If your group is currenlty contracted with McLaren Health Plan and you would like to add a new physician to that contract, please fill out the following provider profile and press submit.

Contract Provider Addition

PROVIDER NAME :

GROUP PRACTICE NAME (if applicable):

INDIVIDUAL NPI#: GROUP NPI #:

CAQH#: LICENSE #:

TIN: SPECIALITY:

PCP: ____YES or ____NO BOARD CERTIFIED: ____YES or ____NO

PRIMARY HOSPITAL AFFILIATION:

PRIMARY PRACTICE ADDRESS:

CITY, STATE, ZIP(ZIP MUST BE 9 DIGITS):

PRIMARY PRACTICE PHONE NUMBER:

PRIMARY PRACTICE FAX NUMBER:

SECONDARY PRACTICE ADDRESS:

CITY, STATE, ZIP(ZIP MUST BE 9 DIGITS):

SECONDARY PRACTICE PHONE NUMBER:

SECONDARY PRACTICE FAX NUMBER:

BILLING ADDRESS:

CITY, STATE, ZIP(ZIP MUST BE 9 DIGITS):

PAY TO ADDRESS:

CITY, STATE, ZIP(ZIP MUST BE 9 DIGITS):

CONTACT NAME & TITLE :

CONTACT PHONE: FAX: EMAIL:

PHO PHYSICIAN AFFILIATION ACKNOWLEDGMENT
BETWEEN
MCLAREN HEALTH PLAN, INC., MCLAREN HEALTH PLAN COMMUNITY, INC. AND HEALTH ADVANTAGE, INC.
AND
OAKWOOD ACCOUNTABLE CARE ORGANIZATION, LLC

PHYSICIAN AFFILIATION ACKNOWLEDGEMENT

This PHO Physician Affiliation Acknowledgment ("**Acknowledgement**") is effective _____ (date assigned by Plan), by and among McLaren Health Plan, Inc., a non-profit health maintenance organization (**"HMO"**), for and on behalf of itself and its subsidiaries, Health Advantage, Inc., a Michigan for-profit corporation and third party administrator and McLaren Health Plan Community, a non-profit corporation and HMO, (each a **"Plan"** and collectively the **"Plans"**) and **OAKWOOD ACCOUNTABLE CARE ORGANIZATION, LLC**, a Physician Hospital Organization (**"PHO")** and _____ (**"Provider"**), who is a member of the PHO.

Recitals

A. The Plans and PHO entered into a Physician Hospital Agreement (**"Agreement"**); and

B. Provider desires to participate in the Agreement and be bound by the terms of the Agreement and this Acknowledgment.

The parties agree as follows:

1. GENERAL PROVISIONS

1.1 Agreement. Provider acknowledges that Provider has received a copy of the Agreement and Provider agrees to be bound by the terms of it. As a condition to Provider's Participating Provider status, Provider agrees that PHO has authority to execute participation agreements and other participation-related contracts, amendments and other documents with the Plans on Provider's behalf. Provider agrees to be bound by any such agreement, amendment or other document.

1.2 Member Hold-Harmless. Provider shall only look to a Plan for compensation for services rendered to a Member when the services are covered by the Plan. Provider shall not bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member (other than the Plan), except if the applicable Certificate of Coverage specifies a Copayment, Coinsurance or Deductible must be collected by Provider or as permitted under the coordination of benefits section of this Agreement. Provider shall not maintain any action at law or in equity against a Member to collect sums that are owed to Provider under the terms of this Agreement, even if the Plan fails to pay, under the terms of the Agreement, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This section will survive termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. The Parties do not intend this section to apply to the collection of sums that are owed to Provider for services provided after this Agreement has terminated,

except as otherwise provided in this Agreement, or to services that are not Covered Services or to Copayments, Deductibles or Coinsurance. Provider further agrees that this provision supersedes any oral or written agreement entered into between Provider and any Member or person acting on a Member's behalf, if the agreement relates to payment for services provided under the terms and conditions of this Agreement.

