DEPARTMENT OF REHABILITATION SERVICES

NETWORK PROVIDER

FACILITY

CONTRACT

DRSNFCv1.0

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DEPARTMENT OF REHABILITATION SERVICES
NETWORK FACILITY CONTRACT

It is hereby agreed between the State Department of Rehabilitation Services and the Facility named on the signature page, that the Facility shall be a provider in the State Department of Rehabilitation Service's network of providers.

This contract is entered into for the purpose of defining the conditions for reimbursement by the State Department of Rehabilitation Services to the Facility. It in no way is meant to impact on the Facility's decision as to what is considered appropriate medical treatment.

I. RECITALS

1.1 The State Department of Rehabilitation Services (hereinafter, DRS) is a statutory body created by 74 O.S., § 166.1, as amended, to administer and manage a certain program of medical care for persons eligible for public assistance.

1.2 The Facility is duly licensed by the State of Residence and is certified to participate in the Medicare program under Title XVIII of the Social Security Act, and/or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and shall comply with all applicable Federal, State, and Local laws regulating such a Facility providing general acute health services and satisfies the criterion as established by the DRS.

1.3 The intent of this contract is to provide access to enhanced quality health care at an affordable, competitive cost to the DRS and its beneficiaries.

1.4 Failure to abide by any of the following provisions may result in non-renewal of the Contract or may be cause for termination.

II. DEFINITIONS

2.1 "Allowable Fee" means the maximum charge payable to a Facility for a specific procedure in accordance with the provisions in Article VI of this Contract. The Facility shall charge the usual and customary fee unless the fee schedule limits otherwise.

2.2 "Emergency" means a sudden onset of a medical or mental condition displaying acute symptoms that are so severe that the absence of immediate medical attention could reasonably result in:

a) permanently placing the patient's health in jeopardy; or
b) causing other serious medical consequences; or
c) causing serious impairment to bodily functions; or
d) causing serious and permanent dysfunction of any body organ or part.

2.3 "Facility Services" means those acute care inpatient and outpatient Facility services that are pre-authorized by the DRS.

2.4 "Medical" means belonging to the study and practice of medicine for the prevention, alleviation or management of a physical or mental defect, illness, or condition.

2.5 "Medically Necessary" means services or supplies that, under the provisions of this Contract, are determined to be:

a) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
b) provided for the diagnosis and treatment of the medical condition, and
c) within standards of acceptable, prudent medical practice within the community, and
d) not primarily for the convenience of the beneficiary, the beneficiary's Hospital or another provider, and
e) any condition which, if left untreated, could deteriorate into a life threatening situation, and
f) the most appropriate supply or level of service that can safely be provided. In the event of an inpatient Hospital stay, acute care is necessary due to the types of services the beneficiary is receiving or the severity of the beneficiary's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

2.6 "Medical Services" means the professional services provided by a Network Facility and pre-authorized by the DRS' Plan.

2.7 "Beneficiary" means all persons eligible for benefits as determined by established criterion.

2.8 "Network Facility" means a certified Facility that has entered into this Contract with the DRS to accept scheduled reimbursement for pre-authorized medical services provided to beneficiaries.

2.9 "Network Physician" means a licensed practitioner of the healing arts who has entered into a Contract with the DRS to accept scheduled reimbursement for pre-authorized medical services provided to beneficiaries.

2.10 "Outpatient Services" means medically necessary Facility services for treatment rendered by a Facility to a beneficiary, including, but not limited to, emergency room care, clinic care, ambulatory surgery, radiology, pathology and other services which are provided without the admission of the patient.

2.11 "Prior Authorization" means a function performed by the DRS to assess the health care services available to the beneficiary and authorize appropriate services prior to services being rendered.

2.12 "Psychiatric Day Treatment" means an approved treatment that provides a therapeutic environment consisting of appropriate mental health therapy, supportive care, case management, and reintegration into the home and community.

2.13 “Rehabilitation” means an approved treatment that leads to the restoration of an ill or injured person to self sufficiency at their highest attainable skill.

