PARTICIPATING

PROVIDER

MANUAL

March 2011

Dear Participating Provider:

Thank you for participating in the Beech Street network. With over 50 years of reliable service in the healthcare industry, Beech Street can offer you access to approximately 16 million eligible individuals nationally. We constantly strive to improve our products and services to meet the needs of our clients and participating providers.

This Provider Manual is a reference tool designed to provide information regarding the administrative procedures, programs, and products that apply to your network participation agreement with Beech Street ("Provider Agreement"). Since the Provider Manual is updated regularly, visit our website often at www.beechstreet.com to review the most current edition of the Provider Manual.

As you may know, on March 12, 2010, MultiPlan, Inc. acquired Viant, Inc. and since that time, we have been finalizing our plan to integrate Viant's Beech Street network into MultiPlan's network offerings. Certain functions, such as credentialing, have already been integrated. This Provider Manual currently outlines these processes applicable to Beech Street under the MultiPlan name. During 2011, providers who participate in Beech Street will receive information regarding the integration. Please follow the instructions provided in the letter regarding demographic updates, provider communication, information on the MultiPlan website, and other important information. For questions regarding the MultiPlan Network, please refer to the MultiPlan Provider Handbooks available at MultiPlan.com.

We appreciate and thank you for your participation in the Beech Street network.

Sincerely,

Keith Vangeison
Executive Vice President
Beech Street
A MultiPlan Network

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Please note that if a provision in this Provider Manual conflicts with state or federal law or the terms of your Provider Agreement, the state or federal law or your Provider Agreement will control. The terms of this Provider Manual may be modified at the sole discretion of Beech Street

SECTION 1

PROVIDER PROCEDURES OVERVIEW

Eligible person Identification

- As applicable under the eligible person's plan, eligible person identification materials are issued to the eligible person by the client or payer.
- The information provided on the eligible person's identification identifies the client and/or payer and provides instructions regarding claims submission and other claim requirements.
- Beech Street or the name of a Beech Street affiliate will appear on the Explanation of Payment (EOP).
- Please complete all required information on the claim for services provided to the eligible person prior to submission of the claim for payment.
- Make a copy of the eligible person's identification materials, as appropriate, for your records. Questions regarding claims procedures should be directed to the client or payer at the telephone number located on the eligible person's identification materials.
- The format and content of eligible person's identification materials may vary by plan.

Key Client Information

The following key client information can vary by plan and can change periodically:

- Plan Office Location
- Claims Payer
- Claims Mailing Address
- Employer Name
- Policy/Group Number

To facilitate claims processing, please review the eligible person's identification for information on these key items.

Eligibility and Benefit Verification

- Plan designs, eligibility and payer information vary by plan and must be verified with the appropriate party as identified on the eligible person's identification/insurance materials.
- Beech Street does not have access to eligibility/benefit information and is not an administrator, insurer, underwriter, guarantor, or payer of claims. Beech Street is not liable for any payment of claims submitted to Beech Street or any client or payer for services provided to an eligible person pursuant to a plan.

- The payer is responsible for payment of claims and supplying information related to coinsurance, deductible, copayment, and plan design.
- Unless prohibited by law, the copayment amount, deductible, or coinsurance may be collected at time of service, when known.
- The website tools found at www.beechstreet.com can help you to locate benefit office information. You will need the name of the eligible person's employer or insurer.

Claims Submission Process

- Claims should be submitted on appropriate industry standard forms, such as a CMS HCFA-1500 form, UB-92 form, or other successor or standard industry form, 1) within ninety (90) days after providing services; 2) if payer is the secondary payer, within ninety (90) days of the explanation of payment from the primary payer; or 3) as otherwise required by applicable law or your Provider Agreement.
- Unless otherwise required under applicable law or your Provider Agreement, all requests for appeals or adjustments with regard to underpayment of a claim by payer must be submitted within one hundred eighty (180) days from the date of the payer's payment or explanation of payment. Requests for appeals or payment adjustments regarding underpayment of a claim submitted after this date will be denied, and you may not bill Beech Street, the payer or the eligible person for such denied services.
- All claims should be submitted using your usual billed charges. As appropriate, the most recent versions of CPT-4 procedure codes (AMA Current Procedural Terminology), CMS (Center for Medicare and Medicaid Services), HCPCS (Healthcare Common Procedure Coding System) codes, revenue codes, DRGs, ICD-9 procedure codes or ICD-9 diagnostic codes (International Classification of Diseases, 9th Revision, Clinical Modification) should be utilized.
- Claims should be submitted to the location as directed on the eligible person's identification materials

