Dear Potential Provider:

Thank you for speaking with us in regard to providing transportation services for ProCare. We specialize in arranging transportation and language services for Worker's Compensation claimants.

Enclosed is our New Provider Packet with our Provider Application and Agreement, to be completed and returned to us along with the required credentialing documents as soon as possible. Please remember to check on your Application whether you are Commercial or an Independent Driver. A checklist of the needed documents for each provider type is provided below for your convenience.

If you have any questions, please contact Provider Relations by emailing ProviderRelations@theprocare.com or call us toll-free at (866) 941-7878, and select Option 5 for Provider Relations when prompted. We will be happy to assist you.

We look forward to working with you.

Sincerely,

Provider Relations
ProCare Transportation and Language Services

Send copies of the following documents to:
Provider Relations Department
Email: ProviderRelations@theProCare.com
Fax: (813) 769-3883

Document Checklist for Commercial Providers **(Have Commercial Auto Insurance – *PREFERRED*)**	**Document Checklist for Independent Providers** **(Do not have Commercial Auto Insurance)**
Transportation Application and Agreement (initial in bottom right-hand corner of each page) Transportation Provider Rate Sheet W-9 Form Current Business/Occupational License Current Certificate of Auto Insurance (must be on the Acord Form 25 with ProCare named as the Certificate Holder) Supplemental Vehicle List (list of insured vehicles) Driver Hiring Criteria (brief description of criteria you use when hiring Drivers, such as background checks and drug testing)	Transportation Application and Agreement (initial in bottom right-hand corner of each page) Transportation Provider Rate Sheet W-9 Form Current Driver's License Current Auto Policy Declarations (must show insured's name, amount of coverage, and expiration dates of auto policy) Current Vehicle Registration Current Criminal Background Check Current 3-Year Motor Vehicle Report

Please keep the following service terms in mind when providing services for ProCare:

*Provider must report any issues or changes during the assignment to ProCare immediately.

*If driver arrives to pick-up address and claimant is a no show, provider must notify ProCare immediately. ProCare must authorize driver to be released to guarantee payment of no show fee.

*The claimant or any party other than ProCare shall not be asked for payment or tip money.

*Use of ride-sharing services such as Uber or Lyft to transport the claimant for ProCare is prohibited.

*No additional passengers are allowed unless an additional passenger has been pre-authorized by ProCare.

*Provider's appearance must be professional at all times.

*Any vehicle used to transport the claimant for ProCare must be clean and in good, working condition.

*Any requests or fees not listed on the authorization must be reported to ProCare for approval before proceeding in order to guarantee payment.

*If trip has been authorized by ProCare with wait time, driver must wait on site and in a visible spot for the claimant. Wait Time starts from the time that driver and claimant arrive at the facility and ends when claimant returns to the vehicle after the appointment.

*The total amount of wait time MUST be submitted within 48 hours after completion of an assignment. Wait time received more than 48 hours after the assignment will be adjusted to a minimum 1 hour on Provider's invoice.

*All information about the claimant, including any legal or financial matters, must be kept confidential.

Confirmation Process for Services that have been assigned to you (excluding Rushes):

*You will receive an EMAIL from ProCare in the morning 1 day before your scheduled assignment to confirm that all assignment information is on schedule.

*You MUST CLICK on either the **GREEN CONFIRM COVERAGE BUTTON** or the **RED UNABLE TO COVER BUTTON** in the email to confirm your coverage, or advise ProCare that you are unable to cover the assignment.

*After your selection, you will see a Confirmation Screen letting you know that ProCare received your selection. Once you confirm, you will not be contacted by ProCare again to confirm this assignment unless there are changes to the assignment.

- ProCare will attempt to CALL you if we are unable to confirm via email.
- If ProCare is still not able to confirm your coverage of the next-day assignments, they may be reassigned to another provider.

If you have a question regarding these service terms, please email ProviderRelations@theprocare.com.
If you have a question about an assignment that was sent to you, please email Dispatch@theprocare.com.