1.3 Compliance with Laws, Regulations and Instructions. Provider agrees that he/she will comply with all applicable laws, regulations and instructions including, without limitation, Medicare laws and CMS instructions. [42 CFR Sections 422.504(i)(4)(v)]

1.4 Obligations of Recipients of Federal Funds. Provider acknowledges that payments to Provider pursuant to this Acknowledgment are made, in whole or in part, from federal funds and that this Acknowledgment is subject to all laws applicable to entities and individuals receiving federal funds. Provider shall comply with all requirements of laws applicable to recipients of federal funds, including the False Claims Act (32 USC 3729, et. seq.), the Anti-Kickback Statue (section 1128B(b)) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

1.5 Adverse Actions.

A. No Adverse Actions or Investigations. Provider asserts that, to the best of his/her knowledge, information and belief, there are no pending investigations, legal actions, or matters subject to arbitration involving Provider, employees, contractors, board members, or any major shareholders (5% or more) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.

B. No Criminal Convictions or Civil Judgments. Provider asserts that, to the best of his/her knowledge, information and belief, neither Provider nor any of its employees, contractors, board members, or any major shareholder (5% or more) has been criminally convicted or had a civil judgment entered against it for fraudulent activities, nor has Provider been sanctioned under any Federal program involving the provision of health care or prescription drug services.

C. No Excluded Or Debarred Individuals. Provider asserts that, to the best of his/her knowledge, information and belief, neither Provider nor any employees, contractors, board members, or any major shareholders (5% or more) appears on the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General, nor on the List of Debarred Contractors as published by the General Services Administration. The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be accessed online at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp. The System for Award Management can be found at http://sam.gov/.

D. Notice of Change of Circumstances. Provider is obligated to notify the Plans promptly of any change in circumstances occurring after the effective date of this Acknowledgment which would require a modified response to paragraphs A – C above.

E. Audit Compliance. The Plans reserve the right to audit Provider for compliance and/or to request verification that employees, contractors, board members, and major shareholders

have been checked against the List of Excluded Individual/Entities and the List of Debarred Contractors on at least an annual basis.

1.6 Certification of Accuracy of Data. If Provider generates data to determine payment on behalf of the Plans, then Provider must certify (based on best knowledge, information and belief) as to the accuracy, completeness, and truthfulness of the data.

1.7 Automatic Incorporation of MDHHS or CMS Requirements. Provider agrees to incorporate into this Acknowledgment such other terms and conditions as MDHHS or CMS may find necessary and appropriate, including amendments to MDHHS or CMS rules, regulations and guidance. Provider also agrees to incorporate into its downstream contracts all terms and conditions contained in this Acknowledgment and the Agreement.

1.8 Notification Requirements. Provider shall promptly provide written notice to the Plans of any changes in address, telephone number, and hours of operation.

1.9 Amendments. This Acknowledgment may be amended by the Plans in accordance with the terms of the Agreement.

1.10 Product Specific Requirements. If Provider participates in a Product, Provider shall comply with the requirements attached to the Agreement that are specific to the Product. Specifically, for Exchange products, Provider shall comply with the Exchange Regulatory Requirements Addendum. For Medicaid products (including Healthy Michigan), Provider shall comply with the Medicaid Regulatory Requirements in the Medicaid Requirements Addendum. For Medicare Advantage products, Provider shall comply with the Medicare Regulatory Requirements in the Medicare Requirements Addendum.

OAKWOOD ACCOUNTABLE CARE ORGANIZATION, LLC
Provider

_____
Provider Signature

_____ _____
Provider Name (Print or Type)

_____ _____
Date Provider Address

Provider agrees to participate in the following Plan Products:
[X] 1. Commercial and self-funded products.
[X] 2. Medicaid/MIChild (including Healthy Michigan) products.
[X] 3. Medicare Advantage products.

Execution of the PHO Physician Affiliation Acknowledgement by use of facsimile or electronically scanned signature will have the same force and effect as original signatures.

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.