Submitting Claims Electronically

All claims may be submitted electronically through transaction networks and clearinghouses in a process known as Electronic Data Interchange (EDI). This method promotes faster, more accurate processing than paper claims submitted by mail, and is required by federal benefit plans. We encourage you to exercise your best efforts to implement electronic claims submission capability as soon as reasonably practicable.

Billing Requirements

Properly completed billing forms are an integral part of the claims submission process. The omission of any of required fields may result in the delay of the processing or payment of claims. Information identifying the employer, payer, and policy number is

required for payment. Use of the appropriate procedure codes and modifiers is also essential.

Prior to submitting a claim for payment, please validate that all information applicable to the eligible person, provider and payer has been completed appropriately.

Providers must bill payers using the provider's usual billed charge, which charge will not discriminate based upon the identity of the payer

Requests for Claims Adjustments/Claims Appeals

- For questions regarding payment of a claim, contact the payer or payer designee first at the number or address listed on the eligible person identification card. For questions regarding a network related issue, including situations where, after contacting the payer or payer designee, you believe there was an incorrect application of the contract rate, contact Beech Street.

- We strive to resolve issues raised by providers on initial contact whenever possible. If issues cannot be resolved on initial contact, we offer a one-level internal appeal process.
- To initiate an appeal, please submit a written request for an appeal. Include a copy of the explanation of payment, billing, and any other pertinent information. Please submit appeals using the "Provider Claim Appeal Submission Form." The form can be found on the Beech Street website under the Provider tab. Appeals may be submitted:

  By Fax: (630) 649-5416

  By Mail: Beech Street
  535 East Diehl Road, Suite.100
  Naperville, IL 60563

- Unless otherwise required by applicable law or your Provider Agreement, all requests for appeals or adjustments with regard to underpayment of a claim by payer must be submitted within one hundred eighty (180) days from the date of the payer's original payment or explanation of payment. Requests for appeals or payment adjustments regarding underpayment of a claim submitted after this date will be denied, and you may not bill Beech Street, the client, the payer or the eligible person for such denied services.

Coordination of Benefits (COB)

Eligible persons are sometimes covered by more than one insurance policy, benefit plan or other health plan or program.

- Coordination of benefits is defined by the eligible person's plan.
- As a participating provider in the Beech Street network, please cooperate fully with Beech Street and/or Beech Street clients or payers in supplying information about other entities providing primary medical coverage or otherwise having payment responsibility for services rendered to members, and in all other matters relating to proper coordination of benefits.

Billing of Eligible Persons

- Your contract rate with Beech Street is payment in full for services rendered to eligible persons. Payment for covered services will be made net of applicable copayments, coinsurance and, deductibles which are the responsibility of the eligible person.
- Do not bill the eligible person for amounts in excess of the contract rate.
- The Explanation of Payment (EOP) sent by the payer or payer designee should identify the amount billable to the eligible person. Any questions regarding the EOP or eligible person responsibility should be directed to the payer or payer designee.
- In addition to collecting the applicable copayment, coinsurance, or deductible amount, providers may bill eligible persons for services not covered by the eligible person's plan if the eligible person has agreed in writing to pay for those services prior to the receipt of services.

Reimbursement Policies

Administrative Fees

When fees are negotiated for covered services pursuant to your Provider Agreement, it is recognized that such covered services may include an administrative and maintenance component. As a result, the fees paid for covered services pursuant to your Provider Agreement include payment for administrative, oversight, overhead and/or similar charges related to the provision of any covered service rendered. You may not separately bill or collect from the eligible person, the client or payer any additional amount for administrative, oversight, overhead and/or similar charges related to the provision of such covered services.

