



Excelsior Medical IPA Healthcare Professional Opt-In Form

I, the undersigned, healthcare professional, having an agreement directly with Excelsior Medical IPA, LLC ("IPA"), agree to be a participating provider in the network of providers maintained by the HMOs and Insurers ("Insurers") chosen by me below.

By signing this Healthcare Professional Opt-In Form:

1. I agree to be bound by the Independent Practice Association agreement between the IPA and the Insurers
2. I understand that this agreement applies to me and all of the services I provide in all my practice arrangements and for all my tax identification numbers, except that if my services are covered under a direct agreement between the Insurers and a medical group that I am a part of without the participation of the IPA, services that I provide through that medical group will be subject to that other agreement and not this agreement
3. I acknowledge that I am subject to credentialing by the IPA and the Insurers and must be approved in writing for participation by them before rendering Covered Services to Customers
4. I understand that the fact that Excelsior Medical IPA is applying to the above agreements in my name is no guarantee of acceptance by the Insurers

I Wish

to participate in the
agreements of
Excelsior Medical IPA with:

- | | |
|--------------------------|----------------------------------------|
| <input type="checkbox"/> | Access Medicare (through Balance IPA) |
| <input type="checkbox"/> | Amerigroup |
| <input type="checkbox"/> | Healthfirst |
| <input type="checkbox"/> | HIP (through Health Care Partners IPA) |
| <input type="checkbox"/> | Metroplus |
| <input type="checkbox"/> | United Community Care |
| <input type="checkbox"/> | VNS Choice of NY (through Balance IPA) |
| <input type="checkbox"/> | Wellcare (through Balance IPA) |

I Decline

to participate in the
agreements of
Excelsior Medical IPA with:

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Signature: _____

Name: _____

Date: _____