2.14 "Residential" means an approved treatment Facility which provides temporary accommodations. It is a structured, safe, and therapeutic environment in which residents receive psychotherapy appropriate to their individualized treatment plan.

2.15 “Skilled Nurse Hospital” means an approved treatment Hospital rendering services prescribed by a physician that could not be given safely or reasonably by a person who is not medically skilled and would need continuous supervision of the effectiveness of the treatment and progress of the condition of the patient. These services are not custodial in nature.

2.16 "Third Party Payor" means an insurance company or other entity making payment directly to the Hospital on behalf of the DRS.

III. RELATIONSHIP BETWEEN THE DRS AND THE FACILITY

3.1 The DRS has negotiated and entered into this Contract with the Facility on behalf of the beneficiaries of the DRS. The Facility is an independent contractor that has entered into this Contract to become a Network Facility and is not, nor is intended to be, the employee, agent or other legal representative of the DRS in the performance of the provisions of this Contract. Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of independent contractor for the purposes of this Contract.

3.2 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies of any third party, including but not limited to, a beneficiary or a Network Provider other than the Facility named in this Contract.

IV. FACILITY SERVICES AND RESPONSIBILITIES

4.1 The Facility shall provide quality, medically necessary services to beneficiaries, in a cost efficient manner, when such services are ordered by a licensed practitioner of the healing arts, and pre-authorized by the DRS. The ordering Provider must be a member of the Facility's medical staff and have been awarded the prerequisite clinical privileges to order and/or perform such services. Nothing in this Contract shall be construed to require the medical staff of the Facility to perform any procedure or course of treatment which the staff deems professionally unacceptable or is contrary to Facility policy.

4.2 The Facility shall provide Facility services to beneficiaries in the same manner and quality as those services are provided to all other patients of the Facility.

4.3 The Facility has, and shall maintain, in good standing while this Contract is in effect, all licenses required by law, and if applicable, certification to participate in the Medicare program under Title XVIII of the Social Security Act and/or JCAHO certification.

4.4 The Facility agrees to submit billing data and records of treatment in the manner and form prescribed by the DRS. The individual's medical case records will be available during regular working hours to authorized representatives of the DRS and copies thereof will be furnished by the Facility when requested by an authorized representative of the DRS. The Provider agrees to retain one copy of the billing data and records of treatment and all other records upon which a claim is base, in its file for a period of six (6) years.

4.5 It is understood that any person seeking medical services has the right to make application for payment on his behalf by the DRS for compensable services provided by the Facility. The Facility and/or Facility's office staff agrees to assist the patient in making application for such care and services.

4.6 Authorized representatives of the DRS and/or the Secretary of Education shall have the right to make physical inspections of the Hospital's office and to examine such records as they relate to financial statements submitted under this Contract or to payments claimed by the Facility under this Contract; and to conduct audits of the financial records of the Facility, at any time, as provided by Code of Federal Regulations, Title 34 § 74.53.

4.7 The Facility agrees that all information provided is true, accurate and complete. The Facility understands that payment and satisfaction of all claims will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may subject the Facility to prosecution under applicable Federal and State laws. The Hospital further agrees that work, services, or materials shown by any invoice or claim have been completed or supplied in accordance with the plans, specifications, order or requests furnished. The Facility further agrees that it has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly to any elected official, officer or employee of the State of Oklahoma of money or any other thing of value to obtain payment.

4.8 The Facility agrees to disclose to the DRS, prior to approval or renewal of this Contract, the name of any person who has an ownership or controls an interest in, or is an agent or managing employee of the Facility who has been convicted of a criminal offense related to such person's involvement in any program under Titles V, XVIII, XIX, or XX of the Social Security Act since inception of these programs.

4.9 The Facility shall accurately complete the network Facility application that is attached to and made a part of this Contract. The Facility shall notify the Network Manager of any change in the information contained in the application within fifteen (15) days of such change, including resolved litigation listed as "pending" on the original application.

4.10 The Facility shall disclose ownership and control interests at the time of entering into this Contract on the required Federal reporting form and at other times that the DRS or the Secretary of Education may require and in a form designated by the DRS.