TRANSPORTATION PROVIDER APPLICATION

PROVIDER TYPE (CHECK ONE):

COMMERCIAL ____________________ INDEPENDENT ____________________

PROVIDER NAME: ____

ADDRESS: ____

CITY: ________________________________ **STATE:** ______________ **ZIP:** _______________

PHONE NUMBER: ____________________ **ALTERNATE NUMBER:** ________________________

E-MAIL: ______________________________________ FAX **NUMBER:** _______________________

TAX IDENTIFICATION NUMBER: ____

PLEASE LIST KEY PERSONNEL:

Scheduler: ___________________ Phone: ________________ Email: ____________________________

Manager: ____________________ Phone: ________________ Email: ____________________________

Billing Coordinator: ________________ Phone: ______________ Email: __________________________

Contract Coordinator: _______________ Phone: ______________ Email: __________________________

REGULAR HOURS OF OPERATION:

Monday – Friday: __________________A.M. TO __________________P.M.

Saturday/Sunday: __________________A.M. TO __________________P.M.

Holidays: ____

CONTACT FOR AFTER HOURS SCHEDULING OR EMERGENCY:

Name: ____

Phone: ____

Email: ____

TRANSPORTATION PROVIDER AGREEMENT

This TRANSPORTATION PROVIDER AGREEMENT is made by and between ProCare Transportation & Language Services (hereinafter referred to as "ProCare"), and ________________________________ (hereinafter referred to as "Contracting Provider").

1. GOVERNING LAW

A. The laws of the State of Florida shall govern this agreement. Venue for any dispute between the parties shall be in the Courts of Hillsborough County, Florida.

2. TERM AND TERMINATION

A. This agreement shall be effective __________________ for one year, and after the initial term, shall automatically renew for successive one-year terms, without notice, unless either party gives written notice of termination at least ninety (90) days prior to the expiration date of the agreement or any extension thereof. Contracting Provider shall continue to provide service through the end of the notice period without decline in service standards and availability.

B. ProCare may terminate this agreement at any time in the event of fraud, abandonment, or gross or willful misconduct on the part of the Contracting Provider, or if the Contracting Provider fails or refuses to meet its obligations and/or the Terms of Service outlined in this agreement.

C. In the event Contracting Provider elects to terminate service without notice, Contracting Provider shall be responsible for any costs in the excess of the Contracting Provider's rates as outlined in the Rate Sheet (Fee Schedule) incurred by ProCare in the servicing of the Contracting Provider's service area.

3. SERVICE AREA

A. The general service area for this agreement shall be ______________County within the State of ________________. (Indicate specific coverage area information on the Provider Fee Schedule).

B. The boundaries of the service area may be adjusted from time to time via amendment to the Provider Fee Schedule.

4. TERMS OF SERVICE

A. Contracting Provider agrees to participate as a transportation provider in ProCare's provider network in accordance with all the applicable terms of this Agreement, including, but not limited to, the following:

(Any deviation from these Terms of Service may affect Contracting Provider's payment.)

1) Rates must be pre-determined and finalized at time of acceptance of assignment. Additional fees submitted at a later date and/or time may be subject to denial.

2) Contracting Provider agrees that all passengers are required to wear a seatbelt while the vehicle is in motion.

3) Contracting Provider agrees that any and all services completed for ProCare will be rendered by Contracting Provider's own drivers. Use of ride-sharing services such as Uber or Lyft is expressly forbidden.

4) Contracting Provider agrees that subcontracting services that ProCare assigned to the Contracting Provider to another provider is prohibited.

5) Contracting Provider's vehicles must be clean and regularly maintained to ensure proper working condition. Contracting Provider's vehicles must be routinely inspected as required per county and/or state guidelines.

6) Contracting Provider agrees that only one person will be transported at a time in a vehicle. Transporting multiple injured workers at the same time in the same vehicle is not acceptable. Transporting family members or significant others is NOT authorized unless approved by ProCare PRIOR to the scheduled trip. Any and all additional passengers must be authorized by ProCare prior to the transport.

7) Contracting Provider will pick up the injured worker on time according to the scheduled pick-up time indicated on the authorization. Contracting Provider will notify ProCare immediately if running late for any reason to the pick-up address or the injured worker's appointment.

8) Contracting Provider will knock on door when picking up the injured worker. If the driver is unable to get out of the vehicle, Contracting Provider agrees to call ProCare, and the injured worker will be contacted and informed the vehicle is outside.

9) Contracting Provider agrees to call ProCare if the injured worker does not show to obtain ProCare's approval to release the driver. Failure to do so may affect Contracting Provider's payment.

