Dear Potential Provider:

Thank you for your interest in providing interpretation services for ProCare Transportation & Language Services. 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 Interpretation Company or an Independent Interpreter. 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 to leave a voicemail message. We will promptly return your call and assist you.

We look forward to working with you.

Sincerely,

Provider Relations Team
ProCare Transportation & Language Services

Email Agreement and Documents to
ProviderRelations@theProCare.com
Or fax to: (813) 769-3883

Document Checklist for Commercial Providers:	**Document Checklist for Independent Providers:**
☐ Interpretation Application and Agreement (initial in bottom right-hand corner of each page) ☐ Interpretation Provider Rate Sheet ☐ W-9 Form ☐ Business/Occupational License ☐ Certificate of Professional Liability Insurance (preferably on the Acord Form 25 with ProCare named as the Certificate Holder)	☐ Interpretation Application and Agreement (initial in bottom right-hand corner of each page) ☐ Interpretation Provider Rate Sheet ☐ W-9 Form ☐ Resume or Curriculum Vitae ☐ Proof of Certification or Any Language Qualifications Earned (if applicable)

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.
If you have a question about an assignment that was sent to you, please email 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 (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 an interpretation 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 any and all services completed for ProCare will be rendered by Contracting Provider's own interpreters. Transferring services that ProCare 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 immediately. Upon arrival at the facility, Contracting Provider must identify himself/herself as the ProCare interpreter assigned to the injured worker to the injured worker, physician and/or case manager.

4) Contracting Provider agrees to contact ProCare 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 immediately of any incident involving an injured worker.

8) Contracting Provider agrees to cooperate and participate with and in, and be bound by, ProCare'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 Clients (i.e., claimant's case manager and/or adjuster). Rates and/or payment shall only be discussed with ProCare.

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 are the property of ProCare 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 injured worker to select or request service by a Provider other than ProCare.

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.

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. Contracting Provider also agrees to notify ProCare promptly of any drug- or alcohol-related incidents or complaints involving its interpreters and ProCare 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'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 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 for payment for services provided under this Agreement. Contracting Provider must submit an invoice to ProCare or Access*On*Time 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 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 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 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.

I. ProCare does not pay for "Patient No-Show" claims unless approved prior to the interpreter leaving the appointment location. ProCare 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 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 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.

K. 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.

8. INDEMNIFICATION

A. Contracting Provider agrees to indemnify ProCare 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 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 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:_____

INTERPRETATION PROVIDER RATE SHEET	
Professional Charge	$____ /hour Professional Time (__ hour minimum)
Other Charges	Travel Time included in professional time, $___/mile
No Show Flat Fee	$_____ (no additional mileage reimbursed)

Language(s):

_____

_____

Coverage Areas (i.e., Counties):

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

IMPORTANT:

- The **Interpretation Invoice** must be completed and submitted to ProCare **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 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.

_____ _____

Interpreter Printed (Typed) Name Date Rates Accepted

_____ _____

Interpreter Signature ProCare Signature

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

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:

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 for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

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.*

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

PRODUCER

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.

COMPANIES AFFORDING COVERAGE

COMPANY **A** Name of Insurance Company

COMPANY **B**

COMPANY **C**

COMPANY **D**

INSURED

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

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	
	GENERAL LIABILITY	Sample			BODILY INJURY OCC	$
	☐ COMPREHENSIVE FORM				BODILY INJURY AGG	$
	☐ PREMISES/OPERATIONS				PROPERTY DAMAGE OCC	$
	☐ UNDERGROUND EXPLOSION & COLLAPSE HAZARD				PROPERTY DAMAGE AGG	$
	☐ PRODUCTS/COMPLETED OPER				BI & PD COMBINED OCC	$
	☐ CONTRACTUAL				BI & PD COMBINED AGG	$
	☐ INDEPENDENT CONTRACTORS				PERSONAL INJURY AGG	$
	☐ BROAD FORM PROPERTY DAMAGE					
	☐ PERSONAL INJURY					
	AUTOMOBILE LIABILITY				BODILY INJURY (Per person)	$
	☐ ANY AUTO					
	☐ ALL OWNED AUTOS (Private Pass)				BODILY INJURY (Per accident)	$
	☐ ALL OWNED AUTOS (Other than Private Passenger)					
	☐ HIRED AUTOS				PROPERTY DAMAGE	$
	☐ NON-OWNED AUTOS					
	☐ GARAGE LIABILITY				BODILY INJURY & PROPERTY DAMAGE COMBINED	$
	☐					
	EXCESS LIABILITY				EACH OCCURRENCE	$
	☐ UMBRELLA FORM				AGGREGATE	$
	☐ OTHER THAN UMBRELLA FORM					$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	THE PROPRIETOR/ PARTNERS/EXECUTIVE OFFICERS ARE: ☐ INCL ☐ EXCL				EL EACH ACCIDENT	$
					EL DISEASE - POLICY LIMIT	$
					EL DISEASE - EA EMPLOYEE	$
A	**OTHER** Professional Liability - E & O	ABCDEF-000-000	00/00/2013	00/00/2014	Limit per claim Aggregate limit	$ XX $ XX

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

CERTIFICATE HOLDER

ProCare, Inc.
4710 Eisenhower Boulevard
Suite C-2
Tampa, FL 33634

CANCELLATION

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

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
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

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").