TERMS AND CONDITIONS APPLICABLE TO CARE PROVIDED TO QUALIFYING CHOICE CARD-ELIGIBLE VETERANS

A. GENERAL

1. In accordance with the Veterans Access, Choice, and Accountability Act of 2014 (the "Act") (Public Law 113 146, 128 Stat. 1754), as amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (Public Law 113 175, 128 Stat. 1906), and 38 CFR § 17.1515, any Provider rendering services to eligible beneficiaries ("Eligible Veteran") of the Department of Veterans Affairs' Choice Card program (the "Program") (as set forth in 38 CFR §17.1510 and any other applicable eligibility standards regarding particular healthcare services (e.g., health care for a newborn child of a Veteran under 38 CFR 17.38(a)(xiv)) certifies that such Provider complies with the requirements contained herein and will be reimbursed for services according to the terms of this Agreement.

2. This Agreement is made by and between TriWest Healthcare Alliance ("TriWest"), in its capacity as a contractor to the Department of Veterans Affairs ("VA"), and the Provider rendering services subject to this Agreement ("Provider"), including any ancillary providers referred in the course of services under this Agreement.

3. This Agreement covers healthcare services ("Covered Services") provided to the Eligible Veteran to whom the Provider renders services subject to the Authorization for Care (the "Authorization") provided to the Provider rendering such Covered Services.

4. In rendering the Covered Services subject to this Agreement, Provider attests that the Provider, or any other clinician involved in rendering the services authorized under this Agreement at the direction of the Provider*:
    a. has an active, unrestricted license, registration, or certificate in the State in which the Covered Service(s) subject to this Agreement is/are to be performed, as required by applicable State law;
    b. has not had a professional license, registration, or certification terminated for cause in any State, nor has the Provider voluntarily relinquished a professional license, registration, or certification in any State after being notified in writing by that State of potential termination for cause;
    c. has a valid and current National Provider Identifier (NPI) number;
    d. is not excluded from providing Covered Services pursuant to being listed on the Centers for Medicare and Medicaid Services ("CMS") exclusionary list;
    e. as applicable to the Covered Services being rendered, has a valid and current Drug Enforcement Agency ("DEA") number.

    * PROVIDER AGREES THAT TO THE EXTENT PROVIDER UTILIZES ANY ANCILLARY OR OTHER PROVIDER(S) TO RENDER SERVICES FOR THE SAME EPISODE OF CARE FOR WHICH PROVIDER HAS ACCEPTED AN AUTHORIZATION, PROVIDER AGREES TO (1) SHARE WITH SUCH OTHER PROVIDER THE TERMS AND CONDITIONS OF THIS AGREEMENT AND THE RELEVANT AUTHORIZATION; AND (2) OBTAIN ADVANCE ASSURANCE FROM OTHER PROVIDER, PRIOR TO OTHER PROVIDER RENDERING ANY SERVICE OR ACCEPTING AN APPOINTMENT, THAT IT WILL ABIDE BY THE TERMS OF THIS AGREEMENT. IF ANY PROVIDER OR OTHER CLINICIAN PROVIDING SERVICES AT THE DIRECTION OF THE PROVIDER WHO DOES NOT MEET ANY OF THE QUALIFICATIONS LISTED ABOVE, TRIWEST WILL DENY THOSE PORTIONS OF THE CLAIM FOR COVERED SERVICES RENDERED BY THE PROVIDER OR OTHER CLINICIAN.

5. With the exception of payments provided pursuant to Paragraph C(2) of this Agreement, Provider agrees to accept as payment for Covered Services rendered One Hundred percent (100%) of the allowable Medicare rates for care authorized by TriWest in a current Authorization for an Eligible Veteran that is the subject of this Agreement. In the event there is no published Medicare rate for hospital care or medical services, Provider agrees to accept as reimbursement for authorized Covered Services, the rates determined by the process and methodology outlined in 38 CFR § 17.55 or 17.56, as applicable. In no instance shall the Provider be reimbursed by TriWest for care not authorized.

6. Medical Documentation that must be returned to TriWest includes both outpatient and inpatient records. Initial outpatient medical documentation is medical documentation associated with the first appointment of an episode of care. Final outpatient medical documentation is medical documentation that summarizes the results of medical care provided. Initial medical documentation for outpatient care shall be returned within seventy five (75) calendar days of the initial appointment and final medical documentation of outpatient care shall be returned within seventy five (75) calendar days of the completion of the episode of care. Medical documentation associated with inpatient care shall be returned within thirty (30) business days and consist of a Discharge Summary. Medical documentation associated with urgent care must be returned within two (2) business days.

B. COVERED SERVICES

1. Covered Services are those services authorized or approved by TriWest in its capacity as a contractor to VA in the execution the Program authorized by the Act. Provider agrees to furnish only that care which is duly authorized and medically necessary. If Provider believes that additional care is required that has not been authorized by TriWest, Provider agrees to promptly contact TriWest to request an authorization for any such additional services.

C. PAYMENT RESPONSIBILITY

1. Unless otherwise stated clearly on the Authorization for Care to which this Agreement applies, Provider shall submit any claims for Covered Services rendered to TriWest. Veterans shall not be directly billed any amount for any services under this Agreement, except as described in Paragraph 2 of this section.

