

PARTICIPATING PROVIDER OPT-IN AGREEMENT

The Connecticut State Medical Society-IPA, Inc. (“IPA”) and ConnectiCare, Inc. (“Health Plan”) have entered into that certain Independent Practice Association (IPA) Participation Agreement dated effective _____ (the “Agreement”) for Health Plan’s Medicare Advantage program. The undersigned physician (“Physician”) or physician group (“Practice”) is a member of the IPA and has the signatory authority to sign on behalf of Practice. By signing below, the Physician or Practice acknowledges that he/she has made a determination to participate with Health Plan through the IPA.

Physician or Practice acknowledges and agrees that the terms of his/her existing agreement with Health Plan will remain in full force and effect and Physician will continue to be paid in accordance with that agreement; however, pursuant to the Agreement and execution of this opt-in, Physician will be eligible for an upside-only bonus payment to the extent that Physician participates in quality and cost initiatives being developed by the IPA.

IN WITNESS WHEREOF, the undersigned has executed this Opt-In as of the date below.

Practice Name _____

By: _____ Date: _____

Its: _____

(Physician Signature)
(Name)
(Date)
(E-mail Address)

****Please fax signed form to the CSMS-IPA at (203)225-1295**