

## Provider Contract Provisions Section

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### PROVIDER CONTRACT PROVISIONS

#### **Provision of Services Policy**

Provider shall establish effective procedures, including an appropriate call system if necessary, to provide for the availability and accessibility of medically necessary services 24 hours a day, seven days a week. Provider shall provide or arrange for the provision of covered services to members as promptly as reasonable, consistent with the professional standards for the community in which such services are provided.

Provider shall render all covered services consistent with the referral requirements and restrictions (including those generally limiting referrals to only those providers which have been contracted with Physicians Plus except where otherwise authorized by Physicians Plus in writing).

Provider shall render all covered services according to the rules and procedures set forth in the Benefits Contract or as instructed by Physicians Plus.

Provider shall not utilize the services of any provider who has not been credentialed by Physicians Plus to cover for the Provider unless on a locum tenens basis. A provider may not utilize such locum tenens provider to cover for him without first providing notice to Plan of the period and extent of coverage anticipated.

#### **Hold Harmless Provision**

Provider agrees that in no event, including but not limited to non-payment by Physicians Plus, shall Provider bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency, or have any recourse against a member or any person acting on his behalf for any medical services provided under their Agreement or for any other services covered by the member's Benefit Contract. This restriction shall not apply to charges for non-covered services, deductibles, and copayments, which shall be the responsibility of the member and which shall be billed directly by Provider to the member. This provision shall survive the termination of their Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the members.

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### **Operating Rules and Procedures**

Provider shall cooperate with and abide by the rules, regulations, programs, and procedures established from time to time by Physicians Plus, including, but not limited to, quality assurance protocols, external and internal peer review programs, utilization control mechanisms, member grievance procedures, and credentialing and recredentialing procedures.

### **Information**

Provider agrees to provide Physicians Plus such patient histories, review processes, notification of third-party liability and other insurance coverage, records, authorizations, and other information regarding members as may be reasonably required by Physicians Plus for the proper administration of the Benefit Contracts.

### **Medical Records**

Provider shall maintain medical histories, charts, and records for each member in accordance with industry standards. All such records shall remain the property of Provider, subject to the rights of the member. Provider and Physicians Plus agree that all members' medical records shall be confidential as required by state and federal laws. Subject to the foregoing sentence, Physicians Plus shall have the right, upon request, to inspect at all reasonable times any medical records pertaining to members for claims payment determination, utilization review, quality assurance, or other lawful purposes and to obtain copies of medical records as may be necessary to achieve those purposes.

Provider shall provide Physicians Plus, free of charge, copies of medical records requested by Physicians Plus for claims payment determination, utilization review and quality assurance, and Physicians Plus agrees to reimburse Provider for Provider's actual photocopying costs for medical records requested by Physicians Plus for any other purpose, including, but not limit to, audits and underwriting.

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### **Provider Appeals Process**

At times, a provider may be dissatisfied with a decision made by Physicians Plus Insurance Corporation.

If you wish to appeal a decision regarding a claim denial or prior authorization of services, appeals must be submitted to Physicians Plus within six (6) months, unless specifically stated otherwise in the provider agreement, from the occurrence of the event that is the basis for the appeal.

Appeals should be directed via mail or fax to the Appeal and Compliance Administrator.

**Appeal and Compliance Administrator  
Physicians Plus Insurance Corporation  
22 East Mifflin Street, Suite 200  
Madison, WI 53703**

**Fax: (608) 258-1912**

The appeal will be reviewed to make sure that it is a provider appeal and not a grievance on the member's behalf. You will be contacted via phone or in writing to inform you that the appeal has been received, and you will be notified once a decision has been made.

We believe an important way to obtain feedback is to listen to the concerns of our providers, and determine how we can improve our communication with you, our members and our staff. We appreciate the time you take to provide us with feedback.