4.11 The Facility agrees to submit, within thirty-five (35) days of the date on a request by the DRS or Secretary of Education, full and complete information about:

a) The ownership of any subcontractor with whom the Facility has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request,
b) Any significant business transactions between the Facility and any wholly owned supplier, or between the Facility and subcontractor, during the five (5) years period ending on the date of the request.

4.12 The Facility agrees and understands that payment cannot be made by the DRS to vendors providing care and/or services under Federally-assisted programs unless care and/or service is provided without discrimination on the grounds of race, color, national origin, handicap or unless program enabling legislation permits on the basis of age. This assures compliance with the Department of Education, Regulations, Title 34, Code of Federal Regulations, § 76.500 (which implements Title VI and Title VII of the 1964 Civil Rights Act, Title IX of the Education Amendments of 1972, the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975 and the Americans with Disabilities Act). These laws and regulations prohibit excluding from participation in, denying the benefits of, or subjecting to discrimination, under any program or activity receiving Federal Financial Assistance, any person on the grounds of race, color, national origin, any qualified person on the basis of handicap or without distinctions made on the basis of age except as legislatively permitted or required. Written complaints of non-compliance with either law should be made to the Director of Department of Rehabilitation Services, 3535 N.W. 58th St, Suite 500, Oklahoma City, Oklahoma 73112, or the Secretary of Education, Washington, D.C., or both.

V. DRS SERVICES AND RESPONSIBILITIES

5.1 The DRS agrees to pay the Facility compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.

5.2 The DRS agrees to grant the Facility the status of "Network Facility" and to identify the Facility as a Network Facility on informational materials disseminated to beneficiaries.

5.3 The DRS agrees to continue listing the Hospital as a network Facility until this Contract terminates.

5.4 The DRS agrees to provide the Facility access to a listing of all Network Providers.

5.5 The DRS agrees to provide appropriate documentation to beneficiaries for the verification of prior authorization procedures and to establish the provision of appropriate health care.

5.6 The DRS agrees to acknowledge the confidentiality of patient's records and to only release pertinent clinical information in accordance with State and Federal guidelines.

5.7 The DRS shall give a forty-eight-hour (48) notice prior to an audit.

5.8 The DRS shall maintain prior authorization programs for all prescribed medical services.

VI. COMPENSATION AND BILLING

6.1 The Facility shall seek payment only from the DRS for the provision of medical services except as provided in paragraph 6.3. The payment from the DRS shall be limited to the amounts referred to in paragraph 6.2.

6.2 The DRS agrees to pay the Facility's billed charge for each procedure or the fee set by the DRS for the provision of medical services, whichever is less. The DRS shall have the right to categorize what shall constitute a medical service. The DRS and the beneficiary's financial liability shall be limited to the allowable for the medical service, as determined by the DRS, paid by applying appropriate coding methodology, whether the Facility has billed appropriately or not. Benefits will be allowed when the beneficiary has received medically necessary services pre-authorized by the DRS.

6.3 The Facility agrees to accept the payment from the DRS as full and complete payment for services for recipients of public assistance. If the patient is a recipient of Medical Assistance, Rehabilitation Services only, payment from the Department shall represent payment in full except the Facility may collect an amount not to exceed that shown on DRS Form DRS-C-100, Medical Services Authorization.

6.4 The Facility agrees to release all liens for which payment has been made for Title XIX by the DRS and notify the DRS. However, this provision does not affect the Facility's entitlement to file a lien or liens for non-pre-authorized services.

6.5 The Facility shall bill the DRS on form UB-92 in accordance with the UB-92 manual for the State of Practice and provide an itemized bill upon request. The Facility shall bill the DRS within fifteen (15) working days of the date of service or the date of discharge.

6.6 The DRS shall reimburse the Facility within thirty (30) days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this contract. The DRS will not be responsible for the delay of reimbursement due to circumstances beyond the DRS' control.

6.7 The DRS shall have the right at all reasonable times and to the extent permitted by law, to inspect and duplicate all medical and billing records relating to medical services rendered to pre-authorized beneficiaries at no cost to the DRS or the beneficiary.