Professional Fees

Beech Street requires that all providers use the nationally recognized coding standards set by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association for all services performed. We refer to CMS reimbursement methodologies to help us develop our provider reimbursement structure for the services you render at approved clinical, institutional and non-institutional settings.

You may bill a professional fee when you have specifically provided a professional service to an eligible person. You may not bill a professional fee for a computer generated report.

Since we apply the industry standard code sets (CPT and HCPCS), we recommend you verify that all services performed have a signed physician order, are medically necessary and are coded correctly. Beech Street urges you to verify that the codes and descriptors used match the services performed. For further documentation, please refer to your Provider Agreement with Beech Street.

Diagnostic Radiology and Laboratory

- Participating providers are required to refer eligible persons to participating diagnostic radiology and laboratory providers for services that are not performed in the office. A list of participating radiology and laboratory providers can be found at our online provider directory at http://www.beechstreet.com.

- Industry standard billing guidelines will apply to these services.

Client List

Beech Street clients include insurance companies, self funded employer sponsored plans, labor trust funds, third party administrators, regional PPOs, and large managed care or other health plans.

- Access to a list of Beech Street's clients may be obtained at our website at www.beechstreet.com and by calling Customer Service at 800.877.1444 if a client is not listed on the website. Our client listing is subject to change.
- Some of the clients listed access the Beech Street network in limited geographies or for select payers or plans only. This means that not all plans administered by a client on our client list access the Beech Street network. For questions about a particular client, please call Customer Service at 800.877.1444.
- Benefit levels are determined by the applicable plan. Claims for covered services will be reimbursed at an in-network or out-of-network benefit level as applicable under the particular plan.
- Clients listed on our website may choose not to access the Beech Street network in certain circumstances. The Explanation of Payment or ERA will indicate when the Beech Street network contract rate has been applied to payment of a claim.
- The client list is considered confidential and proprietary information as defined in your Provider Agreement. Unauthorized use is prohibited.

Beech Street Participating Provider Listing

- Access to a current list of participating providers in the Beech Street network may be obtained at our web site, www.beechstreet.com.
- Information includes the names, addresses, telephone numbers and specialties of participating providers.

Please see Section 7 of this Manual for the appropriate procedures for submission of changes to your demographic information.

Proprietary Information

All information and materials provided to you by Beech Street, clients or payers remain proprietary to Beech Street, clients or payers. This includes, but is not limited to, your Provider Agreement and its terms, conditions, and negotiations, any program, rate or fee information, Beech Street client or payer lists, any administrative handbook(s), and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your Provider Agreement.

SECTION 2

BILLING AND REIMBURSEMENT GUIDELINES

Services should be billed in accordance with industry standard coding guidelines.

Group Billing Guidelines

- Beech Street requires that you provide all Tax Identification Numbers (TINs) currently in use, including the name of the owner of each TIN, for each of your practice locations. If a TIN is not recorded with Beech Street, benefits under the eligible person's plan may be reduced and your payment may be delayed. Please inform Beech Street promptly of any change in TIN, practice location, telephone number or billing address. Failure to provide updated information may result in a delay or error in payment of claims for covered services rendered to eligible persons.
- All sites at which you practice shall be considered in-network sites. If you also practice independently and have not contracted with Beech Street directly with respect to that independent site, services rendered by you at that site will be considered out-of-network. You must use different Tax Identification Numbers to distinguish between in-network and out-of-network sites.

Guidelines for Coding and Bundling of Claims

- Beech Street and payers have the right to establish coding guidelines generally based on the Current Procedural Terminology (CPT), as published by the American Medical Association and updated annually by the organization.
- In addition to CPT guidelines, guidelines adopted by the Centers for Medicare & Medicaid Services (CMS), industry standard guidelines and other coding and bundling guidelines may also be applied.
- Providers must comply with payer claim payment guidelines and the Utilization Management Program selected by the payer.
- Claims may be reviewed to identify services/items that are not in compliance with guidelines. No allowance for reimbursement will be made for services/items found not to be in compliance with such guidelines, unless otherwise specified in your provider agreement.
- In instances where the payer has reimbursed a provider for items not in compliance with such guidelines, the provider may be required to refund to the payer the amount of the overpayment.
- Review of provider claims for coding and billing may occur at the time of claims processing or may occur retrospectively.

