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| A picture containing text  Description automatically generatedThe Arizona Chapter of the American Pediatrics presents **Provider Participation Agreement** (Please complete the entire form) | | | |
| Questions? Contact the Senior Coordinator at 602.532.0137 Ext.419 | | | |
|  | Provider Name |  |  |
|  | Clinic/Practice Name |  |  |
|  | Office Contact |  |  |
|  | Address |  |  |
|  | City |  |  |
|  | ZIP/Postal Code |  |  |
|  | Phone |  |  |
|  | Email |  |  |
|  | Services offered Circle all that apply | Audiology; Dental; Dermatology; Endocrinologist; ENT; Gastroenterologist; Lab Services; Mental/Behavioral; Neurology; Optometry; Ophthalmology; Orthopedic; Primary Care; Pulmonology; Radiology; Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Description Special instructions for MSP staff when processing referral |  |  |
|  | In-Kind Value | (Enter your fee schedule here) |  |
|  | Billing cycle Circle your billing frequency | After every patient Weekly Monthly Quarterly  Invoices will only be paid for services within the current school year. |  |
| Thank you for your generosity. We appreciate your support! | | | |

**What is the Medical Services Project?**

Implemented in 1993 by the Arizona Chapter of the American Academy of Pediatrics (AzAAP), the Medical Services Project (MSP) is a grant-funded, community-service project. The project was designed to connect Arizona’s uninsured and underinsured disadvantaged children to necessary primary and specialty care. This is accomplished through a network of referral sources and health care professionals. During the 2019-20 school year, the Medical Services Project processed 985 referrals which accounted for services of 470 children across the state. Children served through this program receive the vital care they need in an effort to avoid accessing care through emergency rooms. Your generosity and dedication to community service is immensely valued, but we want you to know that MSP is devoted in assisting providers with the fiscal burden of connecting these children with quality care and rising healthcare costs. ***MSP can cover up to $500 worth of services per child per school year.***

**MSP Service Fee per office visit: $5.00 – Primary Care visits $10.00 – Specialty Care visits**

* I am willing to allocate appointments for Medical Services Project referrals and agree to accept the above program-determined fee(s) as payment-in-full for services received during the office visit(s) *by the patient*. MSP will incur the remaining cost up to $500/child per school year. Services delivered by other providers may affect the compensation amount for services rendered on your behalf.

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| Provider Signature |  | Date |  |

*By checking the electronic signature box, typing your name in the “Provider” line and dating this form, you are signing this agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. Furthermore, your electronic signature indicates your certification that all information provided on the agreement is true and correct to the best of your knowledge. It is recommended that you print a copy of this document for your records. I understand my participation is non-binding and can be cancelled at any time by notifying the Health Initiatives Coordinator in writing, via mail, fax or email.*

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| The Arizona Chapter of the American Pediatrics presentsINSTRUCTIONS: Provider Participation Agreement | | | |
| Questions? Contact the Program Manager at 602.532.0137 Ext.419 | | | |
|  | Provider Name | Enter the name of the health care provider/s who will deliver MSP services |  |
|  | Clinic/Practice Name | Enter the clinic/organization name or the private practice name |  |
|  | Office Contact | Enter the name and contact information of the person/s who will handle MSP referrals including the scheduling of patients |  |
|  | Address | Enter the address of your location or locations that will accept referrals |  |
|  | City | City (Phoenix, Glendale, Tempe, etc.) You can also include “Arizona” |  |
|  | ZIP/Postal Code | You MUST enter the zip code |  |
|  | Phone | Enter the contact or contacts phone numbers who will handle MSP Referrals |  |
|  | Email | YOU MUST ENTER A CONTACT EMAIL |  |
|  | Services offered Circle all that apply | Circle the primary or specialty services your practice offers |  |
|  | Description Special instructions for MSP staff when processing referral | PLEASE BE VERY DETAILED IN THIS SECTION. Explain your demands for accepting MSP patients (limited volume, age limits, etc.). You may also expand on your ability to accept urgent referrals or only routine examinations. Highlight the types of services you are willing to provide. |  |
|  | In-Kind Value | Please include a fee schedule or an average cost for the services. For example, glasses range in price so please estimate what an average cost would be. We don’t need precision here. This allows MSP to report the “in-kind” savings of health care costs to our grantor. |  |
|  | Billing cycle Circle your billing frequency | Circle the frequency option in which you will bill MSP |  |
| Thank you for your generosity. We appreciate your support! | | | |