NON PARTICIPATION REIMBURSEMENT AGREEMENT

THIS NON PARTICIPATION REIMBURSEMENT AGREEMENT (this "Agreement"), is entered into between United Healthcare of the Midwest, LLC ("United") and _____ ("Provider"). This Agreement shall be for the purpose of making available to the Covered Person certain medically necessary covered services (the "Covered Services") as identified on the attached claim herein. As such, the parties hereby agree to the following:

1. **Compensation.** Provider shall be reimbursed the lesser of the (i) payment rate set forth by the Kansas Medical Assistance Program non participation reimbursement policy, or (ii) billed charges for Covered Services rendered to the Covered Person. Payments to Provider are subject to all applicable health plan benefit designs in accordance with the Covered Person's benefit plan including and by United's utilization review policies, procedures and guidelines.

2. **Claim Submission.** Provider must submit the clean claim in alignment with State of Kansas Policy. All information necessary to process a claim must be received by United no more than one hundred twenty (120) days from the date Covered Services are rendered, or other period as specified by state law. Provider understands that failure to execute and promptly return this Non Par Reimbursement Agreement to United in conjunction with the submission of an otherwise clean claim will result in the Provider's claim being denied.

   The clean claim must be submitted to United Healthcare Community Plan, PO Box 5270, Kingston, NY 12402. ***To ensure reimbursement, you must submit a copy of this Agreement with the claim.***

3. **Billing and Appeals.** Provider must comply with the Provider Grievance, Reconsideration, Appeal and State Fair Hearing Process outlined herein as Attachment 1.

4. **Hold Harmless.** Provider shall accept as payment in full for Covered Services rendered to Covered Person such amounts as are paid by United or the payer pursuant to this Agreement and shall not bill Covered Person for non-covered charges which result from United's reimbursement methodologies. Provider hereby agrees that in no event, including, but not limited to, non-payment, insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against Covered Person or persons other than United or the payer for Covered Services provided pursuant to this Agreement, for any amount other than co-payments, coinsurance, or deductibles, as applicable. Provider shall comply with any additional hold harmless requirements as applicable under state or federal law. Provider further agrees that this provision shall survive termination of this Agreement.

5. **Confidentiality.** United and Provider agree that medical records and all other protected health information of Covered Person shall be treated as confidential and

that the parties to this Agreement shall comply with all federal and state laws and regulations regarding the confidentiality of Covered Person's protected health information.

6. **Compliance.** Provider warrants that it is in compliance with all applicable, local, state and federal laws relating to the provision of Covered Services and that Provider and employees of Provider shall perform their duties in accordance with all applicable local, state and county standards of professional ethics and practice, and shall maintain all licenses and other authorizations required to perform the Covered Services.

7. **Governing Law.** This Agreement shall be governed by, and construed in accordance with, the laws of the state of Kansas and any other applicable law.

8. **Malpractice Insurance.** Provider agrees to procure and maintain medical malpractice insurance consistent with state requirements, and maintain all federal state and local licenses, certifications, and permits, without restriction, required to provide health care services in the state services are provided throughout the term of this Agreement. Provider agrees to comply with all applicable statutes and regulations, including but not limited to all statutes and regulations related to confidentiality of medical records and protected health information.

9. **Access to Medical Records.** Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Provider Agrees to provide within 10 days of the receipt of a request from United a copy of the Covered Person's medical record at no charge.

10. **Overpayment.** Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment.

11. **Kansas Medical Assistance Program (KMAP) Participation.** Upon notification from the State of Kansas that Provider's enrollment has been denied or terminated, United must terminate any payments to Provider immediately. United will exclude payments to any provider who is on the State of Kansas' exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

[SIGNATURE PAGE FOLLOWS].

