Medical Services agrees to the following:

1. Provide a current list of recipients assigned to the Provider.
2. Reimburse the Provider a monthly per member per month fee for each enrolled and eligible recipient on the Provider's caseload.
3. Reimburse the Provider additional fees for covered services that they qualify for and bill for.
4. Maintain program guidance in an online provider manual and post notice of changes to the provider manual.

TO BE COMPLETED BY PROVIDER

I declare and affirm under the penalties of perjury that this Agreement has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further declare and affirm under the penalties of perjury that any claim to be submitted pursuant to this Agreement will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct.

Provider Name

Name: ____

(Printed Legal Name of Individual Provider for Individual Enrollment)

Signature: ____Date: _____________

(Must be Individual Provider)

Servicing NPI: ____

Information for Pregnancy Program List

Address: ____

Provider Credentials: _____________________

Phone Number: _____________________

Clinic Contact Person: ____

Billing NPI(s): ____