TECQ PARTNERS
8278 Bellaire Blvd, Ste B | Houston, TX 77036
www.tecqpartners.com | Tel: (888) 319-0777 | Fax: +1 (877) 766-4971
*(Please include **+1** or fax may fail)*

# LETTER OF AGREEMENT

This Letter of Agreement ("LOA") is executed between **IPA/CIN** with and _____ (“Specialist"), **Specialty:** _____ collectively referred to as the "Parties", to be effective from **Start Date** ("Effective Date") which is the first day of any given month to **End Date** (“Expiration Date”) twelve (12) months from the Effective Date. Specialists are expected to work in good faith during this LOA period to execute an agreement and successfully participate in the IPA/CIN credentialing process. If no action is taken the contract will expire earlier in writing by IPA/CIN or the “Expiration Date”, whichever comes first.

**WHEREAS,**

(a) IPA/CIN is an independent practice association, medical group or clinically integrated network that currently has an agreement with TECQ Partners and/or its affiliated company. Van Lang IPA, TEACO Provider Network & TEACO Health are IPA/CIN currently managed by TECQ Partners and/or its affiliated company.

(b) Specialist is experienced, properly licensed and in good standing to provide health care services in the State of Texas to Medicare and/or Medicare/Medicaid eligible persons under the Medicare Advantage (MA or MA-PD) program and desires to be a participating Specialist contracted with IPA/CIN to provide services to such persons.

**THEREFORE,**

1. Compensation: IPA/CIN and Specialist agree to enter into negotiations in good faith to execute a formal Specialist Services agreement (“Agreements”). **For Medicare or Medicare-Medicaid only Enrollees/members: at One Hundred Percent (100%) of Current CMS Medicare allowable rates for Part B (Professional)** for authorized services for which claims shall be processed in accordance with CMS Medicare Processing and Payment Guidelines, timely filing (95 Days from Date of Service) and timely payment, within sixty days of execution of this LOA, under terms mutually acceptable to both IPA/CIN and Specialist, to enable Specialist to provide health care services, to IPA/CIN members in the MA/MA-PD program. Applicable co-payment(s)/coinsurance shall offset the amount(s) approved by payable claims.
2. This LOA only guarantees reimbursement amounts owed to Specialists for specific services pre-authorized by the IPA/CIN. For any service provided by Specialists without a pre-authorization will result in a claim denial. Specialists may appeal the claim determination following the IPA/CIN appeal process for non-contracted providers.
3. Any other CPT code services identified in the IPA/CIN CPT auto approval list are excluded from this LOA. All services and CPT codes require a prior authorization by IPA/CIN to qualify for payment under the reimbursement terms of this LOA.
4. Specialist understands that IPA/CIN will be submitting this LOA to Health Plans as evidence that the Specialist is a potential participating Specialist and consents to IPA/CIN doing so;
5. Term and Termination: Either party may terminate this agreement with a 30- day written notice. IPA/CIN and Specialist agree to hold in confidence all terms and conditions of this LOA and information disclosed by one party to another during the negotiations to follow toward the execution of the Agreement. This provision shall survive termination of this LOA.
6. Claims will be processed according to industry and/or government program guidelines (Medicare clean claims will be paid within 45 calendar days according to CMS standards). Claims Timely filing: 95 Days from Date of Service. IPA/CIN contracted providers will enforce a 95 days timely filing deadline. This includes all Provider with signed Letter of Agreement. Claims submitted 95 days after services are rendered will be denied.
7. Specialist agrees to obtain prior authorization from IPA/CIN (by adhering to IPA/CIN Prior Authorization policy prior to rendering services). Medicare Fee Schedule may be accessed via the internet website at: http://www.cms.gov

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**IN WITNESS WHEREOF**, the parties have duly executed this LOA effective as of the date first written above. **The End Date will be the 1st day of the month of the Expiration Date.**

| **IPA/CIN** | | **SPECIALIST PROVIDER** | |
|---|---|---|---|
| **Signature By:** | | **Signature By:** | |
| **Name:** | | **Name:** | |
| **Title:** | | **Title:** | |
| **Date:** | | **Date:** | |

All fields are **Required:** Specialist please complete the information requested below, so we may appropriately add you to the network while the contract and credentialing are pending. Additionally, please provide a Current W9 for claims submissions.

| | | | |
|---|---|---|---|
| **Specialist Full Name (First, MI, Last):** | **Title:** | **Gender:** | |
| **Specialty** | **Subspecialty** | | |
| **Practice/Group Name:** ***(if applicable)*** | **PCP/Specialist:** | | |
| **Primary office address:** | **City:** | **TX** | **Zip:** |
| **Phone Number:** | **Fax Number:** | | |
| **Contact Person:** | **E-Mail Address:** | | |
| **Secondary office address:** | **City:** | **TX** | **Zip:** |
| **Phone Number:** | **Fax Number:** | | |
| **Medicare UPIN #:** | **Medicaid ID #:** | **Accept Medicaid? (Y/N)** ☐ **Yes** ☐ **No** | |

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| | | | |
|---|---|---|---|
| **DEA Number:** | | **DEA Exp. Date:** | |
| **Provider Medical License #:** | | **Provider Medical License Exp. Date:** | |
| **Provider SSN:**<br>*(Mandatory field requirement for OIG/SAMs)* | | **Provider DOB:**<br>*(Mandatory field requirement for OIG/SAMs)* | |
| **Medicare Participation? (Y/N)**<br>*(This is a Mandatory field requirement for OIG/SAMs)* | ☐ **Yes**<br>☐ **No** | **Medicare Excluded? (Y/N)**<br>*(This is a Mandatory field requirement for OIG/SAMs)* | ☐ **Yes**<br>☐ **No** |
| **Malpractice Carrier:** | | **Malpractice Policy #:** | |

| | |
|---|---|
| **Malpractice Policy Coverage Amounts:**<br>☐ $200,000 / $600,000<br>☐ **Other:** | **Malpractice Expiration Date:** |
| **Name of Certifying Board:** | **Board Certification Expiration Date:** |
| **Hospitals Where Privileged:**<br>1. 2. 3. | |
| **Facilities for Procedures if not at Hospital (i.e. ASC)**<br>1. 2. 3. | |
| **Medical School** | **Start Date:**<br>**End Date:** |
| **Residency** | **Start Date:**<br>**End Date:** |
| **Fellowship (if applicable)** | **Start Date:**<br>**End Date:** |

| | | |
|---|---|---|
| ***Billing Information Required for Proper Claims Payment*** | | |
| **Billing Organization Name:** | | |
| **Billing Address:** | **State** | **Zip:** |

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| |
|---|
| **Tax ID Number:** |
| **Organizational NPI Number:** |
| **Individual NPI Number:** |

| | ***Claim Submission Instructions*** | ***Resources*** |
|---|---|---|
| **Claims Submission** | **https://www.tecqpartners.com** | **Resources > How to submit a claim *(top menu)*** |
| **Claims Via Fax:** | ***(not accepted)*** | |