



\_\_\_\_\_  
 Last Name      First Name      Initial      Professional Degree      Birth Date

\_\_\_\_\_  
 Address of Office      City      State      Zip      (\_\_\_\_) Telephone

\_\_\_\_\_  
 Office Hours      Monday      Tuesday      Wednesday      Thursday      Friday

\_\_\_\_\_  
 Languages Spoken by physician      Languages Spoken by office staff      Practice Restrictions(Age, Gender)

Are you applying to Community Health Network as a member of a group or as a partner to a current Community Health Network member? If so, please identify:

\_\_\_\_\_  
 Group Name/Member Name      Telephone Number

\*\*\*\*\*

**SPECIALTIES:**

	Board Certified? (circle one)	American Board Board	Year Certified
Primary _____	Y / N	_____	_____
Secondary _____	Y / N	_____	_____

\*\*\*\*\*  
 \*\*\*\*\*

**STATISTICAL INFORMATION:**

\_\_\_\_\_  
 MT Professional License #      Exp. Date      /      Federal Tax Identification #      /      Social Security #

\_\_\_\_\_  
 NPI – National Priverid ID      /      DEA Number      /      UPIN

\*\*\*\*\*  
 \*\*\*\*\*

**EDUCATION & TRAINING:**

\_\_\_\_\_  
 School / Degree      City      State      Date of Graduation

<b>TRAINING</b>	<b>LOCATION</b>	<b>MONTH/YEAR</b>	<b>COMPLETED</b>
			<b>Yes/No</b>

\_\_\_\_\_  
 Internship      Institution      From      To      \_\_\_\_\_

\_\_\_\_\_  
 Residency      Institution      From      To      \_\_\_\_\_

\_\_\_\_\_  
 Fellowship      Institution      From      To      \_\_\_\_\_

\*\*\*\*\*

**HOSPITAL STAFF PRIVILEGES:** List all area hospitals where you hold privileges

Hospital / City	Level of Privileges	% of Admits
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

\*\*\*\*\*

**ADDITIONAL INFORMATION:**

**If you answer YES to any of the questions # 3 – 11 below, an explanation and a copy of any related order or settlement must be attached to the application.**

1. How many years have you practiced ? \_\_\_\_\_ Years
2. Malpractice carrier: Please include declarations page.
3. Has your license to practice in any jurisdiction ever been revoked, suspended, or subject to probation or any conditions or limitations? Y / N
4. Have any complaints been filed against you with any Board? Y / N
5. Has your professional liability insurance cancelled, restricted, declined or not renewed in the past five years? Y / N
6. Have you ever been named as a defendant in a malpractice action that resulted in a settlement of more than \$10,000? Y / N
7. Have your privileges at any facility ever been denied, revoked, suspended or restricted ? If yes, name the facility \_\_\_\_\_ Y / N
8. Has your DEA or other license ever been suspended or revoked? Y / N
9. Do you presently have any physical or mental health problems which would interfere with your ability to provide high quality professional services? Y / N
10. Are you unable to perform the essential functions involved in delivering safe, efficient, quality care due to chemical dependency, substance abuse, or current mental or physical health conditions? Y / N
11. Have you ever been convicted of, or plead no contest to, or are you currently under investigation for any felony charges brought against you? Y / N
12. Do you use physician assistants or nurse practitioners in the office? Y / N
13. Are you accepting new patients? Y / N

\*\*\*\*\*

**CURRICULUM VITAE**

The National Committee for Quality Assurance requires Community Health Network to have work history in provider files. **Please return a CV or resume** with at least 5 years of work history, explaining gaps of 6 months or more.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

All information submitted by me in this Application is true and accurate to the best of my knowledge and belief. I fully understand that any misleading statement or material omissions in this application may constitute cause for denial of eligibility.

By signing this Authorization to Release Information, I, the undersigned, hereby consent to the inspection by Community Health Network or its representative and SourceOne CVO of all records and documents that may be material to an evaluation of my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter that may be considered material to my qualifications. I understand that this may include the inspection and/or verification of educational records, professional organization and/or association records, court records, licensing board or certification records, professional liability insurance records, as well as inspection of a personal credit report, query of the National Practitioner Data Bank, contact with personal and/or professional references and any other records or third parties that may have a direct bearing upon my being considered for a position.

