AUTHORIZATION AND RELEASE

This Authorization and Release ("Authorization") is executed as of _____ by _____ ("Provider"), with a principal place of business at _____, Federal Tax Identification Number _____, in favor of **Helping Hands Training and Consulting d/b/a Helping Hands Credentialing**, a Florida business entity ("Consultant"), in connection with administrative credentialing, contracting, and enrollment services performed by Consultant on Provider's behalf.

1. **Authorization to Act as Designated Representative.** Provider appoints Consultant as its designated administrative representative for credentialing, contracting, and enrollment purposes with Medicaid fee-for-service programs, Medicaid managed care organizations, commercial insurance payors, and TRICARE, in any state in which Provider requests participation, and authorizes Consultant to:

   (a) prepare, complete, submit, and track credentialing, contracting, enrollment, revalidation, and maintenance applications on Provider's behalf;

   (b) communicate with state Medicaid agencies, the Centers for Medicare and Medicaid Services, managed care organizations, commercial insurance carriers, TRICARE contractors, credentialing verification organizations, and other verification entities regarding Provider's applications;

   (c) receive, request, and respond to correspondence, deficiency notices, and information requests issued in connection with Provider's applications;

   (d) submit administrative updates on Provider's behalf, including demographic changes, roster additions, electronic funds transfer, and electronic remittance advice enrollment; and

   (e) execute applications and forms on Provider's behalf solely where expressly permitted by the applicable payor or agency.

   The authority granted under this Section is administrative in nature. It does not authorize Consultant to bind Provider to contract terms or reimbursement rates, to provide legal advice, or to make clinical or regulatory determinations on Provider's behalf.

2. **Authorization to Obtain and Verify Information.** Provider authorizes Consultant, and any payor, agency, or credentialing verification organization to which Provider's application is submitted, to obtain, verify, and review information concerning Provider's qualifications, including professional

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licensure and certification status and any related disciplinary history (including certification issued by the Behavior Analyst Certification Board, the American Speech-Language-Hearing Association, and the National Board for Certification in Occupational Therapy, and any state-issued license); education, training, and work history; professional and general liability insurance coverage and claims, settlement, or malpractice history; queries to the National Practitioner Data Bank where applicable; federal and state exclusion, sanction, and debarment screenings, including the Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, and applicable state Medicaid exclusion lists; and background screening and criminal history results where required by the applicable state, agency, or payor.

3. **Release of Information and Hold Harmless.** Provider authorizes any individual, institution, licensing board, certification body, insurance carrier, employer, professional organization, government agency, or other entity in possession of information described in Section 2 to release that information to Consultant and to the payors and agencies processing Provider's applications. To the fullest extent permitted by law, Provider releases from liability any person or entity that furnishes such information in good faith and without malice, and releases Consultant from liability for acts performed in good faith within the scope of the authority granted under this Authorization. This release does not extend to gross negligence or willful misconduct.

4. **Attestation and Duty to Update.** Provider attests that all information and documentation furnished to Consultant is true, current, complete, and accurate to the best of Provider's knowledge, and acknowledges that Consultant prepares and submits applications based exclusively on the information Provider supplies. Provider shall notify Consultant promptly, and in no event later than ten (10) business days, of any material change affecting credentialing or enrollment, including changes in licensure or certification status, ownership, address or service location, liability insurance coverage, exclusion or sanction status, or disciplinary action. Provider understands that inaccurate, incomplete, expired, or misrepresented information may result in denial, delay, termination, or revocation of enrollment or network participation, and that Consultant shall not be responsible for such outcomes.

5. **Confidentiality.** Information collected under this Authorization shall be used solely for credentialing, contracting, and enrollment purposes. Consultant shall maintain the confidentiality of all non-public information and implement reasonable administrative and technical safeguards to protect it. To the extent Consultant accesses Protected Health Information, such access is governed by the Health Insurance Portability and Accountability Act of 1996 and the separate Business Associate Agreement executed between the parties.

6. **Term, Revocation, and Copies.** This Authorization takes effect on the date signed below and remains in effect for the duration of the credentialing and enrollment engagement, including revalidation and maintenance, unless revoked earlier by Provider in writing. Revocation is effective upon Consultant's receipt and does not affect actions already taken, applications already submitted, or disclosures already made in reliance on this Authorization. A photocopy,

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facsimile, scanned, or electronically transmitted copy of this signed Authorization shall be as valid and effective as the original.

7. **Additional Payor Requirements.** Provider acknowledges that payor and agency requirements differ by state, county, and program, that certain payors require their own authorization, release, or delegated-representative forms in addition to this Authorization, and that certain payors require an original signature or notarization. Consultant shall identify and furnish any additional forms required for each requested state, county, and payor.

By signing below, Provider acknowledges that it has read and understood this Authorization and agrees to be bound by its terms.

Authorized Organization Representative Signature: _____

Printed Name: _____

Title: _____

Date: _____

Individual Practitioner (if applicable) Signature: _____

Printed Name: _____

Credential: _____

Date: _____

A countersigned copy will be provided upon signature.

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