Fragmentation (Unbundled Billing)

Individual CPT codes may include more than one associated procedure. It is inappropriate to bill separately for any of the procedures included in the value of another procedure.

REIMBURSEMENT Place of Service

Place of Service (POS) codes are two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the healthcare industry.

- Reimbursement is based on the Place of Service as listed in box 24b of the CMS 1500 form.

- Professional services are processed using the Facility Allowed Amount defined by CMS for claims submitted with the following Place of Service Codes:

Place of Service Code	Description
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Center

- All other Place of Service Codes submitted on a professional claim will be processed based on the Non-Facility Allowed Amount.

- If the place of service is not indicated on a professional claim, reimbursement will be made based on the value assigned to services rendered in the provider's office.

Ambulatory Surgery Center

- Multiple Surgical Procedures – Standard reimbursement for multiple surgical procedures is 100% of the contract rate for the procedure with the highest contract rate, and 50% of the contract rate for all subsequent procedures.

Modifiers

Certain modifiers (TC, 26, P1-P6, NU and RR) are applied at the time claims are repriced by Beech Street. All other modifiers are considered optional. Clients/payers can elect to turn processing "off" for these optional modifiers. Clients/payers may or may not apply those modifier rules upon receipt of repriced claims from Beech Street. If clients/payers elect to turn processing "on," Beech Street will apply the appropriate

rule(s) before sending the repriced claim back to the client/payer and the client/payer will not apply any additional modifier rules. The vast majority of clients utilize this option.

Integrated Modifiers

The table below summarizes all modifiers supported by Beech Street for purposes of repricing claims on behalf of clients/payers that access the Beech Street network. Except where noted, the rules specified below with regard to modifiers were effective as of January 1, 2011.

MODIFIER	DESCRIPTION	REPRICING RATE
22	Unusual procedural services	120%
23	Unusual anesthesia	120%
24	Unrelated evaluation and management service by the same physician during a postoperative period	100%
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	100%
47	Anesthesia by surgeon	100%
50	Bilateral procedure	100%, then 50%
51*	Multiple procedures	100%, then 50%
52	Reduced services	80%
54	Surgical care only	70%
55	Postoperative management only	30%
56	Preoperative management only	10%
59	Distinct procedural service	100%
62	Two surgeons	62.5%
66	Surgical team	100%
76	Repeat procedure or service by same physician	100%
77	Repeat procedure by another physician	100%
78	Unplanned return to the OR by the same physician following initial procedure for a related procedure during the postoperative period.	100%
80	Assistant surgeon	20%
81	Minimum assistant surgeon	10%
82	Assistant surgeon (when qualified resident surgeon not available)	20%
90	Reference (outside) laboratory	100%
AA	Anesthesia	Accepted
AS	Services performed by an assistant to the MD, covering non-MD assistants	10%

MODIFIER	DESCRIPTION	REPRICING RATE
P1	Anesthesia Modifier - A normal healthy patient	0 ASA Base Units
P2	Anesthesia Modifier - A patient with mild systemic disease	0 ASA Base Units
P3	Anesthesia Modifier - A patient with severe systemic disease	1 ASA Base Unit
P4	Anesthesia Modifier - A patient with severe systemic disease that is a constant threat to life	2 ASA Base Units
P5	Anesthesia Modifier - A moribund patient who is not expected to survive w/o the operation	3 ASA Base Units
P6	Anesthesia Modifier - A declared brain dead patient	0 ASA Base Units

MODIFIER	DESCRIPTION	REPRICING RATE
	whose organs are being removed for donor purposes	
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.	50%
QX	CRNA service: with medical direction by a physician	50%
QY**	Medical direction of one CRNA by an anesthesiologist	50%
QZ**	CRNA service: without medical direction by a physician	100%
26	*Professional component*	Fee Schedule
NU	*New equipment*	Fee Schedule
RR	*Rented equipment*	Fee Schedule
TC	*Technical component*	Fee Schedule

* Beech Street reprices the highest allowable procedure code that contains the 51 modifier at 100% of the contract rate, and all subsequent codes that contain the 51 modifier at 50% of the contract rate.