Additionally, I, the undersigned, hereby release from liability all representatives and agents of aforementioned organization for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from liability any and all individuals and organizations who provide information to this facility's representative, in good faith and without malice and I hereby consent to the release of such information.

A copy of this Authorization to Release Information shall be as binding as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



## CHN Credentialing Documents Requirements

For Represented Providers with the following degrees: MD, DO, DPM, DDS, DMD, DC, and OD, nurse practitioners, certified midwives, certified nurse midwives, physician assistants, certified registered nurse anesthetists:

- Signed application
- Signed participation agreement
- Copy of Liability Insurance
- CV or Resume

Please return these documents to:  
Community Health Network  
P.O. Box 2403  
Kalispell, MT 59901



## CHN Credentialing Documents Requirements

For Represented Providers who are non-physician acupuncturists, naturopaths, physical therapists, speech therapists, occupational therapists and other allied health practitioners:

- Signed application
- Signed participation agreement
- Copy of Liability Insurance
- Copy of Diploma
- CV or Resume

Please return these documents to:  
Community Health Network  
P.O. Box 2403  
Kalispell, MT 59901

## PARTICIPATING PROVIDER AGREEMENT

**THIS PARTICIPATING PROVIDER AGREEMENT** ("Agreement") effective as of the \_\_\_ day of \_\_\_\_\_ 2013, (the "Effective Date"), is made and entered by and between Community Health Network ("CHN") and \_\_\_\_\_ the ("Provider").

### WITNESSETH

**WHEREAS**, CHN desires to provide the opportunity for health care providers in its community to participate in a cost-effective, coordinated health care delivery system (the "Provider Network" or "Network");

**WHEREAS**, CHN is contacted periodically by health benefit plans and other payors looking to contract with health care providers that participate in the Provider Network;

**WHEREAS**, CHN believes it is in the best interest of the community to provide health benefit plans and other payors the opportunity to utilize CHN's health care providers that participate in the Provider Network;

**WHEREAS**, Provider is duly licensed under Montana law;

**WHEREAS**, Provider agrees to provide services to Health Benefit Plan's or Payor's Members (as herein defined) under the terms and conditions of this Agreement; and

**WHEREAS**, CHN and Provider, in order to comply with all applicable regulatory requirements, agree to be bound by the provisions of this Agreement.

**NOW, THEREFORE**, in consideration of the mutual covenants and conditions contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, CHN and Provider agree as follows:

### ARTICLE I. DEFINITIONS

For purposes of this Agreement, the following terms have the ascribed meaning:

- 1.1 **Co-payment** Any amount, excluding the premium, required to be paid by or on behalf of a Member for Covered Services.
- 1.2 **Covered Services** Those health care services Members are entitled to receive under a Health Benefit Plan or Payor's Plan.
- 1.3 **Emergency** Services which are rendered because of the sudden onset of a health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, where the absence of immediate health attention could reasonably be expected to result in serious impairment of a bodily function or serious and permanent dysfunction of any body organ or body part, or to cause other serious health consequences, which include placing a Member's health in jeopardy; or, in the case of Members who are Medicare or Medicaid enrollees, "Emergency Services" shall be defined as in 42 C.F.R.~ 417.401.
- 1.4 **Member** Any enrollee in a Health Benefit Plan or Plan offered by a Payor in which Provider has agreed to participate.
- 1.5 **Normal Charge** The usual and customary charge per individual unit of service or supply as calculated by the Payor.
- 1.6 **Participating Health Care Provider** A Health Care Provider who has contracted, directly or indirectly, as an independent contractor with CHN to provide certain Covered Services to Members and, if applicable, has never been excluded from Medicaid, Medicare, or another federal health or social service program.

- 1.7 **Participating Provider** A Participating Health Care Provider, Participating Provider, and any other licensed health care facility or professional, who or which has entered into a written agreement with CHN to provide services to Members.
- 1.8 **Payor** The party entering into a Payor Agreement with CHN.
- 1.9 **Payor Agreement** An agreement by and between a Payor and CHN under which CHN arranges for the provision of certain Covered Services to Members.
- 1.10 **Plan** A program offered by or through a Payor for the benefit of Members which includes, directly or under arrangement, providing or arranging to provide Covered Services.