VII. UTILIZATION MANAGEMENT

7.1 The Facility shall adhere to and cooperate with the DRS' established Prior Authorization procedures.

VIII. LIABILITY AND INSURANCE

8.1 Neither party to this Contract, the DRS nor the Facility, or any agent, employee or other representative of a party, shall be liable to third parties for any act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.

8.2 The Facility shall be required to obtain general and medical liability coverage for claims of acts and omissions of the Facility and its employees and agents. Such coverage shall be maintained at a level of not less than that which is mandated by state statute or less than One Million Dollars ($1,000,000) per incident, when the Facility is not regulated by statute. The DRS shall be notified thirty (30) days prior to cancellation. If coverage is lost or reduced below specified limits, this contract may be canceled by the DRS.

IX. DISPUTE RESOLUTION

9.1 The DRS and the Facility agree that their authorized representatives will meet in a timely manner, and negotiate in good faith, to resolve any problems or disputes that may arise in performance of the terms and provisions of this Contract. Nothing in this Article shall interfere with either party's rights under Article X.

X. TERM AND TERMINATION

10.1 The initial term of this Contract shall be for one year commencing on the prescribed date, or the effective date on the signature page, whichever is later, and shall remain in effect until terminated by either party subject to 11.2

10.2 Either party may terminate this Contract with or without cause, upon giving thirty (30) days notice pursuant to 12.2 at any time during the term of this Contract.

10.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.

10.4 Following termination of this Contract, the DRS shall continue to have access, at no cost to the DRS, to the Facility records of care and services provided to beneficiaries for six (6) years from the date of provision of the services to which the records refer as set forth in paragraph 6.7.

10.5 This Contract shall terminate with respect to a Facility upon:

a) the loss or suspension of the Facility's license to operate in the State of Residence, JCAHO/Medicare certification; or
b) failure to maintain Facility's professional and general liability coverage in accordance with this contract.

XI. GENERAL PROVISIONS

11.1 This Contract, or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.

11.2 Any notice required to be given pursuant to the terms and provisions of this contract shall be in writing, postage prepaid, and shall be sent by certified mail, return receipt requested, to the Department of Rehabilitation Services at the mailing address listed on the application. The notice shall be effective on the date indicated on the return receipt.

Department of Rehabilitation Services
P.O. Box 57630
Oklahoma City, OK 73157-7630

11.3 Not withstanding the provisions in Section 11.1, the DRS may designate an administrator to administer any of the terms of this Contract.

11.4 This Contract, together with exhibits, contains the entire agreement between the DRS and the Facility relating to the rights granted and the obligations assumed by the parties concerning the provision of Facility Services to beneficiaries. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract, not expressly set forth in this Contract, are of no force or effect.

11.5 This Contract, or any part or section of it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the DRS and the Facility.

11.6 This Contract is subject to all applicable Federal laws, Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract, which is not in conformity with existing or future legislation, shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with Federal laws and the State of Oklahoma statutes.

11.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Contract, or any one provision, in accordance with the intent and purpose of the parties hereto.

11.8 Nothing in this contract shall imply that the Facility is obligated to perform any medical procedure which would be contradicted by the Directives for Catholic Health Care Facilities.

Department of Rehabilitation Services

NETWORK PROVIDER FACILITY CREDENTIALING INFORMATION

CONTRACT APPLICATIONS

- Department of Rehabilitation Services requires all three addresses on the respective pages of the application.

1. **Service Address**-This address is used for the location where health care services are performed and/or the physical location of the provider. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all Department of Rehabilitation Services Network Providers

2. **Mailing Address**-This address is used for all correspondence (not related to claims) and credentialing information.

3. **Billing Address**-This address is used for submitting all claims to Department of Rehabilitation Services for processing and appears in box 33 of the CMS-1500 claim form or box 2 on the UB-04. If box 2 is not used by the facility, the billing address appears in Box 1 of the UB-04. Claims will be paid exclusively to the billing address.

- Each address must have a corresponding phone number, fax number and contact person.

- Insurance Certificate/Face Sheet must have name of the applicant listed as the insured. The insurance limits must be at the levels required in the contract and must indicate clearly the coverage type(s) stated in the contract. Product liability coverage in lieu of professional/medical liability is acceptable for DME only.