** Effective February 1, 2011

SECTION 3

MEDICAL MANAGEMENT

Beech Street requires that network providers participate in and cooperate with the medical management programs selected by the client, payer, or plan. Utilization management is a medical management program which may include, but is not limited to, pre-certification, concurrent review, and retrospective review. Medical management programs may also include case management, disease management, maternity management, and mental health management services.

Utilization management programs may require that you obtain pre-certification for specific services prior to rendering the services. The eligible person's identification card typically provides a telephone number for questions regarding the applicable utilization management program Please verify any pre-certification or other medical management requirements at the time you verify benefits and eligibility.

Medical records requested by the payer, Beech Street or their designee in connection with utilization management or other medical management programs must be provided at no charge and within the time frame requested which time frame must be reasonable under the circumstances, unless otherwise required by your Provider Agreement.

Unless otherwise required by state or federal law or your Provider Agreement, payment may be denied for failure to comply with medical management requirements, and providers cannot bill Beech Street, clients, payers or eligible persons for any such denied payments.

Appeals of medical management determinations will be handled in accordance with the procedures defined by the applicable payer or plan.

SECTION 4

NETWORK PARTICIPATION: CREDENTIALING AND QUALITY MANAGEMENT PROGRAMS

MultiPlan, Inc. performs all credentialing and quality management activities on behalf of Beech Street with regard to the Beech Street network.

Provider Responsibilities and Requirements

As part of the Beech Street network, you are responsible for meeting certain requirements for network participation. You have the responsibility for:

- The care and treatment of eligible persons under your care. You must ensure that all care is rendered in accordance with generally accepted medical practice and professionally recognized standards and within the scope of your applicable license, accreditation, registration, certification and privileges;
- Complying with any and all applicable state and/or federal laws related to the delivery of health care services and the confidentiality of Protected Health Information and taking all precautions to prevent the unauthorized disclosure of such eligible person's medical and billing records;
- Complying with Beech Street? and client and/or payer requests for copies of a eligible person's medical and billing records for those purposes which Beech Street and/or its clients or payers deem reasonably necessary, including without limitation and subject to any applicable legal restrictions, quality assurance, medical audit, credentialing, recredentialing or payment adjudication and processing;
- Cooperating with the Quality Management and Utilization Management programs of client or payers;
- Meeting the MultiPlan credentialing criteria for participation in the Beech Street network, as referred to later in this section; and
- Honesty in all dealings with MultiPlan or Beech Street, its clients and payers. As a provider participating in the Beech Street network, you agree not to make any untrue statements of fact in any claim for payment, nor any untrue statements of material fact or any intentional misrepresentations of any fact in any statement made to MultiPlan or Beech Street or any Beech Street client or payer.

In addition, you must meet the following requirements for participation in the Beech Street network:

- You may not engage in inappropriate billing practices, including but not limited to billing for undocumented services or services not rendered, unbundling, up-coding or balance billing.
- You may not change hospital affiliations, admitting privileges or specialty status in such a way as to substantially limit the range of services you offer and/or access to your services by eligible persons.
- You may not be the subject of publicity that adversely affects the reputation of Beech Street, as determined by Beech Street. You may not commit professional misconduct that violates the principles of professional ethics.

- You may not engage in any action or behavior that disrupts the business operations of Beech Street or any client or payer.
- Your responses to inquiries by Beech Street shall be timely, complete and delivered in a professional manner.

