



Dear Potential Provider:

Thank you for your interest in providing interpretation services for ProCare/AccessOnTime. 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. 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](mailto:ProviderRelations@theprocare.com) or call us toll-free at (866) 941-7878, and select Option 5 to leave a voicemail message for Provider Relations. We will promptly return your call and assist you.

We look forward to working with you.

Sincerely,

**Provider Relations**  
**ProCare Transportation & Language Services/AccessOnTime**

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

<b><u>Document Checklist for Commercial Providers:</u></b>	<b><u>Document Checklist for Independent Providers:</u></b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Interpretation Application and Agreement (initial in bottom right-hand corner of each page)</li> <li><input type="checkbox"/> Interpretation Provider Rate Sheet</li> <li><input type="checkbox"/> W-9 Form</li> <li><input type="checkbox"/> Business/Occupational License</li> <li><input type="checkbox"/> Certificate of Professional Liability Insurance (preferably on the Acord Form 25 with ProCare named as the Certificate Holder)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Interpretation Application and Agreement (initial in bottom right-hand corner of each page)</li> <li><input type="checkbox"/> Interpretation Provider Rate Sheet</li> <li><input type="checkbox"/> W-9 Form</li> <li><input type="checkbox"/> Resume or Curriculum Vitae</li> <li><input type="checkbox"/> Proof of Certification or Any Language Qualifications Earned (if applicable)</li> </ul>



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

- \*Interpreter's appearance must be professional at all times.
- \*Interpreter should arrive at the appointment 15 minutes prior to the scheduled appointment.
- \*Interpreter must report any issues or changes regarding the assignment to ProCare immediately.
- \*If Interpreter arrives to the assignment and claimant is a no show, Interpreter must notify ProCare immediately. ProCare must authorize Interpreter to be released to guarantee payment of no show fee.
- \*Interpreter must maintain objectivity and impartiality at all times during an assignment.
- \*Any requests or fees not listed on the authorization must be reported to ProCare for approval before proceeding in order to guarantee payment.
- \*Final appointment length and/or any additional authorized fees must be reported to ProCare within 72 hours of completion of the assignment. Appointment information received more than 72 hours after the assignment will be adjusted on the invoice to Contracting Provider's minimum hourly rate.
- \*The claimant or any party other than ProCare shall not be asked for payment or tip money.
- \*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 of the assignment, 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 assignments for the next day, the assignment may be reassigned to another provider.

*If you have a question regarding these service terms, please email [ProviderRelations@theprocare.com](mailto:ProviderRelations@theprocare.com).  
If you have a question about an assignment that was sent to you, please email [Dispatch@theprocare.com](mailto:Dispatch@theprocare.com).*

# INTERPRETATION 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: \_\_\_\_\_

# INTERPRETATION PROVIDER AGREEMENT

This INTERPRETATION PROVIDER AGREEMENT is made by and between ProCare Transportation & Language Services/AccessOnTime (hereinafter referred to as "ProCare/AccessOnTime"), 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/AccessOnTime 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/AccessOnTime 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 an interpretation provider in ProCare /AccessOnTime'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 any and all services completed for ProCare/AccessOnTime will be rendered by Contracting Provider's own interpreters. Transferring services that ProCare/AccessOnTime assigned to the Contracting Provider to another provider is prohibited.
- 3) Contracting Provider agrees to arrive at each appointment 15 minutes prior to the scheduled appointment. If Contracting Provider is running late, or can't make the appointment, Contracting Provider must notify ProCare/AccessOnTime immediately. Upon arrival at the facility, Contracting Provider must identify himself/herself as the ProCare/AccessOnTime interpreter assigned to the injured worker to the injured worker, physician and/or case manager.
- 4) Contracting Provider agrees to contact ProCare/AccessOnTime immediately if the injured worker does not arrive within 15 minutes of the scheduled appointment, or if the scheduled appointment will require a prolonged wait time (longer than 30 minutes).
- 5) Contracting Provider agrees to maintain objectivity and impartiality during all assignments. Contracting Provider must communicate in a thorough and precise manner. Contracting Provider may only ask questions of the physician, case manager, therapist, etc., that are posed by the injured worker or one of the above.
- 6) Contracting Provider's appearance must be professional at all times, i.e., collared shirt/blouse, slacks or skirt, and dress shoes. (No sneakers, sandals, jeans, shorts, T-shirts, etc. allowed.) Contracting Provider's clothes must be clean and pressed.
- 7) Contracting Provider agrees to notify ProCare/AccessOnTime immediately of any incident involving an injured worker.