10) Contracting Provider understands and agrees that if trip has been authorized by ProCare with wait time, driver must wait on site and in a visible spot for the claimant. Contracting Provider understands and agrees that Wait Time starts from the time that driver and claimant arrive at the facility and ends when claimant returns to the vehicle after the appointment.

11) Contracting Provider will provide, in a timely manner, updated information to ProCare, as to the status of each injured worker assigned to them by ProCare.

12) Contracting Provider will notify ProCare immediately of any incident involving an injured worker.

13) Contracting Provider agrees to cooperate and participate with and in, and be bound by, ProCare policy and procedures, quality assurance, record keeping, audit and grievance procedures.

14) Contracting Provider shall not contact, solicit or seek payment from injured workers or ProCare Clients (i.e., claimant's case manager and/or adjuster). Rates and/or payment shall only be discussed with ProCare.

15) Contracting Provider's staff, drivers, or agents shall not at any time discuss financial or legal matters or advise injured worker to seek the services of an attorney or medical provider or to provide the name and/or telephone number of such Service Providers.

16) Contracting Provider agrees to identify to each injured worker during each contact made in person, via telephone, through correspondence or in any fashion that Contracting Provider is providing services as a result of Contracting Provider's contractual agreement with ProCare.

17) Contracting Provider agrees to accept injured worker without discrimination based upon age, sex, race, color, religion, national origin, or the medical nature of the illness involved.

18) Names, addresses, phone numbers, etc., of claimants transported by Contracting Provider on behalf of ProCare are the property of ProCare and shall not be distributed for any purpose. Contracting Provider shall not solicit or entice claimants with any incentives, discounts or gifts in order to maintain or increase patronage, or to encourage a ProCare injured worker to select or request service by a Provider other than ProCare.

5. DRIVER STANDARDS

A. Contracting Provider agrees that all of its drivers will meet and maintain the following Driver Standards:

1) Be able to understand and speak English.

2) Be a minimum of 21 years of age and have at least 5 years of driving experience.

3) Have a valid driver's license issued by the DMV or driver's current state of residence.

4) Submit a recent Motor Vehicle Record issued by the DMV or driver's current state of residence for the past 3 years.

5) Have a good driving record, which would include the following:

    a. No more than 2 violations in last 3 years or 1 violation in last 12 months (Does not include violations involving drugs/alcohol, reckless driving, license suspension/revocations, negligent driving, etc. Violations of these types may make the driver unacceptable).

b. No more than 1 accident in last 3 years.

c. May not have a conviction for a DWI/DUI within 5 years of providing service.

6) Background Check must be clear of:

   a. Elderly/child abuse offenses

   b. Sexual offenses

   c. Any felony convictions where driver has pled guilty to, or been found guilty of, a felony offense within 5 years of the provision of service.

7) Be in compliance with all applicable city, county, state, and federal laws and regulations, including the laws and regulations setting requirements regarding licensing, certifications, and insurance for all transportation-related personnel and vehicles.

8) Meet current state and federal motor carrier safety regulations.

9) Keep required vehicle or driver permits current.

10) Have appropriate certification or license for the function they are performing.

11) Ambulance personnel must have a current state MAV and/or EMT certification, or other certification, to practice and all applicable add-on certifications.

12) Must be able to pass any DOT Physical exams that may be required (hearing, eyesight, drug testing, etc.).

13) Where required, drivers are to complete a state-mandated EVOC (Emergency Vehicle Operator Course) prior to assuming driver responsibilities.

14) Be aware of and follow proper restraint and securement procedures.

B. Contracting Provider agrees to monitor its drivers to ensure their compliance with the Driver Standards. Contracting Provider agrees to permanently remove any drivers found to be in violation of any of the Driver Standards from its driver roster to ensure that driver is not utilized for ProCare.

C. Contracting Provider agrees to maintain a zero-tolerance drug and alcohol policy with its drivers. Contracting Provider agrees to permanently remove any driver found to be in violation of the drug and alcohol policy from its driver roster to ensure that driver is not utilized for ProCare. Contracting Provider also agrees to notify ProCare promptly of any drug- or alcohol-related incidents or complaints involving its drivers and ProCare claimants.

D. Contracting Provider understands that failure on its part to ensure that its drivers are meeting and maintaining the Driver Standards may result in the Contracting Provider's suspension or termination from ProCare's network.

6. AUTO INSURANCE COMPLIANCE

A. Contracting Provider agrees to maintain the minimum amount or greater in auto liability coverage required by the Contracting Provider's state. Contracting Provider agrees to submit a current and valid Certificate of Insurance to ProCare showing that Contracting Provider meets this requirement.