Quality Monitoring Activities

The Quality Management Committee

The MultiPlan Quality Management Committee is a company wide council that provides support and oversight of quality management and improvement activities at MultiPlan, including Beech Street. The MultiPlan Quality Management Committee also supports and promotes the quality initiatives for Beech Street, including the following:

- To strengthen the position of Beech Street and MultiPlan as organizations that continually strives to deliver services of optimal quality to its clients, payers and their eligible persons;
- To promote company wide awareness of, and participation in, continuous quality improvement;
- To oversee activities throughout the company that contribute to quality and process improvement; and

In addition to the Quality Management Committee, the MultiPlan commitment to quality includes maintaining provider credentialing, recredentialing and quality management programs. Specifics of these programs follow.

Credentialing

We apply rigorous criteria when we credential the providers in the Beech Street network. MultiPlan has established and periodically updates credentialing criteria for all categories of providers it accepts into the Beech Street network. The credentialing criteria applicable to network professionals include but are not limited to:

- Board certification or requisite training in stated specialty
- Acceptable licensure history as provided by the National Practitioner Data Bank (NPDB) and/or the state licensing board(s)
- Acceptable malpractice claims payment history
- Adequate liability insurance
- Admitting privileges at a network facility
- Current, valid, clinically unrestricted license

The MultiPlan Credentials Committee makes all decisions regarding provider participation in the Beech Street network in accordance with MultiPlan credentialing criteria. Credentialing criteria vary by provider type. To obtain a copy of the MultiPlan credentialing criteria, please contact Service Operations at (800) 950-7040.

Recredentialing

Network Professionals

MultiPlan recredentials providers participating in the Beech Street network on a set schedule in accordance with state and federal law and national accreditation standards. MultiPlan compares qualifications for providers participating in the Beech Street network to credentialing criteria and considers any history of complaints against the network provider. Recredentialing activities may also be triggered as a result of quality management investigations or information received from state or federal agencies. Following the submission of a signed, complete recredentialing profile, providers are considered to be successfully recredentialed unless otherwise notified by MultiPlan

Quality Management Program

MultiPlan maintains a quality management program that is responsible for the management of complaints originating from various sources, including members, clients or payers. The quality management program acknowledges, tracks and investigates complaints about network professionals, and manages their resolution through a standard process. Complaints may include but are not limited to perceptions of:

- Unsatisfactory clinical outcome
- Inappropriate, inadequate, over-utilized or excessive treatment
- Unprofessional behavior by network professional or office staff
- Inappropriate billing practices

As part of your participation in the Beech Street network, you are responsible for participating in, and observing the protocols of the MultiPlan quality management program. The MultiPlan quality management program consists of the following:

Investigation Process

MultiPlan facilitates the complaint investigation process by gathering information from various parties (including the network professional involved) to determine the circumstances surrounding the complaint. Requests for information from network professionals may include an eligible person's medical and/or billing records. MultiPlan recognizes that the network professional's participation in the investigation process is critical. When requesting information, MultiPlan reports the complainant's concerns and affords the network professional an opportunity to respond to the complaint.

While complaints are investigated in a timely fashion, it is important to note that timeframes are predicated upon the receipt of information necessary to complete the investigation. Depending upon the nature of the complaint, it may be thirty to sixty (30-60) days before an initial determination is reached. MultiPlan conducts the investigation process with strict confidentiality. If the complaint is of a clinical nature, MultiPlan clinical staff (including a MultiPlan Medical Director) participates in the investigation process.

Outcome of Investigation

Investigation outcomes vary based on the type and severity of the complaint and the complaint record of the network professional. Based upon the outcome, complaints may be categorized as “No Incident,” or in levels ranging from “Patient Dissatisfaction” to “Termination.” If the investigation reveals the presence of imminent danger to patients, termination may be immediate.

MultiPlan communicates investigation outcomes and resulting actions directly to the network professional involved. Network professionals terminated from participation in the Beech Street network are notified in writing and informed of the right to appeal. All complaint records are maintained confidentially and reviewed during the recredentialing process. Data obtained from analysis of complaint records may also be used in aggregate form to support other initiatives, including provider education.

