Contract and Credentialing Checklist for Individual and Group Providers

Thank you for your interest in joining the Superior HealthPlan Network! Please use the checklist below to ensure you have all necessary contract and credentialing components to avoid processing delays.

Important Things to Note

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 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 that Superior collects during this process. However, this does not include references or recommendations or other information that is peer review protected.

Contract Steps

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

Documents Listed Below Must Be Fully Completed and Returned

☐ Practitioner Demographic Form(s) for each practitioner, containing your CAQH number. ENCLOSED
- Please ensure you have a current attestation in CAQH and that all the credentialing documents are current in the record. This is where we will obtain the credentialing documents.

☐ W-9, for each individual practitioner or one for a group. ENCLOSED
- Signed and dated with IRS registered legal business name and billing address information.
- Fill in the legal name on the first line. This must match the practitioner name on the contract.
- Populate only one SSN or EIN/TIN on form. Do not complete an SSN and TIN on the same form.

☐ Signed and dated Participating Practitioner Agreement. SENT SEPARATELY
- Return entire original contract.
- Do not populate any effective dates.

☐ Certification documentation (per pages 5-6 – Treatment Expertise/Specialties) if applicable. ENCLOSED

☐ Read and complete the Participation Practitioner Conflict of Interest and Healthcare Entity Financial Interest Policy and Disclosure Statement in its entirety. ENCLOSED
- Ensure you have selected either "I do" or "I do not" on page 10, as well as "Yes" or "No" on page 11 and 12. Each practitioner must complete this form and it cannot be completed by a practitioner's agent, such as an office manager. The practitioner him/herself must complete this form.

☐ Signed and dated Participating Provider Attestation on page 15.

Return all documents to:

Mail: Superior HealthPlan, ATTN: Contract Management, 7990 Interstate 10 Frontage Rd, Ste. 300, San Antonio, Texas 78230

Email: SHP.NetworkDevelopment@SuperiorHealthPlan.com

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

Provider Profile

Group Practice Name: Date:

Billing Tax ID: Group NPI:

Practitioner Information

Professional Category: MD ☐ DO ☐ DPM ☐ DC ☐ NP ☐ PA ☐ Other:

Applying As: PCP ◯ Specialist (non-PCP) ◯ PCP/Specialist ◯

Practitioner First Name: Practitioner Last Name:

Date of Birth: Social Security Number:

Specialty: Subspecialty:

Practitioner Website: Practitioner Email:

CAQH Number: Practitioner NPI Number:

If practitioner is not registered with CAQH, please provide a current TDI Credentialing application with a current date and signature.

Is the practitioner hospital based? Yes ◯ No ◯ Note: A yes response indicates the practitioner only practices in a hospital.

Practice Restrictions: Ages ____ to ____ Male Only ◯ Female Only ◯ Accepting New Patients Yes ◯ No ◯

Credentialing Contact Name: Contact Email:

Does the practitioner perform Advanced Imaging Services (CT/CTA, MRI/MRA, PET Scan)? Yes ◯ No ◯

Race/Ethnicity (Optional)

Please Note: If you do not want to disclose your race/ethnicity please select "Not Provided"

___ White
___ Black
___ Asian or Pacific Islander
___ American Indian or Alaskan Native
___ Hawaiian
___ Non-Hispanic
___ Hispanic/Latino and American Indian/ Alaskan Native
___ Hispanic/Latino and Asian
___ Hispanic/Latino and Black
___ Hispanic/Latino and White
___ Hispanic / Latino and Native Hawaiian or Other Pacific Islander
___ Other:
☐ Not Provided

STAR Health (Foster Care) Practitioners Only

Does the practitioner have experience in treating any of the following:

Children with Post-traumatic Stress Disorder ☐
Children with sexual abuse ☐
Children with developmental disabilities ☐
Children with physical abuse ☐
Members with Special Health Care Needs (MSHCN) ☐

Does the practitioner have experience with:

Evidence-based practices (EBPs) modalities or promising practices such as TIC? ☐

Data Element Requirements for Practice Locations

	Street Address, City and Zip	Phone Number	Ext
Primary			
Practice 2			
Practice 3			
Practice 4			