- 8) Contracting Provider agrees to cooperate and participate with and in, and be bound by, ProCare/AccessOnTime's policy and procedures, quality assurance, record keeping, audit and grievance procedures.
- 9) Contracting Provider shall not contact, solicit or seek payment from injured workers or ProCare/AccessOnTime Clients (i.e., claimant's case manager and/or adjuster). Rates and/or payment shall only be discussed with ProCare/AccessOnTime.
- 10) Contracting Provider's staff 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.
- 11) 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.
- 12) Names, addresses, phone numbers, etc., of claimants serviced by Contracting Provider on behalf of ProCare/AccessOnTime are the property of ProCare/AccessOnTime and shall not be distributed for any purpose.
- 13) Contracting Provider shall not solicit or entice injured workers with any incentives, discounts or gifts in order to maintain or increase patronage, or to encourage a ProCare/AccessOnTime injured worker to select or request service by a Provider other than ProCare/AccessOnTime.

## **5. INTERPRETER STANDARDS**

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

- 1) Be fluent in English and the target language.
- 2) Be able to interpret effectively, accurately, and impartially.
- 3) Be able to understand and present information of a medical nature.
- 4) Be professional in their dress and behavior, and act professionally with any and all parties they come into contact with during an assignment.
- 5) Adhere to the standard code of ethics for interpreters in health care.
- 6) Accreditation by a recognized interpretation entity or completion of a recognized medical interpreter course is preferred.

- 7) Bachelor's Degree is preferred.
- 8) A minimum of 2 years' experience in medical interpretation is preferred.

B. Contracting Provider agrees to monitor its interpreters to ensure their compliance with the Interpreter Standards. Contracting Provider agrees to permanently remove any interpreters found to be in violation of the Interpreter Standards from its interpreter roster to ensure that interpreter is not utilized for ProCare/AccessOnTime.

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

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

## **6. 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/AccessOnTime within one (1) business day of notification of lack of compliance by any regulatory body.

## **7. INVOICING / PAYMENT OF SERVICES**

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

B. ProCare/AccessOnTime agrees to process payment within thirty (30) days of ProCare/AccessOnTime's receipt of a clean invoice from the Contracting Provider. ProCare/AccessOnTime agrees to compensate Contracting Provider at the agreed-upon rates for

the services assigned to Contracting Provider by ProCare/AccessOnTime that are billed properly and in a timely fashion.

C. 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.

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

E. 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, professional time, parking receipts, and any additional authorized fees. Incorrect or missing information will delay payment process.

F. Contracting Provider agrees to report final appointment length and/or any additional authorized fees to ProCare/AccessOnTime within 72 hours of completion of the assignment. Appointment information received more than 72 hours after the assignment will be adjusted on the invoice to Contracting Provider's minimum hourly rate.

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

H. If Contracting Provider disagrees with the mileage listed on the referral authorization form, Contracting Provider must notify ProCare/AccessOnTime 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/AccessOnTime.

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

J. 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/AccessOnTime or a Payor. Contracting Provider expressly waives any amounts from ProCare/AccessOnTime, Payor or Covered Person in excess of the agreed-upon contracted rates or the previously agreed-upon rates with ProCare/AccessOnTime. ProCare/AccessOnTime 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/AccessOnTime, 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/AccessOnTime 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.

