



Please send completed form to:
CMN Inc.
Attn: Provider Relations
 150 Commerce Valley Drive West, 9th Floor
 Thornhill, Ontario, Canada L3T 7Z3
 Tel: +1-905-669-4333 x1247
 Fax: +1-905-669-2318
 E-mail: nlubsey@cmn-global.com

Global Preferred Provider Participation Form (non-US)

CMN Inc. is very interested in learning more about your healthcare services and would like to include your facility as a Global Preferred Provider. Please complete the form and return to Provider Relations via e-mail to nlubsey@cmn-global.com or fax +1-905-669-2318.

A. TYPE OF FACILITY

Hospital Medical Centre/Clinic Physician/Specialist Dentist Lab/Diagnostic Centre Pharmacy Medical Equipment

B. FACILITY INFORMATION

Facility Name			
Physical Address			
City	Region/Province/State	Postal/Zip Code	Country
Telephone (include city and country codes)	Fax (include city and country codes)	Website Address	

Languages - Please check all that apply

English speaking staff and doctors List other languages

Translators

C. DEPARTMENTAL CONTACT INFORMATION

International Department	E-mail Address	Telephone (include area code) ()
Scheduling and Admissions	E-mail Address	Telephone (include area code) ()
Contracting	E-mail Address	Telephone (include area code) ()
Billing/Patient Accounts (Department Manager)	E-mail Address	Telephone (include area code) ()

D. JCI ACCREDITATION

Is your hospital JCI Accredited? Yes No

If Yes, please specify details of your most recent accreditation

	Date of Last Accreditation (MM/DD/YYYY) / /
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Global Preferred Provider Participation Form - non-US (page 2)

E. SPECIALTY INFORMATION - Hospitals and Physicians

Please specify the specialty or specialties practiced by your hospitals/physicians

<input type="checkbox"/> Allergy and Immunology	<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Pulmonology
<input type="checkbox"/> Andrology	<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Otolaryngology (ENT)	<input type="checkbox"/> Radiology
<input type="checkbox"/> Cardiology	<input type="checkbox"/> General Practice	<input type="checkbox"/> Pathology	<input type="checkbox"/> Reconstructive/Cosmetic Surgery
<input type="checkbox"/> Cardiothoracic Surgery	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Surgery (please specify type) _____
<input type="checkbox"/> Counselling and Social Work	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Pediatrics (please specify any sub-specialties) _____	<input type="checkbox"/> Urology
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Neurology	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Obstetrics and Gynecology	<input type="checkbox"/> Proctology	
<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Oncology and Hematology		

F. ADDITIONAL HOSPITAL INFORMATION- Hospitals Only

Number of general acute care beds	Number of ICU beds	Number of pediatric ICU beds	Number of neonatal ICU beds	Number of inpatient admissions in the last 12 months
Most common surgical procedure performed in the last 12 months			Mortality rate	Complication rate
Is the hospital currently a member of a broader hospital group?		If YES, which one?		
<input type="checkbox"/> Yes <input type="checkbox"/> No				

G. ACCEPTANCE OF TERMS

PROVIDER and CMN Agree:

- Services.** PROVIDER will perform services that PROVIDER is licensed, equipped and staffed to provide which are medically necessary and consistent with the standard of quality of care generally accepted in its medical community.
- Compensation.** PROVIDER shall bill the insurance carrier directly and not request any payment upfront from COVERED PERSONS and CMN shall ensure that insurance carriers and their clients forward payment to PROVIDER for covered services rendered based on the terms of reimbursement set forth in this agreement.
- Terms of Reimbursement (please make your selection and initial).

<input type="checkbox"/> 10% Prompt Payment Discount _____ on billed charges and payment within 30-days of receiving clean claim (Initial)	<input type="checkbox"/> 0% Discount on billed charges _____ and payment within 45-days of receiving a clean claim (Initial)
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- Notification.** CMN will notify COVERED PERSONS that they must present at time of registration of service an ID card indicating participation through CMN or CMN must submit to PROVIDER a patient authorization form (PAF) prior to or at time of service, or other evidence that is satisfactory to PROVIDER. CMN will confirm that COVERED PERSONS have valid insurance coverage that is in effect on the date that the proposed healthcare services are to be provided.
- Timely Filing.** PROVIDER shall ensure that claims are submitted within 180 days of the date of service.
- Balance Billing.** PROVIDER shall accept reimbursement as set forth in this Agreement as payment in full for covered services rendered. This provision shall not prohibit collection of supplemental charges, co-payments, co-insurance, deductibles, or payment for non-covered services, in accordance with the terms of a COVERED PERSON'S health plan.
- Term.** This Letter of Agreement is effective on the date of signature with consecutive yearly renewals and may be terminated by either party with sixty (60) days written notice without cause.
- Confidentiality.** CMN and PROVIDER shall ensure that they and their directors, officers, employees, contractors, and agents hold confidential information in the strictest confidence.
- Hold Harmless.** Each party agrees to indemnify and hold the other party and its officers, directors, employees, and agents harmless from liability, demands, damages, or claims, including attorney's fees arising from any failure to indemnify part or all of its officers, directors, employees, or agents, to perform obligations under this Letter of agreement.
- Independent Contractor.** The relationship of the parties hereunder shall be an independent contractor relationship, and not an agency, employment, joint venture, or partnership relationship. Neither party shall have the power to bind the other party or contract in the name of the other party.
- Venue.** This Letter of Agreement shall be governed by and construed in accordance with the laws in force in the plaintiff's country, and venue for proceedings to enforce the terms hereof shall be agreed upon accordingly between PROVIDER and CMN.
- Notices.** All notices hereunder shall be in writing, delivered personally, by certified or registered mail.

This Letter of Agreement contains the entire agreement between the parties relating to the rights granted and the obligations assumed by this Letter of Agreement. Any prior agreements, promises, negotiations, or representations relating to the subject matter of this Agreement not set forth herein are of no force or effect. This Letter may be amended only by written instrument signed by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their officials thereunto duly authorized.

Print Name _____	Title _____
Signature _____	Date (MM/DD/YYYY) / /