	Primary	Practice 2	Practice 3	Practice 4
1. Does this location offer non-English languages (including ASL) on site by qualified healthcare interpreters?				
American Sign Language	☐	☐	☐	☐
Arabic	☐	☐	☐	☐
Cantonese	☐	☐	☐	☐
French	☐	☐	☐	☐
German	☐	☐	☐	☐
Haitian	☐	☐	☐	☐
Hindi	☐	☐	☐	☐
Italian	☐	☐	☐	☐
Japanese	☐	☐	☐	☐
Korean	☐	☐	☐	☐
Mandarin	☐	☐	☐	☐
Polish	☐	☐	☐	☐
Portuguese	☐	☐	☐	☐
Russian	☐	☐	☐	☐
Spanish	☐	☐	☐	☐
Tagalog	☐	☐	☐	☐
Vietnamese	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐
2. Does this location supply translation services for written materials?	☐	☐	☐	☐
3. What accessibility options does this location offer for individuals with physical disabilities?				
Parking spaces, curb ramps, or loading zones at building entrance	☐	☐	☐	☐
Doorways wide enough to ensure safe passage by individuals using mobility aids	☐	☐	☐	☐
Wheelchair accessible restrooms with grab bars and accessible	☐	☐	☐	☐
ASL Signage and raised tactile text characters at office or elevator	☐	☐	☐	☐
Medical equipment accessible to patients using mobility aids	☐	☐	☐	☐
Exam rooms accessible to patients using mobility aids	☐	☐	☐	☐
4. Is this location an accessible public transportation route?	☐	☐	☐	☐
5. What are the location days and hours of operation?	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____

Data Element Requirements for Additional Locations

	Street Address, City and Zip	Phone Number	Ext
Practice 5			
Practice 6			
Practice 7			
Practice 8			

	Practice 5	Practice 6	Practice 7	Practice 8
1. Does this location offer non-English languages (including ASL) on site by qualified healthcare interpreters?				
American Sign Language	☐	☐	☐	☐
Arabic	☐	☐	☐	☐
Cantonese	☐	☐	☐	☐
French	☐	☐	☐	☐
German	☐	☐	☐	☐
Haitian	☐	☐	☐	☐
Hindi	☐	☐	☐	☐
Italian	☐	☐	☐	☐
Japanese	☐	☐	☐	☐
Korean	☐	☐	☐	☐
Mandarin	☐	☐	☐	☐
Polish	☐	☐	☐	☐
Portuguese	☐	☐	☐	☐
Russian	☐	☐	☐	☐
Spanish	☐	☐	☐	☐
Tagalog	☐	☐	☐	☐
Vietnamese	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐
2. Does this location supply translation services for written materials?	☐	☐	☐	☐
3. What accessibility options does this location offer for individuals with physical disabilities?				
Parking spaces, curb ramps, or loading zones at building entrance	☐	☐	☐	☐
Doorways wide enough to ensure safe passage by individuals using mobility aids	☐	☐	☐	☐
Wheelchair accessible restrooms with grab bars and accessible	☐	☐	☐	☐
ASL Signage and raised tactile text characters at office or elevator	☐	☐	☐	☐
Medical equipment accessible to patients using mobility aids	☐	☐	☐	☐
Exam rooms accessible to patients using mobility aids	☐	☐	☐	☐
4. Is this location an accessible public transportation route?	☐	☐	☐	☐
5. What are the location days and hours of operation?	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____	S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____ to _____

Treatment Expertise/Specialties

Please select the types of services you offer, including the disorders you treat and the modalities you practice (check all that apply).

Note: Please submit evidence of certificates or transcripts that account for the associated trainings in the treatment modalities and/or disorders selected below.

Cultural Competence

- ☐ African American
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ Other:_____

Settings/Populations Treated

- ☐ Adolescents
- ☐ Adults
- ☐ Blind/Low Vision
- ☐ Children
- ☐ Community Based
- ☐ Deaf/Hard of Hearing
- ☐ Developmental Disability
- ☐ Emotionally Disturbed
- ☐ Geriatric
- ☐ Home Based
- ☐ Homelessness
- ☐ LGBTQ+
- ☐ Men
- ☐ Mobile Crisis
- ☐ Nursing Home
- ☐ Physical Disability
- ☐ School Based
- ☐ Serious Emotional Disturbance School Based
- ☐ Serious Mental Illness
- ☐ Severe Persistent Mentally Ill
- ☐ Telehealth
- ☐ Telemedicine
- ☐ Telemonitoring
- ☐ Women
- ☐ Young Children

Treatment Modalities/Approaches

- ☐ Applied Behavioral Analysis (ABA)
- ☐ Addictive Disorders
- ☐ Adolescent Psychotherapy
- ☐ Adolescent Sex Offender
- ☐ Adolescent Psychiatry
- ☐ Adoption Issues
- ☐ Alcohol/SA Treatment
- ☐ Anger Management
- ☐ Art Therapy
- ☐ Attachment Therapy
- ☐ Behavioral Therapy
- ☐ Brief Therapy
- ☐ Biofeedback
- ☐ Chemical Dependency Assessment
- ☐ Child Parent Psychotherapy (CCP)
- ☐ Child Psychiatry
- ☐ Child Psychological Testing
- ☐ Christian Counseling
- ☐ Client Centered Therapy
- ☐ Cognitive Behavioral Therapy
- ☐ Cognitive Rehab Therapy
- ☐ Community Support Program
- ☐ Community Support Program for the Homeless
- ☐ Couples Therapy
- ☐ Crisis Intervention/Stabilization
- ☐ Critical Incident Debriefing
- ☐ Dialectical Behavioral Therapy
- ☐ Developmental Evaluation
- ☐ Domestic Violence
- ☐ ECT
- ☐ EMDR
- ☐ Evaluation/Assessment
- ☐ Family Systems
- ☐ Family Therapy
- ☐ Fetal Alcohol Syndrome

