APPENDIX A

Health-Care Providers for Whom Group Receives Payment

GROUP NAME: _____

GROUP FEDERAL EMPLOYER IDENTIFICATION NO. _____

OKLAHOMA HEALTH CARE AUTHORITY GROUP PROVIDER NO: _____

PAY TO / MAILING ADDRESS: _____ **PHYSICAL ADDRESS:** _____

_____ _____

TELEPHONE NUMBER: _____

NOTICE: *By signing this document the PROVIDER appoints the above named GROUP as his or her agent for receipt of payment for Medicaid-compensable health-care services and directs the Oklahoma Health Care Authority (OHCA) to make all such payments to GROUP in keeping with the agreement attached hereto, regardless of any other Agreement PROVIDER has with OHCA. The PROVIDER accepts all terms and conditions in the attached Agreement.*

By executing this document, the following Provider is notifying the Oklahoma Health Care Authority that Provider agrees to be bound by the terms and conditions of this Group Agreement through the Board of Regents of the University of Oklahoma, as executed by an authorized representative of the Board of Regents of the University of Oklahoma. This Acceptance Clause is the Provider's official request to participate in this Agreement through the Board of Regents of the University of Oklahoma.

PROVIDER SIGNATURE: _____ **SIGNATURE DATE:** _____

PROVIDER NAME: _____ **SOCIAL SECURITY NO:** _____

NPI (REQUIRED): _____ **STATE LICENSE NO:** _____

MEDICAID NO: _____ **SPECIALTY (IF ANY):** _____

MEDICARE NO: _____ **DATE ENTERED SERVICE:** _____