B. Contracting Provider will name ProCare as a certificate holder on said insurance certificate as allowed by the Contracting Provider's insurance agent.

C. Contracting Provider agrees to maintain said insurance coverage in full force and effect during the term of this Agreement. Any termination, modification or alteration in said coverage or status shall be communicated to ProCare within one (1) business day of such action.

7. REGULATORY COMPLIANCE

A. It is the sole responsibility of the Contracting Provider to be informed of and to comply with any and all Federal, State, County, or Local Laws, statutes and ordinances which regulate or oversee the Contracting Provider's business segment.

B. Contracting Provider shall notify ProCare within one (1) business day of notification of lack of compliance by any regulatory body.

8. INVOICING / PAYMENT OF SERVICES

A. Contracting Provider agrees to look solely to ProCare for payment for services provided under this Agreement. Contracting Provider must submit an invoice to ProCare for each service in order to be paid. ProCare shall only be obligated to pay Contracting Provider for services authorized by ProCare. Failure to comply may result in non-payment. No advance billing will be accepted.

B. ProCare agrees to process payment within thirty (30) days of ProCare's receipt of a clean invoice from the Contracting Provider. ProCare agrees to compensate Contracting Provider at the agreed-upon rates for the services assigned to Contracting Provider by ProCare that are billed properly and in a timely fashion.

C. Contracting Provider agrees that Automated Clearing House (ACH) Payment is the preferred payment method.

a. ProCare will remit payment to Provider electronically via ACH to the bank account that the Provider indicates on the completed ACH Form.

b. If Provider is not already on ACH, Provider must complete the ACH Form included with the Transportation Provider Agreement and email it to Finance@theprocare.com along with a Voided Check to set up ACH Payment.

D. Contracting Provider agrees that all invoices must be presented in a timely manner. Invoices received after 45 days from the original date of service on invoice will not be considered for payment.

E. Contracting Provider agrees that any revisions to an invoice already submitted must be received within 24 hours of the original invoice submission date.

F. Contracting Provider agrees that all invoices and receipts, including tolls for services, will clearly state the dates of and type of service provided along with the Injured Worker's name, locations, mileage, wait time, parking receipts, and any additional authorized fees. Incorrect or missing information will delay payment process.

G. Contracting Provider agrees to report any appointment with authorized wait time or additional fees within 48 hours of completion of the assignment. Wait time received more than 48 hours after the assignment will be adjusted to a minimum 1 hour on Contracting Provider's invoice.

H. Contracting Provider is paid only for mileage incurred when injured worker is in the vehicle. ProCare does not pay "Dead Miles." Any other fees incurred must be discussed and authorized by ProCare prior to services being rendered.

I. Loaded mileage is determined using Google Maps. This mileage will be included on the referral authorization form sent to the Contracting Provider.

J. If Contracting Provider disagrees with the mileage listed on the referral authorization form, Contracting Provider must notify ProCare as soon as possible before the assignment is completed to justify any differences. Mileage will be paid based on the referral authorization form from ProCare.

K. ProCare does not pay for "Patient No-Show" claims unless approved prior to the driver leaving the pick-up location. ProCare will consider the Contracting Provider/driver a "No-Show" if he/she does not arrive as scheduled. In the event of an "Injured Worker No-Show," ProCare will reimburse the Contracting Provider the agreed upon No-Show amount indicated on the referral authorization.

L. Contracting Provider shall accept the Contracted Rates as payment in full for all Services billed, irrespective of whether such services were provided on a prospective basis with or without a referral by ProCare or a Payor. Contracting Provider expressly waives any amounts from ProCare, Payor, or Covered Person in excess of the agreed-upon contracted rates or the previously agreed-upon rates with ProCare. ProCare has the sole right to bill Payors for Covered Services rendered by Provider hereunder. Should Contracting Provider bill, collect, or attempt to collect from any Covered Person or his or her employer, or any party other than ProCare, except as required by law and in accordance with this Provider Agreement, then, in addition to any other remedies that may be available to ProCare at law or in equity, any amounts due Contracting Provider will be subject to a thirty percent (30%) reduction from the Contracted Rates or other applicable price hereunder.