- W-9 forms must be signed and list only the Tax ID number for each location listed on the application which will be used on claim forms

Please return entire application packet with the new information.

DEPARTMENT OF REHABILITATION SERVICES
NETWORK FACILITY APPLICATION REQUIREMENTS

Thank you for your interest in the Department of Rehabilitation Services Provider Network.

Please complete the following application and submit it with the required attachments listed below to the address listed on the application.

Type or print your responses and complete all sections of the Application. If an area of inquiry is not applicable to the Facility, please indicate. If you need additional space to provide COMPLETE responses, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

Retain the contract for your records. Do not send it back with the Application.

REQUIRED ATTACHMENTS

Attach a copy of each of the following documents to your completed Application:

Current state(s) license(s)

Face sheet of current professional liability insurance policy
Insurance Certificate/Face Sheet must have the name of the applicant listed as the insured. The insurance limits must be at the levels required in the Contract and must indicate clearly that it is professional liability coverage.

W-9 form for each Federal Tax ID Number
W-9 forms must be signed and list only the Federal Tax ID Number or Social Security Number for each location listed on the Application which will be used on claim forms submitted to DRS.

Contract Signature Page

Provider Payment Options Election Form

Copy of Voided check, if electing Electronic Funds Transfer

Incomplete applications will be returned

DEPARTMENT OF REHABILITATION SERVICES
NETWORK PROVIDER FACILITY APPLICATION

The Facility Application should be completed and returned to the Department of Rehabilitation Services Network Manager in its entirety, accompanied by any applicable attachments. Please retain the Network Provider Facility Contract for your records.

You may mail or fax the Application to:

Department of Rehabilitation Services
ATTN: Provider Relations/Network Management
P.O. Box 57630
Oklahoma City, OK 73157
Phone: 405-717-8921 or 1-888-835-6919
FAX: 405-717-8977

GENERAL INFORMATION

Legal Name of Owner: _____

Trade Name/dba: _____

Medicare Facility Classification: _____ Medicare Number: _____

LICENSE INFORMATION

State: _____ License Number: _____ Expiration Date: _____

Copy of facility license is required for each state of practice

ACCREDITATION

Is this Facility accredited by the Joint Commission? Yes ☐ No ☐

Joint Commission Program ID Number: _____

Date of most current accreditation: _____ Expiration Date: _____

INSURANCE INFORMATION

Copy of Insurance Certificate/Face Sheet is required

Please provide the following information about your current general and medical liability insurance coverage:

Name of Carrier: _____

Limits of General and Medical Liability:

Per Occurrence: _____

Expiration Date: _____

ADDRESS INFORMATION

Federal Tax ID Number: _____ National Provider Identifier Number: _____

Attach a completed W-9 form for each Federal Tax ID Number

PHYSICAL ADDRESS –Physical Location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE

Physical Address: _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: ( ) _____

Contact Person: _____

Email: _____ Phone: ( ):_____

MAILING ADDRESS – for Correspondence/Credentialing

Mailing Address:_____

_____
(City) (State) (Zip)

Credentialing Contact Person:_____

Phone: (_____) _____ Fax: _____

Email: _____

BILLING/REMIT ADDRESS – for claim payments and Provider Remittances

ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS

Name submitted on claims: _____

Billing Office (if applicable): _____

Billing Address:_____

_____
(City) (State) (Zip)

Credentialing Contact Person:_____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

ADDITIONAL LOCATION(S)

Federal Tax ID Number: _____ National Provider Identifier Number: _____

Attach a completed W-9 form for each Federal Tax ID Number

PHYSICAL ADDRESS –Physical Location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE

Physical Address: _____

_____
(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Credentialing Contact Person: _____

Email: _____ Phone: (_____) _____

MAILING ADDRESS – for Correspondence/Credentialing

Mailing Address: _____

_____
(City) (State) (Zip)

Credentialing Contact Person: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

BILLING/REMIT ADDRESS – for claim payments and Provider Remittances

ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS

Name submitted on claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

_____
(City) (State) (Zip)

Credentialing Contact Person: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

