



Out of Network Hospital Single Client Inpatient Application/Agreement

To find this form online, go to Partners' website at www.partnersbhm.org, click **Providers** > PartnersACCESS and Utilization Management > [Hospitals Working with Partners](#).

ALL areas are required to be completed.

Hospital Classification:	☐ For Profit ☐ Non-Profit/Gov. Agency/501C3		
Type:	☐ Corp. ☐ S. Corp. ☐ LLC		
Provider Legal Name:			
DBA Name (if applicable):			
Mailing Address:	Street:		
	City:	State:	Zip+4:
Telephone Number:		Fax Number:	
Federal Tax ID:			
Remittance Billing Address:	Street:		
	City:	State:	Zip+4:
Site Address:	Street:		
	City:	State:	Zip+4:
County:			
Hospital CEO Name:			
Primary Clinical Contact:	Name:	Title:	
	Phone:	E-mail:	
Billing Contact:	Name:	Phone:	E-mail:
<i>Please list all associated Medicaid/NPI & Taxonomies you intend to use by site (or attach spreadsheet)</i>			
Main Medicaid Number:			
Main NPI Number:		Taxonomy Number(s):	
Are you accredited?	☐ Yes ☐ No		
	If yes, list accrediting body:		
Do you currently have a network contract with another LME/MCO?	☐ Yes ☐ No		
	If yes, please list LME/MCO(s):		



Are you self-insured?	☐ Yes ☐ No	
	If no, please identify your carrier(s):	
Professional Liability:	Telephone:	Policy #:
Comm. Gen. Liability:	Telephone	Policy #:
Worker's Compensation:	Telephone:	Policy #:

Required Attachments (must be submitted at least once annually):

1. **Hospital Clinician Registration Worksheet** – complete and return per instructions on form. (This form is on the Partners website, under Providers, Info. and Documents, Info. for Hospitals)

Client Information by Provider (*ALL areas are required to be completed*):

Service Start Date:	Service End Date (if known):
Full Client Name:	Client Medicaid #:
Client Date of Birth:	Client Medicaid County of Origin:
Service Code(s) requested:	

Partners staff complete below:

UM Reviewer:	Approved Service Start Date:
Approved service code(s):	

Upon full execution of this Application/Agreement, the parties agree as follows:

1. Provider shall notify Partners Health Management (Partners) prior to the discharge of Client and shall allow designated Partners staff to attend any discharge planning meetings regarding the Client served under this Agreement.
2. Provider warrants that it is in compliance with all applicable federal, state and local laws, rules and regulations, licensure and accreditation requirements governing the provision of services to Client at all times relevant to this Agreement.
3. Provider shall be responsible for completion and retention of all necessary and customary documentation required for the services provided under this Agreement. Provider agrees and understands that Partners may inspect financial records concerning claims paid on behalf of Client, records of staff who delivered or supervised the delivery of paid services to Client, Client clinical records, and any other clinical or financial items related to the claims paid on behalf of Client deemed necessary to assure compliance with applicable state or federal laws, rules



and regulations. Provider shall provide copies of specifically denominated records necessary to meet State and Federal monitoring requirements within fifteen (15) days of a written request from Partners.

4. Provider warrants that it has and will continuously maintain insurance coverage with a carrier authorized to do business in North Carolina, or maintain equivalent coverage under a self-insurance program that is actuarially sound, meeting the following coverage requirements:
 - a. Professional Liability: Professional Liability Insurance shall protect the Provider and any employee performing work under this Agreement for an amount of not less than \$1,000,000.00 per occurrence and proof of coverage at or exceeding \$3,000,000.00 in the annual aggregate.
 - b. Comprehensive General Liability: Bodily Injury and Property Damage Liability Insurance shall protect the Provider and any employee performing work under this Agreement from claims of Bodily Injury or Property Damage, which may arise from operations under the Contract. The amounts of such insurance shall not be less than \$1,000,000.00 per Occurrence/\$3,000,000.00 per Aggregate/ \$1,000,000.00 Personal and Advertising Injury/\$50,000.00 Fire Damage. The policy shall not include exclusion for contractual liability.
 - c. Workers' Compensation and Occupational Disease Insurance: Provider shall maintain workers' compensation and occupational disease insurance as required by the statutory requirements of the State of North Carolina.
5. All claims must be submitted electronically either through HIPAA Compliant Transaction Sets 820 – Premium Payment, 834 – Member Enrollment and Eligibility Maintenance, 835 – Remittance Advice, 837P – Professional claims, 837I – Institutional claims, or the Partners secure web-based billing Alpha MCS system.
6. Provider understands and agrees that claims for services must be submitted within ninety (90) days of the date of service or discharge (whichever is later), except that Provider may submit claims subsequent to the ninety (90) day limit in instances where the Client has been retroactively enrolled with Medicaid or Partners, or where the Client has primary insurance which has not yet paid or denied its claim. In such instances, Provider may bill Partners within ninety (90) days of receipt of notice by the Provider of the Client's eligibility for Medicaid, or within 90 days of final action (including payment or denial) by the primary insurance or Medicare (whichever is later).
7. Partners agrees to reimburse Provider for approved Clean Claims for covered services for the Client named herein within thirty days of the date of receipt. Within eighteen (18) days after Partners receives a claim from Provider, Partners shall either: (1) approve payment of the claim, (2) deny payment of the claim, or (3) request additional information required for making an approval or denial.

Signatures:

By signing below, Provider certifies that all the information and attachments provided herein are true and accurate to the best of their knowledge. Provider further understands that any false or misleading information may be cause for denial or termination of any and all agreements or contracts with Partners Behavioral Health Management. Provider understands submission of the application does not guarantee the issuance of an agreement. Provider signifies their willingness for Partners to verify all information presented in this application and to provide additional information to Partners, if needed, to verify the accuracy of the information contained herein. Provider agrees to provide any additional information at request of Partners to verify information and address issues of concern prior to the approval of the application.



IN WITNESS WHEREOF, each party has caused this agreement to be executed in multiple copies, each of which shall be deemed an original, as the act of said party. Each individual signing below certifies that he or she has been granted the authority to bind the Provider to the terms of this Agreement and any Addendums or Attachments thereto. Email the application in its entirety to Providers@PartnersBHM.org.

Provider Name:			Partners Health Management
Signature:			Signature:
Title:			Title: Chief Executive Officer/Designee
Date:			Date:
Address:			Address:
City:	State:	Zip:	901 S. New Hope Road Gastonia, NC 28054
Telephone:			Telephone: 877-864-1454
Tax ID Number:			

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act. General Statute 159.

By: _____

Date: _____

Susan Lackey

Chief Financial Officer