AGREED AND ACCEPTED BY:

<<PROVIDER LEGAL NAME>>

Signature _____

Print Name _____

Title _____

Phone _____

FAX _____

Date _____

Provider Payment Information:

Pay To Name: _____

Pay To Address:_____

Tax ID _____

NPI _____

Medicaid Number _____

United Healthcare of the Midwest, LLC

Signature_____

Print Name _____

Title _____

Date _____

Attachments:

Attachment 1: Provider Grievance, Reconsideration, Appeal and State Fair Hearing Process

Attachment 2: Individual Clean Claim

PROVIDER GRIEVANCE, RECONSIDERATION, APPEAL AND STATE FAIR HEARING PROCESS

GRIEVANCE PROCESS

A grievance is any expression of dissatisfaction about any matter other than an Action. If you need help filing a grievance, call Provider Services at 1-877-542-9235 (TDD/TTY: 711).

To file a grievance-

In writing:
UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

By telephone (toll-free):
1-877-542-9235
(During business hours 8am – 5pm CST)

Electronically:
www.uhcprovider.com
Menu > Health Plans By State > KS > Medicaid > Provider Forms

or In Person:
10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During regular business hours 8am-5pm CST)

Providers have one hundred eighty (180) calendar days from the date of the incident being grieved, to file a grievance. UnitedHealthcare Community Plan will keep your grievance private. We will let you know we received your grievance within ten (10) calendar days. We will resolve your grievance within thirty (30) calendar days and tell you in writing how it was resolved.

RECONSIDERATION PROCESS

The provider reconsideration process allows a provider to dispute a claim payment determination prior to requesting an appeal, but is not required prior to the submission of an appeal. If you need help filing a reconsideration, call Provider Services at 1-877-542-9235 (TDD/TTY: 711).

To file a reconsideration-

In writing:
Complete the claim reconsideration form found at UHCProvider.com and mail to
United Healthcare Community Plan
PO Box 5270
Kingston, NY 12401

By telephone (toll-free):
1-877-542-9235
(During business hours 8am – 5pm CST)

Or Electronically:
Using the claimLINK Self-Service Tool at www.uhcprovider.com

Reconsideration requests must be submitted within one hundred twenty (120) calendar days from the remittance date (plus three (3) calendar days is allowed for mailing time). You should submit a fully completed claims reconsideration request form and all supporting documentation. Please do not send a claim or claim copy with your reconsideration request. If you send a claim or claim copy with the reconsideration, the reconsiderations team cannot accept it and will return it to you. If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can file a formal appeal.

APPEAL PROCESS

An appeal is a request for a review of an action. You have sixty (60) calendar days from the date of the notice of action (plus three (3) calendar days is allowed for mailing time) to file an appeal.

To file an appeal:

In writing:
UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

Electronically:
For non-claims related appeals -
www.uhcprovider.com
Menu > Health Plans By State > KS > Medicaid > Provider Forms

For claims related appeals –
Using the claimLINK Self-Service Tool at www.uhcprovider.com

or In Person:
United Healthcare Community Plan – Kansas
10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During regular business hours 8am-5pm CST)

You may also provide supporting appeal documents in person. If you need help filing an appeal, call Provider Services at 1-877-542-9235 (TTY: 711). Within ten (10) calendar days, we will let you know in writing that we got your appeal. You may choose someone, including an attorney or provider, to represent you and act on your behalf. UnitedHealthcare Community Plan does not cover any fees or payments to your representatives. We will keep your appeal private and will send you our appeal decision in writing within thirty (30) calendar days.

State Fair Hearing:

If you disagree with the outcome of your appeal by UnitedHealthcare Community Plan, you can request a State Fair Hearing. You may only file for a State Fair Hearing after you have completed the formal appeal process with UnitedHealthcare Community Plan.

You must file for a State Fair Hearing within one hundred twenty (120) calendar days from the date of the appeal resolution notice (plus three (3) calendar days is allowed for mailing time).

To file a State Fair Hearing-

In writing:
Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

By telephone (toll-free):
1-877-542-9235
(During business hours 8am-5pm CST)

Electronically via Office of Administrative Hearings fax:
(785) 296-4848

or In Person:
10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During business hours 8am-5pm CST)