HMO PHYSICIAN ATTESTATION

This Physician Attestation is given to Hawai`i Independent Physicians Association, a nonprofit corporation organized under the laws of the State of Hawai`i (“HIPA” or “Health Center”) in connection with the HMO Health Center Medical Service Agreement (“Agreement”) entered into by and between Hawaii Medical Service Association (“HMSA”) and Health Center. I hereby attest to the following:

1. I acknowledge and agree that I have been engaged by Health Center and approved by HMSA to provide services as a Health Center Provider to Members of HMSA who have designated or are assigned to Health Center for the provision of Covered Services (“Health Center Members”) pursuant to the Agreement at the locations and facilities approved by HMSA.

2. If I am an Advanced Practice Registered Nurse (“APRN”) or Physician Assistant (“PA”) I acknowledge and agree that I shall only provide services as a Health Center Provider under the supervision of a physician, osteopath, or podiatrist who is a Health Center Provider.

3. If I am a Naturopathic Doctor (“ND”), I acknowledge and agree that I shall only provide services as a Health Center Provider under the supervision of a physician, osteopath, or podiatrist who is a Participating Provider in HIPA’s Physician Organization for HMSA’s Payment Transformation Program.

4. I acknowledge and agree that I shall:

    (a) Be bound by the terms of the Agreement with respect to the services I provide as a Health Center Provider, which terms shall be fully enforceable against me by Health Center and/or HMSA;

    (b) Comply with all requirements imposed on Health Center Providers under the Agreement in connection with the services I provide to Health Center Members;

    (c) Collaborate and cooperate with Health Center to manage cost and quality, including but not limited to by:

        (i) Adhering to evidence-based practice guidelines;

        (ii) Prioritizing referrals to Health Center in-network providers, and if no in-network provider is available, then to HMSA Participating Providers; and

        (iii) Engaging in team-based care as defined by the National Academy of Medicine whenever possible or, at the least, assuring the Physician and his/her staff have defined roles in the management of the patient’s pre-visit, visit, and post-visit care.

(d) Accept as reimbursement in full for the services provided to Health Center Members under the Agreement the amounts set forth on Schedule I to the Agreement, as amended from time to time, a copy of which shall be provided to me upon request; and

(e) Keep my practice information up to date with Health Center and HMSA, including but not limited to notification of changes to my address, email or telephone number(s); closing of my practice to new patients; or retirement.

5. I acknowledge and agree that HIPA shall have discretion to determine whether and how any Gain Share paid to Health Center under Schedule II to the Agreement shall be distributed to Health Center Providers.

6. In the event of a conflict between the terms of my Participating Physician Agreement(s) with HMSA and the terms of the Medical Service Agreement for the Health Center, I acknowledge and agree that the terms of the Medical Service Agreement shall apply to services I provide as a Health Center Provider.

7. I acknowledge and agree that my participation as a Health Center Provider does not mean I am a Member of HIPA, and that membership in HIPA is determined pursuant to criteria established from time to time by the Membership Committee of HIPA.

8. I acknowledge that I have been given the opportunity to request a copy of the Medical Service Agreement in order to familiarize myself with its terms prior to execution of this Physician Attestation.

9. I hereby acknowledge receipt and understanding of the Hawaii Independent Physicians Association Antitrust Policy, and as a condition of participating as a Health Center Provider, I agree to comply with its terms.

IN WITNESS WHEREOF, the undersigned has executed this Physician Attestation the ______ day of ________________, 20__.

Physician

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[Print name]:

Date: ____________________