ACCESS
HEALTHCARE PHYSICIANS, LLC.

Date:

Dear Representative: **TIME SENSITIVE RESPONSE NEEDED**

Please accept this Letter of Intent as our notice that we, Access Health Care Physicians, LLC, TIN: 451444883, NPI: 1245529742, Taxonomy 193200000X (Multispecialty) are adding the below provider to our group for all lines of business for our practice as to assure consistent patient care coverage.

LAST NAME	FIRST NAME	SUFFIX	NPI	CAQH#	EFFECTIVE DATE

TAXONOMY PRIMARY	PRIMARY SPECIALTY

Credentialing / Corporate Address					
Address	**City**	**State**	**Zip**	**Phone**	**Fax**
14690 SPRING HILL DRIVE #101	SPRING HILL	FL	34609-8102	352-799-0046	352-799-0042

Pay to / Remittance Address:					
Address	**City**	**State**	**Zip**	**Phone**	**Fax**
PO BOX 919469	ORLANDO	FL	32891-9469	727-823-2188	727-828-0723

PRACTICE LOCATIONS	
Primary Address:	**Secondary Address:**
Office Hours	Office Hours

If you have any questions, please do not hesitate to contact credentialing at 352-799-0046 or via email to credentialing@accesshealthcarellc.net.

Please confirm receipt of this notice and estimated time of completion. Upon completion of the contracting and credentialing for this provider, please provide:

1. Effective Date
2. Insurance Provider ID#
3. Confirmation of Lines of Business
4. Next credentialing date

Sincerely,
Access Credentialing Department

LETTER OF AGREEMENT
ATTACHMENT

WHEREAS, Humana Insurance Company, Humana Health Insurance Company of Florida, Inc., Humana Medical Plan, Inc. and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**") and _____ (hereinafter referred to as "**Physician**") entered into a Physician Participation Agreement (hereinafter "**Agreement**") on _____, **AND**

WHEREAS, Physician and **Humana** agreed to be bound by the terms and conditions of the Agreement, **AND**

WHEREAS, the undersigned physician (hereinafter referred to as "**Participating Provider**") is a member of **Physician**, and a Participating Provider pursuant to the Agreement between **Physician** and **Humana** , **AND**

WHEREAS, **Participating Provider** acknowledges and agrees that the joinder of the **Humana** companies above shall not be construed as imposing joint responsibility or cross guarantee between or among **Humana** companies.

NOW, THEREFORE, the parties hereby agree as follows:

Participating Provider agrees to abide by all of the terms and conditions set forth in the Agreement, and to abide by all **Humana** policies and procedures established and revised from time to time by **Humana** including, but not limited to, quality assurance, quality improvement, risk management, utilization management, credentialing and recredentialing, and grievances/appeals.

Participating Provider unconditionally authorizes **Humana** and **Physician** to share information, including but not limited to credentialing, recredentialing, quality management and utilization management information as related to treatment of individuals covered under those **Humana** health benefits plans covered under the Agreement (hereinafter "**Members**"). However, it is understood expressly that the information shall not be shared with anyone not a party to the Agreement, unless required by law or pursuant to prior written consent of **Participating Provider**.

Participating Provider acknowledges that **Participating Provider** has been provided an opportunity to read the Agreement, all of the terms of which are hereby incorporated by reference.

Participating Provider further agrees that payment to **Physician** or **Participating Provider**, as applicable, from **Humana**, less any Copayments owed by the Member, is payment in full for health care services provided or arranged for Members in accordance with the applicable Member health benefits contract and the terms and conditions of this Agreement. **Participating Provider** shall look solely to **Physician** for payment and agrees that payments made by **Humana** to **Physician** for Covered Services rendered to Members by **Participating Provider** constitutes payment in full to **Participating Provider**.

Participating Provider further agrees that in the event of termination or expiration of the Agreement, or in the event **Physician** is dissolved for whatever reason, **Participating Provider** shall continue to provide health care services under the terms and conditions of the Agreement and **Humana** agrees to continue to pay **Participating Provider** in accordance with the fee-for-service payment arrangements stated in the payment attachment of the Agreement, for a period of one hundred and eighty (180) days after notice of dissolution of **Physician** or the effective date of termination or expiration of the Agreement, during which time a new physician agreement may be negotiated between **Humana** and the individual **Participating Provider**. **Humana** may terminate such **Participating Provider** participation at any time after dissolution of **Physician** or termination or expiration of the Agreement upon written notice to **Participating Provider**.

PARTICIPATING PROVIDER

Signature: _____
Print Name: _____
Date: _____

HUMANA

Signature: _____
Print Name: _____
Date: _____

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
ACCESS HEALTHCARE PHYSICIANS, LLC

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☑ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
PO BOX 919469

Requester's name and address (optional)

6 City, state, and ZIP code
ORLANDO, FL 32891-9469

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
			–			–				

or

Employer identification number
4	5	–	1	4	4	4	8	8	3

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** [signature] | **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.