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CMN
CORPORATE MEDICAL NETWORK™
Facility Enrollment Form

Instructions

1. Complete this form and attach all requested documentation
2. Sign and date completed form
3. Facility Enrollment Form must be submitted to: **providerrelations@tpa.ea-gcs.com** or your designated Provider Relations representative.

Please attach the following documents:

- ❑ License or any local accreditation documentation
- ❑ Proof of Insurance
- ❑ Copy of Fee Schedule

A. TYPE OF FACILITY

❑ Hospital ❑ Clinic ❑ Lab ❑ Diagnostic Imaging Centre

B. FACILITY INFORMATION

Facility Name			
Physical Address			
City	Region/State/Province	Postal / Zip Code	Country

Telephone (include area code) ( )	Fax (include area code) ( )	Website Address

Payee Name and Information (if different from above)

Billing/Payee Name	Billing/Payment Address		
City	Region/State/Province	Postal / Zip Code	Country
Telephone (include area code) ( )	Fax (include area code) ( )		

Languages - Please check all that apply

Medical Staff and Doctors	Administrative Staff	Medical Documentation	Claims
❑ English	❑ English	❑ English	❑ English
❑ Translators	❑ Translators		
Other________________	Other________________	Other________________	Other________________

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

Date of Last Accreditation (MM/DD/YYYY) / /

If Yes, please specify details of your most recent accreditation:

If No, please list any other accreditation programs:

E. SERVICES INFORMATION - Hospitals and Physicians

Please specify the services offered and specialities practiced by your hospitals/physicians.

- ☐ 24/7/365 Emergency Room
- ☐ Burn Centre
- ☐ Bariatric Surgery
- ☐ Cardiology
- ☐ Cardiothoracic Surgery
- ☐ CT
- ☐ Dental
- ☐ Dermatology
- ☐ Durable Medical Equipment
- ☐ Endocrinology
- ☐ ENT
- ☐ Executive Health and Wellness
- ☐ Gamma Knife Surgery
- ☐ Geriatrics
- ☐ Immunology
- ☐ IMRT
- ☐ Infectious diseases
- ☐ International Services
- ☐ Maternity
- ☐ MRI
- ☐ Neonatal
- ☐ On Site Lab
- ☐ Oncology
- ☐ Plasmapheresis
- ☐ Reconstructive/Cosmetic Surgery
- ☐ Rehabilitation
- ☐ Surgery - Cardiac
- ☐ Surgery - Colon And Rectal
- ☐ Surgery - General
- ☐ Surgery - Hand
- ☐ Surgery - Head and Neck
- ☐ Surgery - Maxillofacial
- ☐ Surgery - Neurological
- ☐ Surgery - Ophthalmology
- ☐ Surgery - Oral
- ☐ Surgery - Orthopedic
- ☐ Surgery - Pediatric
- ☐ Surgery - Plastic
- ☐ Surgery - Thoracic
- ☐ Surgery - Vascular
- ☐ Surgery - Others ____________________
- ☐ Transplant (particular types to be included) ____________________
- ☐ Trauma
- ☐ Urology
- ☐ Other ____________________

F. ADDITIONAL HOSPITAL INFORMATION

Number of Physicians	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?
☐ Yes ☐ No	

G. LETTER OF AGREEMENT

This Letter of Agreement, by and between CMN Global Inc. (hereinafter referred to as "CMN") and the undersigned (hereinafter referred to as "PROVIDER"), commemorates the following understanding:

WHEREAS, Europ Assistance Group has built a healthcare network and given delegation, on behalf of Europ Assistance Group to CMN, a fully owned subsidiary. CMN contracts with foreign and domestic insurance carriers to provide global network management access services and CMN wishes to arrange health care services on behalf of such insurance carriers and their insured clients at reasonable cost, and;

WHEREAS, PROVIDER wishes to provide services to CMN-referred patients ("Covered Persons") as required by this Agreement and CMN wishes PROVIDER to provide those services to referred Covered Persons;

NOW, THEREFORE, in consideration of the potential advantages that will accrue to the Covered Persons of CMN and each of the parties themselves, PROVIDER and CMN hereby covenant and agree with each other as follows:

PROVIDER and CMN Agree:

A. 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.

B. Compensation. PROVIDER shall agree to bill the patient's insurance carrier directly for covered services rendered with the understanding that 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.

C. 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 prior to or at time of service, 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.

D. Timely Filing. PROVIDER shall ensure that claims are submitted within 180 days of the date of service.

E. 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.

F. Term. This Letter of Agreement is effective on the ______________________________ with consecutive yearly renewals and may be terminated by either party with sixty (60) days written notice without cause. Either party may terminate immediately in the case of a material breach of this contract.

G. Confidentiality. CMN and PROVIDER shall ensure that they and their directors, officers, employees, contractors, and agents hold confidential information in the strictest confidence.

H. 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.

I. 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.

J. 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.

K. 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.

Joint Benefit Clause

The rights granted hereunder by PROVIDER shall also benefit to the parent company of CMN, Europ Assistance Holding SA and its subsidiaries. In case CMN is no longer a member of the Europ Assistance Group, both CMN and Europ Assistance Holding SA (and its subsidiaries) shall still be entitled to such rights unless this Letter of Agreement is terminated by PROVIDER pursuant to clause F above.

H. TERMS OF REIMBURSEMENT

Fee Schedule - Please attach a copy of your current Fee Schedule ☐ **Copy Attached**

Reimbursment

In what currency will claims be submitted?	What is your preferred method of reimbursement?
☐ USD ☐ Local Currency	☐ Cheque ☐ Wire Transfer* *If wire transfer, please ensure that you include your banking details with agreement or with all submitted claims.

I. PROVIDER ACCEPTANCE OF TERMS

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

J. CMN ACCEPTANCE OF TERMS

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