## **ARTICLE II. PROVIDER PARTICIPATION REQUIREMENTS**

- 2.1 **Health Care Services** Provider shall be contacted by CHN regarding all proposals received by CHN from Payors. Provider shall notify CHN of its decision to participate in a Payor's Plan. For those Payor arrangements in which Provider agrees to participate, Provider agrees to provide Covered Services to Members pursuant to the terms of this Agreement.
- 2.2 **Availability of Services** Provider shall provide all Covered Services in the same manner, in accordance with the same accepted health standards, and within the same time availability, offered to all of Provider's patients. Descriptions of the Covered Services to which each Member is entitled, any limitations on such Covered Services, any Co-payment features, and the place and manner in which the services may be obtained for each Payor shall be provided to Provider by CHN pursuant to the provisions of Sections 2.4 and 3.1 hereof.
- 2.3 **Non-Exclusivity and Participation Right** This Agreement will not be deemed in any way to limit or restrict Provider from entering into other arrangements or programs of a similar nature with other managed care entities.
- 2.4 **Payor Agreements** CHN shall provide Provider thirty (30) days notice of the amendment of this Agreement by the addition of a Payor, and the effective date of each Payor Agreement which is entered into by or on behalf of CHN. In addition, CHN shall notify Provider if a Payor Agreement is terminated. In the event of the termination of any Payor Agreement, CHN shall not be liable to Provider for any damage or loss of any kind including, without limitation, (i) direct damages, (ii) consequential damages, (iii) loss of profits, or (iv) business interruption. This Section shall survive termination of this Agreement.
- 2.5 **Licensing and Certification: No Sanctions or Convictions** Provider shall maintain all necessary and applicable licenses and certifications in conformity with the Agreement. Provider represents and warrants that as of the date of this agreement Provider has not been sanctioned for failure to provide care of quality care. Provider represents and warrants that, as of the date of this Agreement, it is licensed, and in good standing, in the State of Montana and that it shall maintain such Licensure while this Agreement is in effect.
- 2.6 **Limitation on Services** Provider shall promptly notify CHN of any changes in the nature or extent of services offered by Provider and of any adverse change in Provider's eligibility for participation in Medicare, Medicaid, or other federal health or social service programs.
- 2.7 **Non-Discrimination** Provider shall not discriminate in the rendering of services under this Agreement on the basis of a Member's race, national origin, sex, sexual orientation, age, religion, place of residence, health status or source of payment, including Member's enrollment in Payor's Plan.
- 2.8 **Professional Relationship** Provider shall be solely responsible for all healthcare services Provider performs or prescribes for a Member.
- 2.9 **Required Notifications** Provider shall notify CHN in writing, within the time periods and with a description as set forth below, following the occurrence of any of the following events:

- (a) Provider's license to practice in the State of Montana is suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions (notification within five (5) days);
- (b) Provider (i) learns that it has become a defendant in any malpractice action relating to a Member which also names CHN as a defendant or receives any pleading, notice or demand of claim, or service of process relating to such a suit, or (ii) is required to pay damages in any such action by way of judgment or settlement (notification within ten (10) business days);
- (c) Any change in the nature or extent of Covered Services rendered by Provider (notification within five (5) business days of the event causing notice to be given);
- (d) Any other act, event, occurrence or the like which materially affects Provider's ability to carry out Provider's duties and obligations under this Agreement (notification within five (5) business days of the event causing notice to be given).

The occurrence of one or more of the events enumerated above may result in the termination of this Agreement for cause.

CHN agrees to notify Provider of any written complaints lodged against CHN or Payor.

