entity.

6. Does the conflicted entity bill Medicare, and/or Medicaid?

   _____

*An entity is any provider, supplier, or business that provides any form of healthcare services or products.

Mental Health Rehabilitation Services and Mental Health Targeted Case Management

*Complete if selected Targeted Case Management (TCM)/Senate Bill 58 (Certificate Required) on page 3 of "Certifications."

Provider Attestation
Senate Bill 58

WHEREAS, Integrated Mental Health Services d/b/a Superior HealthPlan ("Superior"), has executed an Agreement with _____ ("Entity") dated _____ pursuant to which Entity has agreed to provide Covered Services to Superior Covered Persons through Entity Clinicians (the "Agreement"); and WHEREAS, Entity has requested that the undersigned ("Entity") annually attest to the ability to provide Mental health rehabilitative services and Mental health targeted case management as required by Senate Bill 58 of the 83rd Legislative Session; and WHEREAS, as a condition of such participation and Entities designation under this Agreement, Entity provider must satisfy Superior's training and certification requirements and execute this Attestation acknowledging their agreement to comply with, and be bound by, the terms and conditions of the Attestation. NOW THEREFORE, Entity hereby agrees as follows, and attests that:

1. Participating Providers are trained and certified to administer, the ANSA and/or CANS assessment tools,agrees to use these tools to recommend a level of care by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system.
2. The Participating Provider has completed all training requirements outlined in the HHSC Uniform ManagedCare Manual (UMCM) Chapter 15.3 before delivering any mental health rehabilitation and mental health targetcase management services.
3. The Participating Entity will complete the Texas Standard Prior Authorization Request Form for all Level of Care (LOC) 4 and LOC deviations and will submit to Superior.
4. The Participating Entity will provide Mental Health Rehabilitative Services and Targeted Case Management using the Department of State Health Services (DSHS) Texas Resiliency and Recovery (TRR) Utilization Management Guidelines and the ANSA or the CANS tools for assessing a member's needs for services.
5. The Participating Entity has the ability to provide Covered Persons with the full array of TTR services either directly or through sub-contract.
6. The Participating Entity is familiar with HHSC's cost reporting process and will participate in this process.

Signature Block to Follow

Entity Name (print): _____

Entity Signature: _____

Signature Date: _____

NPI Number: _____

State Medicaid Number: _____

For questions, please contact Superior Provider Services at 1-877-391-5921.