Appeals Process for Professionals Terminated or Rejected from the Beech Street Network

MultiPlan complies with all state and federal mandates with respect to appeals for providers terminated or rejected from the Beech Street network(s). Terminated or rejected providers may submit a request for an appeal as outlined in the letter of rejection/termination sent by MultiPlan. In addition, the request for appeal must be received by MultiPlan within thirty (30) days of the date of the rejection/termination letter. Upon receipt of the letter by MultiPlan, the appeal is forwarded to the MultiPlan Appeals Committee for review.

The voting members of the Appeals Committee are MultiPlan Medical Directors and network professional(s). Advisory members may include:

- Appeals Committee Chair - MultiPlan Medical Director
- One representative from the Network Quality Department
- One representative from the MultiPlan Legal Services Division

The appeal is conducted on the basis of any written information submitted by the terminated or rejected provider, in conjunction with any information previously in possession of or gathered by MultiPlan. Unless required by state or federal law, MultiPlan does not offer meetings in person or by telephone with the terminated or rejected provider, or any representative thereof, as part of the appeals process.

The appeal information submitted by the terminated or rejected provider is presented to the Appeals Committee by either a representative from MultiPlan Corporate Quality Management or the MultiPlan Medical Director in whose region the provider practices. In the event the terminated or rejected provider is a mental health/behavioral health provider, a MultiPlan psychiatrist attends the Appeals Committee meeting.

By majority vote, the Appeals Committee renders a decision to uphold or reverse the initial decision to reject or terminate the provider. The provider has the right to request a second level of appeal, which is heard by a separate MultiPlan Appeals Committee. The determination of the second level Appeals Committee is final.

In the event that MultiPlan upholds a decision to terminate a provider upon appeal, the original effective date of the termination is upheld unless otherwise determined by the MultiPlan Appeals Committee.

If the Appeals Committee reverses a termination decision, the Network Professional's participating status is reinstated as of the date of the initial adverse decision, unless otherwise determined by the Appeals Committee.

MultiPlan Agreement with the National Practitioner Data Bank (NPDB) for Professionals Terminated from the Network

As a requirement of the participation agreement between MultiPlan and the National Practitioner Data Bank (NPDB), MultiPlan is obligated to report the termination of a network professional if the termination resulted from a quality of care issue resulting in harm to an eligible person's health and/or welfare. Any provider subject to this reporting requirement is notified via a letter of termination from MultiPlan. The network professional may have additional appeal rights afforded by state or federal law.

Section 5

DEMOGRAPHIC CHANGES

Any change to the provider profile that was supplied on the original application for participation in the Beech Street network must be reported in writing or electronically submitted to Beech Street. All notices must contain both the old and new information in order to assure the information is being processed correctly. The written notification must be on letterhead and signed by the provider or group administrator. It is vital that all written notices be as clear and precise as possible. This can help ensure accuracy and allow for changes to be completed in a timely manner.

The following are the types of changes that must always be reported as soon as possible to Beech Street:

- New address. Please indicate whether this is an additional address, or a replacement to an address previously supplied
- New telephone or facsimile number: Indicate which address(es) correspond to each phone number
- Additional office location:. Please include Phone, Fax, and TIN for each office location provided
- Provider joins or leaves practice. Please include Specialty, Add/Term Effective Date, TIN, etc for each provider
- New ownership of practice
- New tax identification number (with effective date and copy of the W-9 form). Please indicate whether this is an additional TIN or a replacement to a TIN previously supplied
- Change in hospital affiliation. Please indicate new affiliation, in addition to the old affiliation, and whether the old affiliation needs to be removed
- Change in board certification status
- Change in liability coverage
- Change in practice limitations

The following data changes require written notification to our Network Administration Department and must be submitted on your office stationery. The chart below outlines the options available for submitting the changes.