- 2.10 **Emergency And Other Services Procedures and Coverage** Provider agrees to fully cooperate with CHN or the Payor in arranging for the provision of Emergency, inpatient, outpatient, and other services in accordance with the provisions of this Agreement.
- 2.11 **Insurance** Provider shall, throughout the term of this Agreement, maintain professional liability insurance with an admitted insurance carrier with coverage amounts in a minimum of \$1/3 million dollars for physicians and \$1/3 hundred thousand for all other providers.
- 2.12 **Compliance with Utilization Management, Quality Assurance, Rules and Regulations, and Policies and Procedures**  
Provider shall comply with all written requirements of CHN and Payor governing utilization management, quality assurance, rules and regulations, and policies and procedures. Such requirements shall include, but not be limited to rules regarding referrals and eligibility of Members; implementation of any required preadmission, concurrent, or retrospective systems of utilization management or review, and will accept the determination of such program concerning payments to the Provider for any Covered Services provided by Provider, subject to any applicable rights of appeal or dispute resolution established by mutual agreement of Provider, CHN and Payor. Provider acknowledges that it shall not be entitled to any compensation from Payor, CHN, nor any Member for any health care service which is determined, pursuant to the applicable utilization review and management program or quality assurance program, to be not medically necessary.
- 2.13 **Member Grievance Procedures** Provider agrees to be available to review, and to cooperate with CHN in resolving, any medically related grievances, as part of CHN's or a Payor's Member grievance process. Provider agrees that such grievances shall be handled in accordance with CHN's or Payor's grievance procedures, a copy of which will be provided to Provider upon request.
- 2.14 **Notice of Termination** Notwithstanding any provision of the Agreement or the Payor Agreement to the contrary, Provider and CHN shall provide at least ninety (90) days advance written notice to the Payor before canceling or terminating Provider's or CHN's participation under this Agreement or under the Payor Agreement for any reason.
- 2.15 **Obligation to Continue Care** If Payor becomes insolvent or fails for any reason to pay compensation for Covered Services as required by this Agreement, Provider nevertheless agrees that, at CHN's or Payor's request, Provider shall continue to treat Members then hospitalized as inpatients, under the terms of this Agreement until provision has been made for their assignment to another Provider or until such treatment has been completed, whichever occurs first. Such period shall not exceed thirty (30) days if Payor's obligations to compensate Provider hereunder have not been assumed by another party. Provider shall not bill Members for Covered Services rendered during such period.



- 2.16 **Non-Covered Service Clause** Provider shall not collect payment for medical services determined, by the Payor, to be not medically necessary unless the Member has agreed in writing prior to services being rendered to be responsible for payment of those charges.
- 2.17 **Pre-Authorization** Covered Member is responsible for pre-authorization before all non-emergency Provider admissions. Emergency admissions must be reported within 24 hours of the admission or on the next business day following a weekend or holiday admission. Per Covered Members policy, Member is responsible for charges if they fail to secure a pre-authorization before services are rendered.
- 2.18 **Identification Cards** Plan shall furnish each Covered Member with an identification card, which is to be presented upon admission to a hospital and upon each instance of provision of services by any Participating Provider. Such identification card shall clearly identify the Plan and network through which Plan is accessing services from Provider.
- 2.19 **Member Verification** Provider agrees upon presentation of Plan identification card to make reasonable and good faith efforts to verify eligibility of the person presenting such card as the Covered Member named thereon. Provider shall verify eligibility of such Covered Member with Plan prior to providing services, except in the case of emergency services.
- 2.20 **Compliance with Payor Contracts** For each Payor's employer contract, Provider agrees to participate and render covered services to CHN members through the end of the employer's benefit plan year, unless CHN consents to waive run-out coverage period.
- 2.21 **Tax Identification Number** Provider will use the tax identification number (TIN) stated on accompanying CHN application for all billing for all service rendered by any licensed provider or physician of provider. Claims containing incorrect TIN's will not be considered or processed as clean claims. If the TIN provided is later identified by the Internal Revenue Service (IRS) through an IRS form CP2100 as being an incorrect TIN, no further claims will be proceed and paid until the TIN is corrected by Provider. All providers billing for services under this TIN will be processed as in network providers.

### ARTICLE III. PAYMENT FOR SERVICES

- 3.1 **Payment for Provider Services** Provider's reimbursement for providing Covered Services is limited to the compensation set forth in Attachment A for each Payor arrangement as determined by the CHN board of directors. CHN contracts shall specify that Payor pay clean claims within 30 days of submittal of a clean claim. CHN contracts shall also specify that the Payor provide insurance verification, preauthorizations and enrollment information to the Provider in a timely manner.
- 3.2 **No Recourse Against Members** Except as otherwise provided in this Agreement, Provider shall not bill, charge or attempt to collect from any Member for any services provided under this Agreement, including the difference between the amount of reimbursement payable under this Agreement and the Provider's Normal Charges for the services rendered. Except for Co-payments not covered by this Agreement, for all Covered Services delivered pursuant to this Agreement to Members, Provider shall not: (1) bill, charge or attempt to collect any money from any Member; (2) maintain any action at law against any Member to collect money owed to Provider by a Payor; or (3) hold any Member liable in any other way for Covered Services provided to such Member. Whenever Payor fails to meet its obligation to pay fees under this Agreement for Covered Services already rendered to a Member, Payor, rather than the Member, shall be liable for such fees. If a member chooses to obtain a Noncovered Service the Provider will not be precluded from charging the patient directly for the service.