M. Contracting Provider agrees to cooperate with ProCare to resolve questions concerning the accuracy and completeness of billings and to make available to ProCare, during normal business hours, such information and records as may be necessary to resolve the questions and disputes.

INDEMNIFICATION

Contracting Provider agrees to indemnify ProCare against the negligent acts of Contracting Provider's employees acting within the scope of their employment.

COMPLAINTS AND GRIEVANCES

All complaints and grievances will be fully investigated and resolved to the satisfaction of ProCare management. Contracting Provider agrees to cooperate and participate in such procedures until such complaints and/or grievances can be resolved.

CONFIDENTIALITY

A. ProCare and the Contracting Provider understand and agree that all information, records and inquiries obtained during the course of providing services to ProCare customers are privileged and confidential. To the extent required by law, and other than information provided under the normal billing process, Contracting Provider shall keep confidential and not disclose any information related to ProCare or its customers for any purpose whatsoever.

B. ProCare and the Contracting Provider understand and agree that the right to information and records of injured workers is governed by state and federal law regarding the confidentiality of medical records including, but not limited to, The Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

C. Each party shall comply with all such laws and regulations in the performance of their respective obligations under this Master Agreement, with the minimum standards attached to any Supplemental Agreement(s).

MISCELLANEOUS TERMS

A. This is a Contract for Professional Services, and Contracting Provider shall not assign or otherwise transfer any interest in this Agreement without the prior written consent of ProCare.

B. Both parties enter into this agreement as Independent Providers and nothing contained in this Agreement shall be construed to create or imply a partnership, joint venture, agency or employment relationship between the parties.

C. The invalidity or enforceability of any terms or conditions of this Agreement shall not affect the validity or enforceability of any term or provision, and the remainder of this Agreement shall continue in

full force and effect.

By signing this Agreement, Contracting Provider indicates that it has read and understands the Agreement.

** Please list ALL company names that will be covered under this contract. Attach an extra sheet if necessary. **

{CONTRACTING PROVIDER}	**{PROCARE}**
Signed:________________________	Signed:______________________________
Name: _______________________	Name:_______________________________
Title: _______________________	Title:________________________________
Date: ________________________	Date:________________________________

TRANSPORTATION PROVIDER RATE SHEET

		Load/Base	Per Mile	Min. Trip	Wait Time	No Show
Ambulatory/Taxi		N/A				
Wheelchair						
Non-Emergency Stretcher						
Ambulance	BLS:					
	ALS:					
Misc.						

**** Rates above apply to pick-ups in the counties listed below ****

Coverage Areas (i.e. Counties):

1._________________________
2._________________________
3._________________________
4._________________________
5._________________________
6._________________________
7._________________________
8._________________________
9._________________________
10._________________________

**** Pick-ups in additional counties will be handled on a call for quote (flat rate) basis ****

IMPORTANT:

- **Additional stops/passengers/alternate routes** must be pre-approved.
- **Unloaded miles** are not paid unless discussed and authorized prior to service.
- **Wait time** must be pre-authorized by ProCare and if authorized, must be reported within 24 hours of completion of the assignment.
- **Tolls/parking/additional expenses** must pre-authorized and receipts must be submitted in order to be reimbursed.
- We reimburse the Minimum Trip amount **OR** the mileage rate multiplied by the number of loaded miles traveled, **whichever is greater**, not both.

*****ALL RATES ARE SUBJECT TO PROCARE APPROVAL*****

Please contact our Provider Relations Department with any questions about our reimbursement rates

I have read, understand and agree to the above rates and policies. All rates are subject to approval by ProCare, Inc.

____________________ ____________________ ______________
Provider Signature Title Date

____________________ ____________________ ______________
ProCare Signature Title 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.

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.)

Requester's name and address (optional)

6 City, state, and ZIP code

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

		–							

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** ▶ **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.