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

### **8. INDEMNIFICATION**

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

### **9. COMPLAINTS AND GRIEVANCES**

A. All complaints and grievances will be fully investigated and resolved to the satisfaction of ProCare/AccessOnTime management.

B. Contracting Provider agrees to cooperate and participate in such procedures until such complaints and/or grievances can be resolved.

### **10. CONFIDENTIALITY**

A. ProCare/AccessOnTime and the Contracting Provider understand and agree that all information, records and inquiries obtained during the course of providing services to ProCare/AccessOnTime 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/AccessOnTime or its customers for any purpose whatsoever.

B. ProCare/AccessOnTime 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/AccessOnTime.

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/ACCESSONTIME }**

Signed: \_\_\_\_\_

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

# INTERPRETATION PROVIDER RATE SHEET

<b>Professional Charge</b>	\$_____/hour Professional Time ( __ hour minimum)
<b>Other Charges</b>	Travel Time included in professional time, \$____/mile
<b>No Show Flat Fee</b>	\$_____ (no additional mileage reimbursed)

**Language(s):**

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**Coverage Areas (i.e. Counties):**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**IMPORTANT:**

- The **Interpretation Invoice** must be completed and submitted to ProCare / AccessOnTime **within 24 hours** of a completed assignment for payment processing.
- Please note there are penalties for late submissions, which are outlined under the section of the Interpreter Agreement entitled “Invoicing/Payment of Services.”
- **Tolls/parking/additional expenses** must be pre-authorized and receipts must be submitted in order to be reimbursed.

\*\*\*\*\*ALL RATES ARE SUBJECT TO PROCARE / ACCESSONTIME 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 / AccessOnTime.

\_\_\_\_\_  
Interpreter Printed (Typed) Name

\_\_\_\_\_  
Date Rates Accepted

\_\_\_\_\_  
Interpreter Signature

\_\_\_\_\_  
ProCare / AOT Signature

# Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

► Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Print or type.  
See Specific Instructions on page 3.

**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 of the person whose name is entered on line 1. 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:** Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its 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.) See instructions.     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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

**Social security number**

				-			-						
--	--	--	--	---	--	--	---	--	--	--	--	--	--

**or**

**Employer identification number**

			-												
--	--	--	---	--	--	--	--	--	--	--	--	--	--	--	--

## Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- 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 for Part II, later.

<b>Sign Here</b>	Signature of U.S. person ►	Date ►
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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

## 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, later.*

# ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY)  
00/00/2013

<b>PRODUCER</b>  Phone #      Fax #  Name & Address of Agency, Producer or Person issuing Insurance Certificate to ProCare  City, State                      Zip	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.
<b>COMPANIES AFFORDING COVERAGE</b>	
<b>INSURED</b>  The Contracted Provider, Vendor or Company that ProCare is using for services plus the address	COMPANY <b>A</b> Name of Insurance Company  COMPANY <b>B</b>  COMPANY <b>C</b>  COMPANY <b>D</b>