2. Only when clearly instructed in writing by TriWest, Provider shall first submit claims for Covered Services rendered to the primary commercial health insurance of the Veteran, to the extent the Veteran provides proof thereof. In such instance, Provider shall follow the terms and conditions of the Veteran's commercial health plan related to the collection of applicable copayments, coinsurance, and any other funds owed by the Veteran if proof of eligibility is determined.

   Following payments received pursuant to the terms of the Veteran's applicable commercial health insurance, TriWest will provide reimbursement to the Provider secondarily to any such commercial health insurance. Said reimbursement, when combined with funds received pursuant to the Veteran's commercial health insurance, shall not exceed the total allowable fees permitted for such Covered Services pursuant to Medicare. If no proof of commercial health insurance is provided by the Veteran, Provider shall submit all claims to TriWest as instructed and collect no funds from the Veteran.

3. Payment is not guaranteed by an Authorization for Care; it is TriWest's policy to detect and prevent any activity that may constitute a compliance concern including fraud, waste, or abuse, following standards set by federal and state law and regulation. All claims must be properly authorized and medically necessary, and not otherwise improper.

D. CLAIMS SUBMISSION

1. Claims for Covered Services (other than those submitted to a commercial health insurance plan when required) shall be submitted in accordance with instructions provided on the Veterans Choice Card or as contained in the Authorization for Care to which this Agreement applies.

2. When claims are submitted to TriWest, Provider shall also submit all required medical documentation and other claim related documents, as described in this letter. TriWest will not pay, and Provider agrees to waive, any costs associated with the aforementioned submission, including but not limited to any copying or handling fees.

E. TERMINATION OF AGREEMENT

1. This Agreement shall commence as of the date that Provider accepts an Authorization for Care for the Program from TriWest, and this Agreement and shall remain in full force and effect until terminated by either party. Either party may terminate this Agreement at any time for any reason by providing thirty (30) days advance written notice of termination to the other party.

F. COMPLIANCE WITH FEDERAL LAWS

1. This Agreement is not subject to the provisions of law governing Federal contracts for the acquisition of goods or services. The Parties to this Agreement are nonetheless subject to all other applicable laws governing the provision of healthcare generally, and submission of healthcare claims for payment specifically.

Prescription Fulfillment Information for Providers Servicing Veterans Under CHOICE or Veterans Affairs Patient-Centered Community Care

Urgent prescriptions could be required for a variety of medical conditions such as acute pain management and infections. To help Veterans obtain **urgently needed* prescriptions,** Providers should follow the steps identified below:

1. Consult the VA National Formulary website to see which medications are available for prescribing: http://www.pbm.va.gov/PBM/NationalFormulary.asp *(There are two (2) file options: VA National Formulary sorted alphabetically by generic drug name and VA National Formulary sorted by VA Drug Class.)*

2. Issue a prescription for up to a fourteen 14 day supply of VA National Formulary (VANF) medication and instruct the Veteran that he/she may take the prescription to any Non-VA pharmacy of their choice to be filled at their own expense, after which they may seek reimbursement from the Purchased Care office at their host VA Medical facility. *(NOTE: While the practice is not encouraged, if a Veteran chooses to take an urgently needed prescription to a VA Pharmacy to avoid out of pocket expenses, it will be filled if it follows the VA National Formulary.* ***In these cases, it is required that the Provider provide a patient with a copy of the provider's care authorization letter/fax which is required for prescriptions to be filled in a VA pharmacy.)***

Routine prescriptions may also be needed to treat a variety of medical conditions. To help Veterans obtain **routine prescriptions,** Providers should follow the steps identified below:

1. Consult the VANF website to see which medications are available for prescribing: http://www.pbm.va.gov/PBM/NationalFormulary.asp *(There are two (2) file options: VA National Formulary sorted alphabetically by generic drug name and VA National Formulary sorted by VA Drug Class*

2. Providers will be contacted by a VA pharmacist if the prescriptions they issue do not follow the VANF. In these situations, the Provider can re-write the prescription for a VA National Formulary drug or they can complete a request for a medically necessary Non-Formulary drug *(NOTE: It can take up to four (4) days after receiving a completed non-formulary request to render an approval/disapproval decision.)* Providers are encouraged to prescribe VANF drugs whenever clinically possible to avoid prescription fulfillment delays and inconvenience to Veterans.

3. The Provider should FAX or mail the Veteran's prescription to host VA Medical Facility. FAX numbers and host VA Medical facility address information is available at http://www.triwest.com/va-pharmacy-locations/. Alternately, the Provider can issue a written prescription to the Veteran who can mail or physically present it to their VA Medical Facility pharmacy for processing. **(It is required that the Provider provide a patient with a *copy of the provider's care authorization letter/fax* which must accompany all prescriptions presented for filling in a VA pharmacy.)**

4. Prescriptions for Schedule II prescriptions may not be FAXed by the Provider; they must be mailed or presented in person in their original form. Prescriptions for Schedule III-IV prescriptions may be FAXed by the Provider and must have a pen and ink (i.e., manual) provider's signature. Electronic signatures are not acceptable.

*An urgently needed prescription is one which in the provider's clinical opinion cannot wait to be filled by a VA pharmacy and mailed to the Veteran. *(NOTE: on average, it takes approximately four (4) days for a prescription to reach a Veteran by mail after it is transmitted to a VA pharmacy by the Provider.)*