COMMERCIAL PROVIDERS - SAMPLE ACORD FORM

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 00/00/2010

PRODUCER	
Name & Addess of Agency, Producer or Person Issuing Insurance Certificate to ProCare City, State Zip	Phone# Fax #

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

The Contracted Provider, Vendor or Company that ProCare is using for services plus the address

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Name of Insurance Company	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC	A[illegible]DEF0000[illegible]00	[illegible]0/00/20[illegible]0	0[illegible]/0[illegible]/2[illegible]11	EACH OCCURRENCE	$
						DAMAGE TO RENTED PREMISES (Ea occurence)	$
						MED EXP (Any one person)	$
						[illegible]RSONAL & ADV INJURY	$
						[illegible]NERAL AGGREGATE	$
						[illegible]ODUCTS - COMP/OP AGG	$
B		AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS X SCHEDULED AUTOS X HIRED AUTOS NON-OWNED AUTOS	ABCDEF00000000	00/00/2010	00/00/2011	COMBINED SINGLE LIMIT (Ea accident)	$
						BODILY INJURY (Per person)	$ XXX,XXX
						BODILY INJURY (Per accident)	$ XXX,XXX
						PROPERTY DAMAGE (Per accident)	$ XXX,XXX
		GARAGE LIABILITY ANY AUTO				AUTO ONLY - EA ACCIDENT	$
						OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY OCCUR CLAIMS MADE DEDUCTIBLE RETENTION $				EACH OCCURRENCE	$
						AGGREGATE	$
							$
							$
							$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATU-TORY LIMITS / OTH-ER	
						E.L. EACH ACCIDENT	$
						E.L. DISEASE - EA EMPLOYEE	$
						[illegible]. DISEASE - POLICY LIMIT	$
C		OTHER Professional Liability - E & O	ABCD[illegible]F[illegible]000[illegible]00[illegible]	[illegible]0/0[illegible]20[illegible]0	0[illegible]/0[illegible]/2[illegible]11	[illegible]imit per claim $XX [illegible]ggregate limit $XX	

Sample

Sample

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL P[illegible]VISIONS

CERTIFICATE HOLDER	CANCELLATION
ProCare, Inc 4710 Eisenhower Boulevard, Suite C-2 Tampa, FL 33634	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE Must be signed by issuing agent

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INDEPENDENT PROVIDERS - SAMPLE AUTO POLICY DECLARATIONS

SAMPLE

AUTO INSURANCE POLICY DECLARATIONS PAGE

NAMED INSURED(S)

Name
Address

POLICY NUMBER	**12345**
POLICY PERIOD	**06/01/13 to 06/01/14**
AGENT:	Mr. Agent
PHONE:	516-555-1212

MAKE	MODEL	BODY STYLE	VEHICLE ID NUM	CLASS
Your Car	Your model	Sedan	ABC-123	auto

COVERAGES			PREMIUMS
See policy for coverage details.			
Bodily Injury/Property Damage liability			
Limits of Liability – Coverage A – Bodily Injury			
Each Person Each Accident			
$ XXX,XXX $ XXX,XXX			
Limits of Liability – Coverage A – Property Damage			
Each Accident			
$ XXX,XXX			
Mandatory Personal Injury Protection		$ XX,XXX	$ XXX.XX
Optional Basic Economic Loss Coverage		$ XX,XXX	
Additional Personal Injury Protection		$ XXX,XXX	$ X.XX
Work Loss Limit per Month (3 year maximum)	$ X,XXX		
Death Benefit	$ X,XXX		
Other Expenses – Limit per Day (1 year maximum)	$ XX		
Total Personal Injury Protection Benefits		$ XXX,XXX	
$500 Deductible Comprehensive and Window Glass			$ XX.XX
(Deductible does not apply to Window Glass)			
$ XXX Deductible Collision $ XXX			$ XXX.XX , $ XXX
Emergency Road Service			$ X.XX
Car Rental/Travel Expenses			$ X.XX
Each Day Each Occurrence			
XX % $ X,XXX			
Supplementary Uninsured/Underinsured Motorists-SUM			$ XX.XX

INDEPENDENT PROVIDERS - BACKGROUND CHECK CONSENT FORM

This form is required for all statewide criminal searches.
For questions, please contact us toll free at 866-941-7878.

Instructions: Complete form, sign at the bottom and return it to the
Provider Relations Department - ProCare, Inc.

Last Name	First Name	Middle Name (if applicable)
Home Phone Number	Social Security Number	Date of Birth

Formal Name, Alias or Maiden Name

PLEASE READ THE FOLLOWING STATEMENT AND CONFIRM YOUR

I hereby consent to have an investigation made relating to statements made on your Provider Application and Contract. I consent to have such information as may be received reported to ProCare, Inc. I also agree to give any further information including documents, records, files containing charges and/or complaints filed against me, formal or otherwise, pending or closed or any other pertinent data and to also permit ProCare, Inc., its agents to inspect and make copies of such documents, records and/or other information.

