

PHYSICIAN/PRACTICE AGREEMENT MANAGED CARE ADVISORY GROUP, LLC (MCAG)

Assistance with Submission of Claims under the Class Action Settlements and/or Payer Audits

This agreement is entered into on this date , _____, 2009 by and on behalf of -
_____(Physician/Physician/Provider Group hereinafter referred to as "Client")
with principal residence _____ Managed Care Advisory Group, LLC
(MCAG) with principal residence 6641 Sylvania Ave., Sylvania, Ohio 43560 for the purposes set forth below.

Purpose of Agreement

This agreement secures the services of MCAG as outlined below for assisting Client in Client's participation under all future Settlements and/or dispute resolutions resulting from Class Action litigation and for audit and recovery work performed by Affiliates of MCAG as approved by Client and MCAG. This form authorizes MCAG to accept Client's claims data and submit a claim under the terms of each Physician Class Action Settlement directly to the Settlement Administrator on Client's behalf.

MCAG and Client Responsibilities

MCAG will utilize its best efforts a.) to help the Client or its representative to collect historical claims data from billing and payment records, b.) to submit a claim for reimbursement under the terms of the Settlements or dispute resolutions related thereto, and c.) to collect and distribute the funds that may be due Client from the Settlements. MCAG will also utilize its full service call center to assist Client in the collection of data and to communicate information required for the submission and collection of claims/refunds due under the Settlements. MCAG will submit the claims, collect the returns, and distribute the net payments to Client. MCAG will extract the service fees outlined below from the settlement recoveries. Client warrants that Client will utilize its best efforts to make claims or billing information available to MCAG. Client agrees to pay the fees outlined below to MCAG. By signing where designated below, Client authorizes MCAG to file claims, collect recoveries through a secure Lock Box, extract the service fees outlined below from the recoveries, and return net recoveries to Client.

Warranties

MCAG warrants that it will use its best efforts to file claims on behalf of Client and to help Client maximize the return available to him/her under the Settlements. However, due to the complexity of the terms and provisions of the Settlements and due to the authority given the Settlement Administrator to determine eligible reimbursement under the Settlements, MCAG cannot warrant or guarantee the dollar amount returned to Client through the Settlement process. Client warrants that Client will use its best efforts to facilitate the efforts of MCAG to collect and submit data required for participation by Client in the Settlement. Client warrants that Client will pay MCAG for services rendered according to the fee schedule outlined below, both fixed fees (if any) and the appropriate recovery fee generated from recoveries, regardless of the ultimate recovery obtained by Client from each Settlement.

Fees

MCAG will base its fees for individual Settlements and/or payer audits on the complexity of the filing and documentation requirements for each Settlement/Audit. **The following fee structures will be charged as a percentage of actual recoveries by settlement or Audit:**

Per Practice Fees (Filing requisite: a single claim form with data analysis to validate claims dollars or multiple claim forms with claims data analysis to select and document individual claims

	% of Recoveries
Non-members of either AMA or Dade County Medical Association	30%
Members of either the AMA or Dade County Medical Association	24%
Members of both AMA and Dade County Medical Association	20%

Payer Audit/Recovery Fees (Filing requisite: for audits and recoveries related to audit of contracted Payers as approved by Client)

	% of Recoveries
Non-members of either AMA or Dade County Medical Association	35%
Members of either the AMA or Dade County Medical Association	29%
Members of both the AMA and Dade County Medical Association	25%

(Practice of Facility Name)

Managed Care Advisory Group, LLC.

By: _____

By: _____

Title: _____

Title: _____

Contact Information (Please complete all information)

Practice or Facility
Name: _____

Contact Name: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Mailing Address: _____

Practice/Facility TIN: _____

Number of physicians in
practice/physician org. : _____

(For multi-physician practices, please attach a list containing the names, SSN and birthdates of each physician in the group)

You may determine that your practice needs to have a **Business Associate Agreement (BAA)** with MCAG in order to comply with HIPAA. If you believe that to be true then you can call us at 800-355-0466 for a copy of our preferred BAA or simply send us/fax us your own BAA for signature (our address is listed in the header above).

Fax this form back to 866-747-8947