

PROVIDER AGREEMENT  
BY AND BETWEEN  
THE OHIO DEPARTMENT OF HEALTH  
AND

---

(“ Provider”), in consideration of the mutual promises hereinafter expressed in this Provider Agreement (PA) and intending to be legally bound, agree as follows:

1. The provider agrees to provide the following services:
  - a. To participate as a service provider in Ohio’s Ryan White Emergency Financial Assistance Program (the “program”) under the terms, requirements, and conditions specified in rule 3701-44-06 of the Ohio Administrative Code (OAC) and any other applicable rules in Chapter 3701-44 of the OAC, as the rules currently exist or as are amended. These rules may be reviewed on line at <http://onlinedocs.andersonpublishing.com> or [http://www.odh.ohio.gov/Rules/Final/Chap44/Fr44\\_1st.htm](http://www.odh.ohio.gov/Rules/Final/Chap44/Fr44_1st.htm). The rules are incorporated by reference into this PA. These rules apply to the establishment of Ohio’s Ryan White Plan. Reimbursement will be made under the Program only for services that are previously authorized by a community-based HIV case manager or his or her designee, as appropriate. Preauthorization will occur when the provider has received notification from the authorized case manager that services needed to be rendered will be covered by Part B (formerly Title II) funds. The list of community-based case management agencies that authorize Part B (formerly Title II) funds for services is attached to this PA. The provider agrees to accept the usual, customary and reasonable rate (UCR) as established for the CPT code and zip code of the provider as set forth by the Third-Party Administrator (TPA) as payment in full. The provider agrees not to seek additional reimbursement for any services for which the Department’s designated TPA has paid the Provider. The provider agrees not to “balance bill” the client for these covered services.
  - b. To provide bill no later than 55 days from the date of service so the community-based case management agency may submit the bill within the required time frame of sixty (60) days from the date of service for payment from the Department’s designated TPA. To provide bill to the community-based case management agency and individuals to whom the Provider provides service under the Program (the “Participants” ) in accordance with Chapter 3701-44 of the OAC and any written instructions furnished by the Department, which are incorporated into this PA upon receipt by the Provider. The bill shall show total charges for the service and subtract out any payments received by the Provider from other sources for the same service.
  - c. To provide your Federal Tax ID number on all bills submitted to the community-based case management agency. Medical and dental providers must include CPT or ADA codes on all claims.
  - d. To refund the TPA any duplicate payment, overpayment, payment for services reimbursed by another third-party payer, or other incorrect payment within thirty (30) days of receipt of the payment or written notification of the incorrect payment, whichever is sooner.
  - e. To maintain complete records concerning the goods and/or services furnished by the Provider under the Program for seven years after they were provided or until any audit is completed and every exception resolved whichever is longer. The Provider agrees to give copies of these records to the Department, community-based case management agency, local HIV care consortia and/or other appropriate local and state officials upon request.
  - f. To keep strictly confidential all information concerning the identity of the Participants and to comply with Section 3701.243 of the Revised Code and all other applicable state and federal laws regarding confidentiality of information about individuals with HIV infection.
  - g. Medical Providers reimbursed by the Ryan White Program must adhere to guidelines developed by the Public Health Service Council. These may be reviewed on line at: [aidsinfo.nih.gov/guidelines](http://aidsinfo.nih.gov/guidelines)

- h. To notify the Director, Ohio Department of Health or designee in writing of any changes in provider's address or provider's practice within thirty (30) days that such changes may occur.
2. The Department agrees to ensure that its designated third-party administrator reimburses the Provider for service rendered to Participants in accordance with the rules governing the Program.
3. The obligations of the Department are subject to the provisions of sections 126.07 and 127.16 of the Ohio Revised Code (ORC) which state that the ODH cannot enter into a contract with a provider unless the appropriation is available, and that these contracts do not involve a need from competitive bidding.
4. The Provider agrees to hold the Department harmless from any and all liability, suits, losses, judgments, damages, or any other demands arising from or connected with provision of goods and/or services by the Provider under this PA. The Provider agrees to have or obtain insurance against liability for such damages or losses.
5. The Department and the Provider agree that neither party is responsible to the other party for nonperformance or delay in performance due to acts of God, wars, riots, strikes, or other causes beyond the control of the parties. The Department is not responsible to the Provider for nonperformance or delay in performance by the TPA for the aforementioned reasons. The Department is not responsible to Provider for nonperformance or delay in performance due to the acts or omissions of the local consortia, the community-based case managers, or the Participants.
6. This PA will become effective upon execution by the parties for the period of July 1, 2005 to March 31, 2010, subject to the cancellation provisions contained in paragraph 7 of this PA.
7. This PA may be canceled by the Department at any time upon at least fifteen (15) days advance written notice. The Provider may cancel this PA at any time upon at least thirty (30) days advance written notice. Notice of cancellation shall be transmitted by certified mail or personal delivery to the other party. If: 1) the Provider breaches any of the terms or conditions of this PA; 2) the Ohio general Assembly at any time fails to make appropriations which allow the Department to carry out the purposes of the Program; or 3) there is a failure of federal funding under which the Department funds the Program, the Department may cancel this PA immediately, notwithstanding the advance-notice provisions specified above. In no event will the Department be obligated to pay for any services performed by the Provider after the effective date of cancellation. Notice to the Department shall be sent to the Administrator of the HIV CARE Services Section, Ohio Department of Health, 246 North High Street, Columbus, OH 43215. After sending or receiving notice of cancellation, the Provider agrees to continue to provide services up to 11:59 p.m. on the effective date of the cancellation.
8. This PA cannot be assigned by either party.
9. The Provider certifies that he/she/it (as appropriate) is in compliance with Section 3517.13 of the ORC and that he/she/it (as appropriate) will remain in compliance with that section during the term of this PA. This section prohibits the spending of these funds for political donations, or for campaigning for a specific political party and/or candidate.
10. The Department and the Provider agrees that in the performance of this PA, there will be no discrimination against any person because of race, color, sex religion, national origin, age, handicap, (except that services are to be provided solely to Participants) or any other factor specified in the Civil Rights Act of 1964, as amended, in Section 504 of the Rehabilitation Act of 1973, as amended, and in any subsequent legislation pertaining to civil rights.

IN WITNESS WHEREOF, the parties hereto have caused this PA to be executed by their duly authorized officials.

To Be Completed By **Provider**

1. Signature of Contractor or Authorized Agent:	2. (Print/Type) Contractor or Authorized Agent:
3. Title:	4. Date:
5. Phone Number: ( ) 6. Fax Number: ( ) 7. Email Address:	8. Federal Tax ID Number:
9. Street Address: (Print/Type)	10. City, State, Zip: (Print/Type)
11. Billing Address: (Print/Type)	12. City, State, Zip: (Print/Type)

To Be Completed By **ODH**

1. Signature of the Director, Ohio Department of Health or designee:	2. Title of Designee: Ohio Ryan White Consortia Coordinator
3. Date:	4. Consortium to be served by this provider: #
5. Approved Service Codes/Description of Services:	