- ☐ Group Therapy
- ☐ Geriatric Psychiatry
- ☐ Gestalt
- ☐ HypnosisIndividual Therapy
- ☐ Intake Assessment
- ☐ Intensive Family Intervention
- ☐ Intensive Outpatient
- ☐ LGBTQ+
- ☐ Medication Management
- ☐ Methodone/Suboxone
- ☐ Mood Disorders
- ☐ Neuro-Linguistic Programming (NLP)
- ☐ Neuropsychological Testing
- ☐ Outcomes Oriented Therapy
- ☐ Pain Management
- ☐ Parent Child Interaction Therapy (PCIT) Play Therapy
- ☐ Play Therapy
- ☐ Psychoanalytic Therapy
- ☐ Psychodynamic Therapy
- ☐ Psychological Testing
- ☐ Psychopharmacology
- ☐ Rationale Emotive Therapy
- ☐ Relapse Prevention
- ☐ Relationship Disorders
- ☐ Sensory Processing/Integration
- ☐ Sex Therapy
- ☐ Sexual Compulsions/Addictions
- ☐ Solution Empowerment Therapy
- ☐ Stress Management
- ☐ Tobacco
- ☐ Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- ☐ Trauma Informed Care (TIC)
- ☐ Trust Based Relational Intervention (TBRI)
- ☐ Weight Management
- ☐ Tobacco Cessation

Provider Specialty

- ☐ Addictive Medicine
- ☐ ADD/ADHD
- ☐ Addictive Disorders
- ☐ Adjustment Disorder
- ☐ Adolescent Behavior Disorders
- ☐ Adoption Issues
- ☐ Adult ADD
- ☐ AIDS/HIV
- ☐ Anger Management
- ☐ Anxiety/Panic Disorder
- ☐ Attachment Disorder
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorders
- ☐ Chemical Dependency
- ☐ Children and Pregnant Women Case Management
- ☐ Child/Parent Bonding
- ☐ Christian/Spiritual
- ☐ Chronic Pain/Pain Management
- ☐ Crisis Stabilization
- ☐ Cultural Disparities
- ☐ Cognitive Disorder
- ☐ Concussion
- ☐ Co-occuring Disorders
- ☐ Criminal Offenders
- ☐ Dementia Disorders
- ☐ Depression
- ☐ Developmental Disability
- ☐ Disabilities
- ☐ Disruptive Behavior
- ☐ Dissociative Disorder
- ☐ Domestic Violence
- ☐ Dual Diagnosis
- ☐ Eating Disorders
- ☐ Equine Assisted Therapies
- ☐ Family Dysfunction
- ☐ Feeding Disorders
- ☐ Gender Identity
- ☐ Grief/Loss/Bereavement
- ☐ Head Trauma
- ☐ Home Visits
- ☐ Impulse Disorders
- ☐ Infertility
- ☐ Inpatient Attending
- ☐ Inpatient Consult MD
- ☐ Intellectual or Developmental Disorders
- ☐ Learning Disability
- ☐ LGBTQ+
- ☐ Medical Evaluation
- ☐ Medical Illness/Chronic Illness
- ☐ Men Issues
- ☐ Mood Disorders
- ☐ Marital Issues
- ☐ Obsessive Compulsive Disorder
- ☐ Oppositional Defiant Disorder
- ☐ Organic Mental Disorder
- ☐ Panic Disorder
- ☐ Parenting Issues
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Physical Abuse
- ☐ Maternal Mental Health (Postpartum Depression and Anxiety)
- ☐ PTSD
- ☐ Reactive Attachment Disorder
- ☐ Relapse Prevention

- ☐ Schizophrenia
- ☐ Self-Injury
- ☐ Separation/Divorce
- ☐ Serious/Persistent Mental Illness
- ☐ Sexual Abuse/Incest
- ☐ Sexual Disorders
- ☐ Sexual Dysfunction
- ☐ Sexual Offender
- ☐ Sexual/Physical Abuse (Adults)
- ☐ Sexual/Physical Abuse (Children)
- ☐ Sleep Disorder
- ☐ Step/Blended Families
- ☐ Stress Management
- ☐ Substance Abuse
- ☐ Suicide
- ☐ Tobacco Cessation
- ☐ Women Issues
- ☐ Work Related Problems