Except as otherwise prohibited by law, I hereby release, waive, discharge, exonerate and agree not to sue ProCare, Inc., its agents, representatives, employees, independent contractors, officers, directors and shareholders from and for any and all claims, damages, losses, liabilities, rights expenses, demands, causes of actions of any nature whatsoever arising out of or related to whether such information, documents or records are provided directly to ProCare, Inc., or its agents by me or obtained independently by ProCare, Inc., or its agents on my behalf.

I also acknowledge that the information contained in this application and all information subsequently obtained through the use of this Authorization and Release is the property of ProCare, Inc. I hereby represent that the information given on this application is true and complete to the best of my knowledge. This agreement shall be governed by and construed in accordance with the laws of the State of Florida.

Candidate's Signature | Date

AGREEMENT BY SIGNING

THIS IS AN EXAMPLE OF OUR TR AUTHORIZATION FORM

This authorization number must be submitted on your invoice

Patient's Name

From: ProCare

Subject: APPOINTMENT DATE: 7/12/2013/ PO#: 405001/ Test Patient/ Authorization Confirmation

Message: HERE IS A Ambulatory PICK-UP ON 07-12-2013 AT 2:00 PM; WAIT TIME AUTHORIZED. MINIMUM TRIP QUOTED AT YOUR CONTRACTED RATES.
THANK YOU,
Dispatch

THIS IS WHERE YOU FIND ANY SPECIAL INSTRUCTIONS SUCH AS WAIT TIME, PICK-UP TIME, ETC.

Authorization Information:

TR Ambulatory	DATE OF SERVICE **7/12/2013 - Friday**	HEIGHT : **5'11"** WEIGHT : **150**

This is where you find the trip details such as mode of transport, appointment date and time, and pick-up time.

PICK UP TIME: **2:00PM**	------	Home **123 George St.** **TAMPA, FLORIDA 33624** Wait Time : **No**
ARRIVAL TIME: **3:00PM**	------	Doctor's Office **456 Main St.** **TAMPA, FLORIDA 33634** Wait Time : **Yes**
ARRIVAL TIME: **5:30PM**	------	Home **123 George St.** **TAMPA, FLORIDA 33624** Wait Time : **No**

This is the pick-up location.

Any additional authorized stops will be located as an additional destination.

Payor Name: ProCare Inc
Payor Address: 4710 Eisenhower Blvd, STE C-2
Payor City: TAMPA
Payor State: FLORIDA
Payor Zip: 33634
Payor Phone: (813)769-3880

Payor Fax: (813)769-3883
Payor Email: billing@theprocare.com
PROCARE AUTHORIZATION/PO#: 405001

If you have any questions or concerns please contact our customer service department.
Phone: (813)769-3880
Fax: (813)769-3883
Email: customerservice@theprocare.com

The information contained in this message may be CONFIDENTIAL and is for the intended addressee only. Any unauthorized use, dissemination of the information, or copying of this message is prohibited. If you are not the intended addressee, please notify the sender immediately and delete this message.

DIRECT DEPOSIT PAYMENT AVAILABLE FOR PROCARE PROVIDERS

Dear Valued Provider:

In an effort to expedite payment, ProCare is continuing to convert ALL providers to ACH payment. To avoid any delays in payment, please fill out and submit the attached form along with a Voided Check to ProCare as soon as possible.

Once you are signed up for Automated Clearing House (ACH) payment, ProCare will remit payment to you directly to the bank account you provide. Your billing terms will remain the same; however, you will receive your payment as a direct deposit to your bank rather than a live check by postal mail. It is a faster and more convenient way of receiving your payments from ProCare.

SUBMIT YOUR COMPLETED ACH FORM ALONG WITH A VOIDED CHECK
BY EMAIL PREFERABLY TO:

Email: Finance@theprocare.com
Fax: (813) 769-3883, Attn: Finance
Postal Mail: ProCare, Attn: Finance
4710 Eisenhower Blvd, Ste C-2, Tampa, FL 33634

Please allow 30 days after you have submitted your form and voided check to ProCare for the ACH authorization to be processed so that you can begin to receive ACH payments. Incorrect or incomplete forms will delay processing, so please make sure your form is completed accurately.

