PROVIDER PARTICIPATION AGREEMENT
SIGNATURE AND DECLARATIONS PAGE

The undersigned, consisting of only members or shareholders or individuals who are duly licensed and qualified to practice medicine in the State of Oregon and in active medical practice, ("Provider") agree with Senior Patient Association dba Patient/Physician Cooperatives ("PPC") to render assurance to those intermediaries listed below, as follows:

1. Provider agrees to accept cash or assignment of insurance benefits for provision of medical services arranged for patients of certain health plans pursuant to this agreement and agreement between PPC and such intermediaries with whom PPC may contract.
2. Provider agrees to such payment schedules as shown in Exhibits C for the latest effective date when issued by the Managers of PPC.
3. Provider instructs any intermediary with whom PPC contracts to accept such schedules when issued by the managers of the PPC.
4. Provider further agrees to be bound by the terms of the Provider Agreement that follows, and instructs any party with whom PPC contracts to make all payments due Provider directly to the Provider, except administrative fees and performance bonuses are paid to PPC at PPC's lockbox account for further distribution pursuant to agreement between Provider and PPC and Health Plan.
5. Provider agrees that any party or Intermediary may accept instruction on Provider's behalf when issued by PPC without further inquiry, and hereby appoints PPC its representative for communication and contracting with such intermediaries for all such purposes, which appointment shall not be terminated without PPC's consent while Provider is a member of PPC.
6. Provider instructs the following intermediaries: Senior Patient Association DBA Patient/Physician Cooperatives, and New Era Life Insurance as follows: All prior contracts for which I have indicated my agreement to participate with through this PPC that are currently held with me either directly or through another IPA are superseded by my agreement with the PPC and the PPC's group provider agreement with your company. This is effective now and continues until my agreement with this PPC terminates and PPC has been given proper advanced notice of such termination in accordance with the terms of the agreement between me and PPC.
7. The companies with whom PPC contracts and for which I have agree to be a participating provider are as follows:

Agreed Plan Participations

	Single	***Family***
. **Provider Rate……**	_____	_____
Senior Patient Association – 10% ….. (dba Patient/Physician Cooperatives)	_____	_____
Member Rate…… ……	_____	_____

NPI # ……_____

*CAQH # ……_____

Application Checklist

Required

* Current Resume, including work history ……..... ___
* List of last year CME credits ……..... ___
* Completed and signed Standardized Application… ___
Copy of medical School Diploma…… ___
Copy of current Malpractice Insurance face sheet…. ___
Copy of state medical license…… ___
Completed and signed W-9 Form…….. ___

As Applies

Copy of current DEA Certificate……..…….. ___
Copy of medical Board Certification or Elig…..….. ___
Copy of liability claims history if any ……..... ___
Copy of residency Certificate…… …..___
Copy of ECFMG (if applicable- foreign med school. ___
Copy of CLIA (if applicable)…….. ___

Exhibit C
Patient Physician Cooperatives: Monthly Payment Agreement between Primary Care Providers and Individual member Patients;

	Annual Contract Rate	**Monthly Payment**	**Notes/Limits/Etc**
Terms:	$_____/year	$____/mo	**# visits/yr -**
Family Plan 3+ members	$_____/year	$____/mo	**# visits/yr -**
			Initial visit rate -
			PPC Plan A Initial visit - Return:

IN WITNESS WHEREOF, the foregoing Agreement between the Association and Provider, is entered into by and between the undersigned parties, to be effective this ___day of _____, 201__.

PPC REPRESENTATIVE:_____

PROVIDER SIGNATURE:

By: _____

Name (print): _____Address: _____

City;_____ State:_____ Zip_____

Tel:_____ Fax:_____Email:_____

Lisa Bakke 503-888-9397 – Submit contract to: lbakke@ppcpdxcoop.org