**COVERAGES**

THIS IS TO CERTIFY THAT 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. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS												
	<b>GENERAL LIABILITY</b> <input type="checkbox"/> COMPREHENSIVE FORM <input type="checkbox"/> PREMISES/OPERATIONS UNDERGROUND EXPLOSION & COLLAPSE HAZARD <input type="checkbox"/> PRODUCTS/COMPLETED OPER <input type="checkbox"/> CONTRACTUAL <input type="checkbox"/> INDEPENDENT CONTRACTORS <input type="checkbox"/> BROAD FORM PROPERTY DAMAGE <input type="checkbox"/> PERSONAL INJURY	<b>Sample</b>			BODILY INJURY OCC      \$ BODILY INJURY AGG      \$ PROPERTY DAMAGE OCC      \$ PROPERTY DAMAGE AGG      \$ BI & PD COMBINED OCC      \$ BI & PD COMBINED AGG      \$ PERSONAL INJURY AGG      \$												
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS (Private Pass) <input type="checkbox"/> ALL OWNED AUTOS (Other than Private Passenger) <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS <input type="checkbox"/> GARAGE LIABILITY				BODILY INJURY (Per person)      \$ BODILY INJURY (Per accident)      \$ PROPERTY DAMAGE      \$ BODILY INJURY & PROPERTY DAMAGE COMBINED      \$												
	<b>EXCESS LIABILITY</b> <input type="checkbox"/> UMBRELLA FORM <input type="checkbox"/> OTHER THAN UMBRELLA FORM				EACH OCCURRENCE      \$ AGGREGATE      \$ _____      \$												
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>  THE PROPRIETOR/PARTNERS/EXECUTIVE OFFICERS ARE: <input type="checkbox"/> INCL <input type="checkbox"/> EXCL				<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;"></td> <td style="width:15%;">WC STATU-TORY LIMITS</td> <td style="width:15%;">OTH-ER</td> </tr> <tr> <td>EL EACH ACCIDENT</td> <td></td> <td>\$</td> </tr> <tr> <td>EL DISEASE - POLICY LIMIT</td> <td></td> <td>\$</td> </tr> <tr> <td>EL DISEASE - EA EMPLOYEE</td> <td></td> <td>\$</td> </tr> </table>		WC STATU-TORY LIMITS	OTH-ER	EL EACH ACCIDENT		\$	EL DISEASE - POLICY LIMIT		\$	EL DISEASE - EA EMPLOYEE		\$
	WC STATU-TORY LIMITS		OTH-ER														
EL EACH ACCIDENT			\$														
EL DISEASE - POLICY LIMIT			\$														
EL DISEASE - EA EMPLOYEE			\$														
<b>A</b>	<b>OTHER</b>  Professional Liability - E & O		ABCDEF-000-000	00/00/2013	00/00/2014	Limit per claim      \$ XX Aggregate limit      \$ XX											

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

<b>CERTIFICATE HOLDER</b>  ProCare, Inc. 4710 Eisenhower Boulevard Suite C-2 Tampa, FL 33634	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.  AUTHORIZED REPRESENTATIVE Must be signed by issuing agent
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**THIS IS AN EXAMPLE OF OUR TL 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 AN APPOINTMENT FOR 07-12-2013 AT 2:00 PM. \*Spanish OnSite\* QUOTED AT YOUR CONTRACTED RATES + (10 Travel Miles).  
THANK YOU,  
Dispatch

THIS IS WHERE ANY SPECIAL INSTRUCTIONS FOR THIS APPOINTMENT WILL BE.

**Authorization Information:**

**Spanish**

**TL OnSite**

DATE OF SERVICE  
**7/12/2013 - Friday**

Here are the trip details such as language, appointment date, time and location.

APPOINTMENT TIME:  
**2:00 PM**

-----  
Doctor's Office  
**456 Main St.  
TAMPA, FLORIDA 33634**

**PAYOR INFORMATION (PLEASE SEND BILLS TO THIS ADDRESS AND INCLUDE AUTHORIZATION # WITH INVOICE)**

**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](mailto:billing@theprocare.com)  
**PROCARE AUTHORIZATION/PO#: 405001**

**NO OTHER FEES WILL APPLY TO THIS ASSIGNMENT. IF THERE IS A DISCREPANCY WITH THE**

**ABOVE QUOTE WE NEED TO BE NOTIFIED WITHIN 24HRS AFTER THE ASSIGNMENT IS COMPLETED (ALL MILEAGES ARE CALCULATED PER GOOGLE MAPS. 24HR DISCREPANCIES WILL NOT APPLY TO MILEAGE CHANGE REQUESTS WHEN USING OTHER SEARCH ENGINES TO CALCULATE MILEAGES)**

**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](mailto:customerservice@theprocare.com)**

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