### ARTICLE IV. RECORDS

- 4.1 **Health Records** Provider shall maintain health records of Members in accordance with applicable state and federal laws. Subject to any Member or any Member's legal representative consenting to the release and/or duplication of health records, or to court order or subpoena duly and validly issued, Provider shall permit, during normal business hours, the inspection and/or copying of the Member's health records at a cost not to exceed limits imposed by applicable federal and state laws and

regulations. Nothing in this Agreement shall require Provider to provide access to any Member's health records in violation of applicable state or federal laws or regulations.

- 4.2 **Access to Records** In the event the Secretary of the Department of Health and Human Services or his or her duly authorized representative is entitled to access, pursuant to Section 1861 (V)(1)(1) of the Social Security Act, as amended, and the regulations promulgated thereunder, any directly pertinent books, documents, papers, and records of Provider involving transactions pertaining to this Agreement, Provider agrees to make the same available for examination in accordance with the terms and requirements of said statutes and regulations.
- 4.3 **Transfer and Confidentiality** Provider agrees to cooperate in the transfer of Members' health records to other Participating Providers, and to assume any cost associated therewith. Provider further agrees to cooperate with CHN and any state or federal agency in making available, and in arranging or allowing inspection of, such records as may be required under state or federal law. CHN and Provider agree that all of Members' health records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of patient records. Notwithstanding termination of this Agreement, the access to records granted hereunder shall survive the termination of this Agreement.

#### ARTICLE V. TERM AND TERMINATION

- 5.1 **Initial Term** This Agreement shall have an initial term of two (2) years, commencing as of the Effective Date and shall automatically renew for consecutive one-year terms.
- 5.2 **Termination** Either party may terminate this Agreement upon ninety (90) days' prior written notice, which notice shall set forth the grounds for termination. Notwithstanding any provision in this Agreement to the contrary, Provider shall continue to provide Covered Services to Members during the ninety (90) day period.
- 5.3 **Termination: Automatic** This Agreement shall automatically and immediately terminate upon the expiration, surrender, revocation, restriction or suspension (whether voluntary or involuntary) of Provider's license to operate an acute care Provider in Montana or Provider's Medicare or Medicaid certification.
- 5.4 **Disclosure of Termination** In the event this Agreement expires or terminates for any reason or cause, Provider consents to CHN's disclosing the same to each affected Plan.

#### ARTICLE VI. PROMOTION AND MARKETING

- 6.1 **Provider of** CHN and each Payor shall have the right to use Provider's name, business address and phone number for purposes of marketing, as it relates to this Agreement, informing Members of the identity of Provider, and otherwise to carry out the terms of this Agreement and the Payor Agreements.
- 6.2 **Promotion of** Provider shall display in a visible and prominent place such a reasonable card, plaque, or similar identifying logo as CHN may provide, which identifies Provider as a Participating Provider.

#### ARTICLE VII. MISCELLANEOUS

- 7.1 **Amendment** Except as stated in Sections 3.1, this Agreement may be amended or modified only by a written agreement executed by both parties.
- 7.2 **Waivers** The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach of this Agreement.
- 7.3 **Severability** The invalidity or unenforceability of any terms or conditions shall in no way affect the validity or enforceability of any other term or provision.

- 7.4 **Assignment** Except as otherwise provided herein, neither this Agreement nor any of the rights or obligations under this Agreement may be assigned or transferred without the prior written consent of the non-assigning party.
- 7.5 **Conformance with Law** Each party shall carry out all activities undertaken by it pursuant to this Agreement in conformance with all applicable federal, state and local laws, rules and regulations. The relationships and transactions contemplated by this Agreement may be subject to regulation by state or federal governmental authorities. In the event that any action of a governmental authority impairs, limits, or delays either parties performance of any obligation hereunder, parties shall be excused from such performance, and CHN's or Provider's failure to perform such obligation for such reason shall not constitute a breach of this Agreement.
- 7.6 **Notice** Any notice required to be given pursuant to the terms and provisions of this Agreement shall be sent by certified mail, return receipt requested, postage prepaid; hand delivery; overnight prepaid delivery; or confirmed facsimile, to the parties at the addresses set forth below or to such other address as may be designated by a party by notice given pursuant to this Agreement:

If to CHN:  
P.O. Box 2403  
Kalispell, MT 59903  
Attn: Thomas V. Caughlan, MD

If to Provider:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 7.7 **Independent Contractor Status** This Agreement is not intended to create nor shall it be deemed or construed to create any relationship between the parties other than that of independent contractors. Neither of the parties to this Agreement, nor any of their respective employees, shall be construed to be the agent, employer or representative of the other.
- 7.8 **Entire Agreement** This Agreement, including any amendments, riders, attachments, or appendices contains the entire understanding between the parties and supersedes any prior understandings and agreements between the parties, whether written or oral, respecting the subject matter of this Agreement.
- 7.9 **Number and Gender** All pronouns used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular, or plural as the context may require.
- 7.10 **Section Headings** All article, section, or paragraph titles or captions in this Agreement are for convenience only and are not deemed part of the content of this Agreement.
- 7.11 **Coordination of Defense of Claims** The parties shall make all reasonable efforts, consistent with advice of counsel and the requirements of the respective insurance policies and carriers to coordinate the defense of all claims in which the other party is either a named defendant or has a substantial possibility of being named.
- 7.12 **Governing Law** This Agreement has been executed and delivered and shall be construed and enforced in accordance with the laws of the State of Montana excluding and without application of any choice of law principles. Any suit, action or proceeding with respect to this Agreement or any judgment entered by any court in respect of this Agreement shall be brought and litigated in the courts of Flathead County, Montana, and the parties accept the exclusive jurisdiction of those courts for the purpose of any suit, action or proceeding.
- 7.13 **Time of the Essence** Time shall be of the essence with respect to each and every term, covenant, and condition of this Agreement.
- 7.14 **Attorneys' Fees** The successful party in any lawsuit to enforce this Agreement shall be entitled to recover from the other party all suit costs and reasonable attorneys' fees, including fees on appeal, and

each party shall pay any suit costs and reasonable attorneys' fees that may be incurred by the successful party in enforcing this Agreement.

- 7.15 **Execution** This Agreement and any amendments may be executed in multiple originals; each counterpart shall be deemed an original and together shall constitute one and the same instrument.
- 7.16 **Impossibility of Performance** Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, employee strikes or other work interruptions, earthquakes, floods, failure of transportation or any similar or dissimilar cause beyond the reasonable control of such party.
- 7.17 **Third-Party Beneficiaries** CHN and Provider agree that Payor and Members are intended third-party beneficiaries of Provider's obligations hereunder and Provider will perform its obligations to Payor and Members hereunder irrespective of CHN's performance (or non-performance) of its obligations to Provider.
- 7.18 **Indemnification** Each party (the "Indemnifying Party") agrees to indemnify, hold harmless, and defend the other party and all other persons or organizations affiliated with the other party and, if applicable, each of their respective shareholders, members, directors, partners, trustees, employees, agents and officers from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorneys' fees), judgments and interest thereon, appeal bonds or obligations whatsoever, for or in connection with any personal or bodily injury (including death) or other damages to any Member or property caused by the act or omission of the Indemnifying Party.
- 7.19 **Arbitration** In the event the parties hereto are unable to resolve any dispute regarding the interpretation or application of any provision of this Agreement through good faith negotiations, such dispute shall be settled by binding arbitration conducted in accordance with the commercial rules of arbitration of the American Arbitration Association and judgment upon the award rendered by the arbitrator(s) may be entered and enforced in any court having jurisdiction thereof. The arbitrator(s) shall have no power to award punitive or exemplary damages or to ignore or vary the terms of this Agreement; the arbitrator(s) shall be bound by controlling law.
- 7.20 **Run Out Clause** For each Payor's employer contract, Provider agrees to participate and render covered services to CHN members through the end of the employer's benefit plan year, unless CHN consents to waive run-out coverage period.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed personally or by their duly authorized officers or agents.

PROVIDER

COMMUNITY HEALTH NETWORK

By:

By:

\_\_\_\_\_

\_\_\_\_\_

Print or Type Name

Print or Type Name

\_\_\_\_\_

Date

\_\_\_\_\_

Date