Type of Change	Method of Submission		
	Facsimile:	**Email:**	**Mail:**
	(866) 241-1644	network.operations@multiplan.com.com	PO Box 22968 Chattanooga, TN 37421
Tax Identification Number (TIN) name and number addition or change (Note: must included copy of W-9 form)	X	A scanned copy of the W-9 form must be attached	X
Tax Identification Number (TIN) removal	X	X	X
Retirement	X	X	X
Disenrollment	X	X	X
Deceased provider	X	X	X

Malpractice changes on the malpractice face sheet	X	X	X
Type of Change	**Facsimile:**	**Email:**	**Mail:**
	(630) 799-3050	nominations@multiplan.com	25500 Commercentre Drive Lake Forest, CA 92630
Adding a new provider to an existing *non-delegated group* agreement - The signed application and all required documents listed below must be attached (use the Add-To-Group form)	X	X	X

NON-DELEGATED GROUP ADD-ON FORM
(Existing Group Only)

Please submit the Beech Street **Provider Application or State Mandated application** for **each provider** you are adding to your group practice. Please ensure the following Credentialing data elements are included with each application:

1. Current Curriculum Vitae (CV) or resume
2. W9 IRS Form, including signature and date, if applicable
3. State Controlled Substance Certificate (CDS, BNDD, etc.) – required for the following states: AL, CT, DC, HI, ID, IL, LA, MD, MO, NV, RI, SC
4. Completed, signed and dated Attachment II for every malpractice case occurring in the last 5 years or any pending claim which involves the death of an eligible person.

You may submit your provider's application to us via:

- Fax @ 630-799-3050
- Email @ nominations@multiplan.com
- Or you may mail your request to:

  Viant, Inc.
  Attention: Contract Support – Beech Street Network
  25500 Commercentre Drive
  Lake Forest, CA 92630

Section 6

PRODUCT GRID

Beech Street Program	Features
Beech Street Primary Network	• A network that is accessed by eligible persons on a primary basis where covered services are payable at the highest or in-network benefit level available under the eligible person's plan. • Eligible persons can access our provider directory to verify provider participation. • Our customers recognize the importance of timely payment for services. • Eligible person identification cards identify Beech Street or a Beech Street affiliate and provide customer contact information, including where to send claims. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate.
Beech Street Complementary Network	• A network that extends provider access to eligible persons who would like to receive medical care from providers that do not participate in their health plan's primary network. • Benefits apply at the in-network or out-of-network benefit level, based on the eligible person's benefit plan. • Eligible persons can access our provider directory to verify provider participation. • Our customers recognize the importance of timely payment for services rendered. • Eligible person identification cards identify Beech Street or a Beech Street affiliate and provide customer contact information, including where to send claims. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate.
Beech Street Supplemental Network	• A network that extends provider access to eligible persons who would like to receive medical care from providers that do not participate in their health plan's primary network. • Benefits typically apply at the out-of-network benefit level, based on the eligible person's benefit plan. • Our customers recognize the importance of timely payment for services rendered. • Potential for reduced administrative expenses with fewer individual claim negotiations. • Eligible person identification cards provide payer contact information, including where to send claims. Identification cards do not include the Beech Street or Beech Street affiliate name, but providers can access a list of customers that access the Supplemental Network on the Beech Street website. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate. • Some plans accessing the Supplemental Network do not include direction mechanisms.
Consumer Card	• Eligible persons can access our provider directory to verify provider participation. • Eligible person identification cards identify Beech Street or a Beech Street affiliate. • Eligible person identification cards also provide contact information, including how to determine the network contracted amount and verify eligible person participation. • The eligible person is responsible for payment of services at the contract rate, and payment may be collected from the eligible person at the time of service.
Workers' Compensation Network	• Network access for services subject to a customer's workers' compensation program. • Adjusters and eligible persons can access our provider directory to verify provider participation. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate.
Auto Medical	• Network access for health care services rendered under a customer's auto medical program. • Eligible persons can access our provider directory to verify provider participation. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate.

The above is a summary of our standard product portfolio. Some of the above listed products may not apply to your Provider Agreement. Our network product portfolio is subject to change.

If you have any questions about participation in these network products, please feel free to contact our Provider Services Department at the numbers listed below:

- Primary/Complementary/Supplemental 800.432.1776
- Consumer Card 800.432.1776
- Workers' Compensation 800.877.1333
- Auto Medical 800.877.1909