PARTICIPATING PROVIDER AGREEMENT WITH HIGHMARK BLUE SHIELD

(AGRPBS)

Under the applicable laws of the Commonwealth of Pennsylvania, I am duly authorized to engage in the practice of ________________________________. In consideration of being registered by Highmark Inc. d/b/a Highmark Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association (hereinafter termed "Blue Shield"), as a participating provider, I do hereby agree as follows:

I will perform services for Blue Shield members, make reports to Blue Shield concerning such services and accept compensation therefore, as provided for in the Blue Shield Regulatory Act, as heretofore or hereafter reenacted or amended, and the Bylaws, the applicable Regulations, the applicable Subscription Agreements and Master Contracts, all as heretofore or hereafter adopted or entered into by Blue Shield under authority of said Regulatory Act, with any required governmental approval.

Copies of the Blue Shield Regulatory Act, and the Bylaws, Regulations, Subscription Agreements and Master Contracts referred to in this Agreement shall be available for examination by me during regular business hours at the principal office of Blue Shield. A copy of the Regulations shall be provided to me upon execution of this Agreement and thereafter upon my request.

I understand that this Agreement constitutes a contract between Blue Shield and me, that Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Shield to use the service mark in the Commonwealth of Pennsylvania, and that Blue Shield is not contracting as the agent of the Association. I further understand and agree that I have not entered into this Agreement based upon representations by any person other than Blue Shield and that no person, entity or organization other than Blue Shield shall be held accountable or liable to me for any of Blue Shield's obligations created under this Agreement.

This Agreement shall continue in effect until terminated by me giving thirty (30) days prior written notice to Blue Shield, unless the Regulations provide otherwise; or until terminated by Blue Shield with the approval of the Pennsylvania Department of Health.

____
Signed

____
Name - *Please print*

____
Date

____
Specialty

____
Social Security number

____
Pennsylvania license number**

Attach a copy of your current Pennsylvania license.

____
Accepted by

____
Date

____
Highmark Blue Shield provider number

Mail To:

PROVIDER DATA SERVICES
POST OFFICE BOX 898842
CAMP HILL, PA 17089-8842

Main practice address* (primary physical practice location)

____
Street

____
City State ZIP code

( ) ______________________________
Telephone number

Mailing address (if different from above)*(where administrative work is done)

____
Street

____
City State ZIP code

Previous main practice address (if at current address less than two years)

____
Street

____
City State ZIP code

Check address* (address to which checks are sent)

____
Street

____
City State ZIP code

Is this a lockbox? ❑ Yes ❑ No

* YOUR PROVIDER RECORD WILL BE UPDATED BASED ON THE INFORMATION REPORTED ON THIS AGREEMENT.
** ACTIVE PENNSYLVANIA LICENSE IS REQUIRED TO BECOME PARTICIPATING.

815 R 5/03

Request for Addition / Deletion to Existing Assignment Account

Name of account ______________________ **Group Account number** ______________________

IRS number ______________________ **Effective date of change** ______________________

Practice address ______________________ **Specialty** ______________________

______________________ ❑ **Change current specialty**

______________________ *Note: For address changes, please complete the PDS Change of Address form (9111).*

Provider name (Typed or printed)	Provider number	Social Security number	Provider signature (Required for additions)	Applicable to: All Highmark Blue Shield networks	Indicate Add ①	Delete ②

① *By my signature, I, as a member of this account, fully agree to abide by the requirements listed on the reverse side of this form.*

② *Deletions - Please provide the following information for providers being deleted from the assignment account:*

Provider name (Typed or printed)	Provider number	New address	New telephone number
			( )
			( )

Mail to: **Provider Data Services**
PO Box 898842
Camp Hill, PA 17089-8842

Fax to: (866) 731-2896

(Please read and sign on the reverse side)

Assignment Account Requirements

1. We hereby agree to only bill those services performed by providers in our account as called for in our written contractual arrangement with Highmark Blue Shield and its subsidiaries.

2. We certify that each member agrees to assign his or her fee to the group account.

3. We agree that every claim submitted to Highmark Blue Shield will include the provider number of the individual provider who actually performed the service. (Place in Block 24K of the claim form.)

4. We agree that the account and each individual member will be jointly and severally liable for any overpayment that the account receives.

5. We agree to notify Highmark Blue Shield, in writing, of any subsequent changes in the membership of the account prior to the effective date of each change.

6. We agree to inform Highmark Blue Shield of any change in the group's contractual arrangements that would necessitate Highmark Blue Shield payments to be made to some entity other than that designated in this assignment account application.

7. We have carefully reviewed the forms and applications associated with the establishment of this assignment account, and each member has verified the accuracy and completeness of all information provided.

8. We understand that for certain networks all individual providers in the group must have the same network status to be added to the groups. Providers may not be added to a group if they have not completed the credentialing process.

On behalf of the group, I verify that all members have reviewed and agree to all assignment account requirements, all applicable network contracts and regulations.

____ __________________________

Signature of authorized representative of group Date

____ (   ) ____________________

Title Telephone number