Use a copy of this page to report any additional locations

HOSPITAL AND NON-HOSPITAL BASED SERVICES (if applicable)

Check the specialty services provided by the hospital:

Yes ☐ No ☐ Ambulance
Yes ☐ No ☐ Ambulatory Surgery Center
Yes ☐ No ☐ Dialysis
Yes ☐ No ☐ Durable Medical Equipment
Yes ☐ No ☐ Home Health Care
Yes ☐ No ☐ Hospice
Yes ☐ No ☐ Independent Diagnostic Testing Facility
Yes ☐ No ☐ Infusion Therapy
Yes ☐ No ☐ Laboratory
Yes ☐ No ☐ Long Term Acute Care
Yes ☐ No ☐ Rehabilitation
Yes ☐ No ☐ Psych/Substance Abuse
Yes ☐ No ☐ Skilled Nursing Facility
Yes ☐ No ☐ Sleep Study

Does the Hospital provide the following services by a group of specialists? If the answer is yes, please list the provider group name below:

Yes ☐ No ☐ Anesthesiology Group: _____
Yes ☐ No ☐ Emergency Physician Group: _____
Yes ☐ No ☐ Pathology Group: _____
Yes ☐ No ☐ Radiology Group: _____

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD

HealthChoice | DRS Oklahoma Department of Rehabilitation Services | DOC Department of Corrections Oklahoma

Electronic Funds Transfer (EFT) Form

SUPPLIER ONLY:

Legal Name of Corporate Owner: _____

Trade Name/dba:: _____ Federal Tax ID #: _____

PRACTITIONER ONLY:

Practitioner's Name: _____

SSN: _____ Federal Tax ID #: _____

BANKING INFORMATION

A voided check is required. If the bank account does not have checks, a bank letter verifying the account and routing numbers will be accepted.

A deposit slip will be accepted only if the information provided below matches the MICR line containing the banking ABA number and account between these symbols | : |:

Financial Institution: _____

Account Number: _____ Routing Number: _____

☐ Checking ☐ Savings

BILLING/REMIT

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

_____
(City) (State) (Zip)

AUTHORIZED SIGNATURE

Signature: _____ Date: _____
(Required)

Printed Signature Name: _____ Phone Number: _____

Please mail, fax or email the completed form to:

HealthChoice
Attn: Provider Relations
3545 N.W. 58th Street, Suite 600
Oklahoma City, OK 73112
Phone: 405-717-8790 or 1-800-543-6044
Fax: 405-717-8977
oseegibproviderrelations@sib.ok.gov

State of Oklahoma

DEPARTMENT OF REHABILITATION SERVICES
NETWORK PROVIDER FACILITY CONTRACT

SIGNATURE PAGE

The Oklahoma Department of Rehabilitation Services and the Facility incorporate by reference the terms and conditions of the Oklahoma Department of Rehabilitation Services Network Facility Contract (Contract), located in Contract DRSNFCv1.0 at www.sib.ok.gov/providers, into this Signature Page and acknowledge the Contract is an electronic record created according to 12A O.S. § 15-101 et seq. The Oklahoma Department of Rehabilitation Services and the Facility further agree that the effective date of the contract is the effective date denoted on the copy of the executed signature page returned to the Facility. The original of the signed document will remain on file in the office of the Oklahoma Department of Rehabilitation Services.

FOR THE FACILITY:

Legal Name of Owner (typed or printed):

_____

Trade Name/dba (typed or printed)

_____

Authorized Officer or Representative (typed or printed)

_____

Signature: _____

Signature Date: _____

FOR THE DEPARTMENT OF REHABILITATION SERVICES:

_____

Michael O'Brien, Ed. D., Director
Department of Rehabilitation Services Director
3545 NW 58th, Suite 500
Oklahoma City, OK 73112

Please return completed application, signature page and attachments to:

Department of Rehabilitation Services
Attn: DRS Network Management
P.O. Box 57630
Oklahoma City, Oklahoma 73157
Phone: 1-405-717-8921 or 1-888-835-6919
Fax: 1-405-717-8977