Certifications

- ☐ Art Therapy
- ☐ Center of Excellence
- ☐ Cognitive Process Therapy
- ☐ Emergency Services Provider
- ☐ Eye Movement Desensitization Reprocessing (EMDR)
- ☐ Lead Behavior Analysis Therapist
- ☐ Parent Child Interaction Therapy (PCIT)
- ☐ Play Therapy
- ☐ Positive Behavior Support
- ☐ Prolonged Exposure
- ☐ SBIRT
- ☐ Trauma Focus Cognitive Behavioral Therapy (TF-CBT)
- ☐ Trauma Informed Care
- ☐ TX CANS / ANSA (Certificate Requierd)

Signature: _____ Date: _____

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.

Signed (required): _____

Name (required): _____

Title (required): _____

Date (required): _____

If "do" is checked above, you are required to fill out the following summary of your disclosure.

This must include 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: _____

_____

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 orinvestment 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 Prior Contracts or Business with Superior HealthPlan

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.

If you answered "Do" on page 10, "yes" on page 11, OR "yes" on page 12, 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.

Participating Provider Attestation

WHEREAS, Superior HealthPlan, Inc. ("MCO"), has executed an agreement with _____ ("Provider") dated _____ pursuant to which Contracted Provider has agreed to provide Covered Services to Covered Persons through the Participating Provider Agreement (the "Agreement"); and

WHEREAS, Provider has requested that the undersigned Contracted Provider serve as a provider under the Agreement and Contracted Provider so desires to participate; and

WHEREAS, as a condition of such participation and Provider's designation as a "Contracted Provider" under this Agreement, Contracted Provider must satisfy MCO's credentialing criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Agreement that are applicable to Contracted Providers.

NOW THEREFORE, Contracted Provider hereby agrees as follows:

1. Contracted Provider agrees to provide Covered Services to Covered Persons in accordance with therequirements of the Agreement that are applicable to Contracted Providers so long as ContractedProvider qualifies as a Contracted Provider.
2. Contracted Provider understands and agrees that his/her initial and continued participation as aContracted Provider under the Agreement is contingent upon meeting and complying with MCO'scredentialing standards and otherwise complying with the terms and conditions of the Agreement.
3. Contracted Provider acknowledges that MCO expressly reserves the right to reject, suspend, and/ orterminate his/her participation under the Agreement for breaching or otherwise failing to: (i) comply withthe term of the Agreement or any Attachment thereto; (ii) meet MCO's credentialing requirements; or(iii)comply with the Provider Manual.
4. This Attestation shall be effective as of _____

Contracted Provider: _____

Signature: _____

Print Name: _____

Specialty: _____

Date: _____

NPI: _____

5900 E. Ben White Blvd.
Austin, TX 78741

Re: Application Addendum "Collaborating and Supervising Physician"

Dear Provider,

Thank you for your interest in becoming a provider with Superior HealthPlan. It is Superior HealthPlan's requirement that physicians without privileges have a collaborative physician who is a participating provider of a like specialty and scope of practice.

The "Collaborating and Supervising Physician" addendum is accepted as fulfilling your obligation to have a collaborative agreement. It is also used to verify if the collaborative physician is a participating provider of a like specialty and scope of practice.

In order to continue with the credentialing process it is imperative that you return the "Collaborating and Supervising Physician" addendum as soon as possible. If we have not received the information your application could be discontinued from the credentialing process.

Please fax the addendum to Superior's Credentialing department at:

Fax: 1-866-702-4831

If you have any questions, please feel free to contact Credentialing at Credentialing@centene.com.

Sincerely,

Credentialing Specialist

Superior HealthPlan

Collaborating and Supervising Physician Addendum

Applying Practitioner Name: _____

Practitioner NPI: _____

Mid-Level Practitioners are required to have an in-network (contracted) supervising physician, and that they themselves or their supervising physician maintain hospital privileges (or arrangements for admissions) at an in-network hospital.

Identify by name, address and specialty, the physician with whom you have an agreement.

☐ Supervising Physician

Supervising Physician's Name: _____

Supervising Physician's NPI: _____

Practicing Specialty: _____

Office Phone: _____

Admitting Hospital: _____

Hospital Address: _____

Physicians without their own hospital admitting privileges are required to have a collaborative physician who is a provider of a like specialty & scope of practice to admit patients to an in-network hospital.

☐ Collaborating (Admitting) Physician

Collaborating Physician's Name: _____

Collaborating Physician's NPI: _____

Practicing Specialty: _____

Office Phone: _____

Admitting Hospital: _____

Hospital Address: _____