If you have any questions or concerns about the information on this email, please contact Provider Relations by emailing ProviderRelations@theprocare.com or call us toll-free at (866) 941-7878, and select Option 5 for Provider Relations to leave a message. Email is preferable; your inquiry will be promptly addressed. Our department's hours of operation are 8:30 am to 5:30 pm EST, Monday through Friday.

Authorization for Direct Payment via ACH (ACH Credit)
CONSUMER AUTHORIZATION FOR DIRECT PAYMENTS VIA ACH (ACH CONSUMERDEBITS)

Company
Name ____ Tax ID Number ___________________________

Company
Address ____

I authorize Larjar Inc. dba ProCare to initiate electronic credit entries for payment of services and if necessary, debit entries and adjustments for any credit entries in error to my: ☐ Checking account (or) ☐ Savings account

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

Date: _______________

Bank/Depository Name: ______________________

Routing Number: ______________________

Account Number: ______________________

Bank/Depository City and State: ______________________

Name(s) on Above Account: ______________________

Payment Confirmation/Remittance Email Address: _________________________________ **Email address required
(Please print legibly)

Contact Number: ______________________

I (we) understand that this authorization will remain in full force and effect until I (we) notify Larjar Inc. dba ProCare in writing that I (we) wish to revoke this authorization. I (we) understand that Larjar Inc. dba ProCare requires at least 1 week in order to cancel this authorization.

Authorized By: _______________________________
(Please print legibly)

Signature: ___________________________________

Please allow 2-3 weeks for your request to be implemented and for ACH credits to commence in your bank account.

[1] The NACHA Operating Rules do not require the consumer's express authorization to initiate reversing entries to correct erroneous transactions. However, Originators should consider obtaining express authorization of debits or credits to correct errors.

[2] Written debit authorizations must provide that the Receiver may revoke the authorization only by notifying the Originator in the time and manner stated in the authorization. The references to notification should be filled with a statement of the time and manner that notifications must be given in order to provide company a reasonable opportunity to act on it (e.g. "In writing by mail to 4710 Eisenhower Blvd., Tampa, FL 33634 that is received at least three (3) days prior to the proposed effective date of the termination of the authorization").

Attention All ProCare Providers!

Dear Provider,

Using ProCare's user-friendly Website at www.theprocare.com, you may submit ALL of your Transportation Invoices as well as your Interpretation Summary Forms in just a few clicks!

Simply follow the steps below:

1) **Log onto your computer. On your address bar, enter www.theprocare.com**
2) **Click on the "Providers" Tab.**
3) **Under WELCOME EXISTING PROVIDERS, you will find two links:**
   - **Transportation**
   - **Interpreter**
4) **Choose the correct form for the service you provided.**
5) **Using the "TAB" key, enter the information requested under the Provider Information section of the form.**
   - **(*) is a REQUIRED field; you must enter the REQUIRED information before you can proceed**
6) **NOTE: To get started on the "Transportation Details" section of the Transportation Invoice Form, you must choose a DOS for each row entry. You must enter a number value in each field. If a field does not apply to you, please enter "0." Once all your information has been entered, it will calculate a "Total Due."**
7) **Click the "Submit" button at the bottom of the page.**

ProCare strongly recommends the use of this website for ALL your invoice submissions. This is a fast and secure way of ensuring timely receipt of your invoices. NO MORE FAXING, EMAILING or SNAIL MAILING!

PLEASE NOTE:

Your payment process will start on the day that you submit your invoice via ProCare's Website.

Please allow your full payment term before calling ProCare for payment status.

DUPLICATE SUBMISSIONS WILL DELAY YOUR PAYMENT!

If you have any questions regarding the above information, please email billing@theprocare.com.

Thank you,

ProCare's Accounts Payable Team

Provider Invoice to ProCare

Provider Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ( ) ______________________________

Tax ID: ______________________________

Week Ending: _____/_____/______

Total Amount of Invoice:

$ ______

Service Details:

Trip Date	Trip I.D.	Patient's Name	Origination	Destination	Wait Time	Miles	Rate per Mile	Total Amount
							TOTAL	$

Please call in to the Customer Service Line upon completion of an assignment to advise start and end times on any approved wait time period

Please Submit Invoice Preferably via email or fax to:
Email: billing@theprocare.com or Fax: 813-769-3883
ProCare, Inc, Eisenhower Tech Park, 4710 Eisenhower Blvd, Ste C-2, Tampa, FL 33634, Attention: Accounts Payable
Customer Service Line: 1-866-941-7878