TEXAS CHILDREN'S HEALTH PLAN
On-Call Provider Agreement

TCHP physician(s) for whom you are taking call: _____
_____
_____

Your Name: _____
Office Address: _____
_____
Billing Address: _____
_____
_____

Checks payable to: _____
(i.e.: association or group)

Office Phone: _____ Office Fax: _____

Fed. TIN: _____ License No.: _____
Medicaid No.: _____ Board Cert.: _____
DEA No.: _____

I, as a physician duly licensed to practice medicine in the state of Texas, do hereby agree to provide medically necessary covered services to covered persons when the above provider is unable to provide such services. In the event reimbursement is made for these services, I agree to accept the same rates and methodologies as the provider. In no event shall I bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any member. This shall not prohibit collection of supplemental charges, copayments, or charges for non-covered services in accordance with the terms of the membership agreement between the member's HMO and the member.

I authorize TCHP and its credentialing committee, directors, officers, employees or agents to consult with hospitals, individuals or organization who may have information bearing on my professional competence or other qualifications.

I agree to comply with TCHP in resolving any issues relating to patient complaints to which I am a party.

_____

Signature of Covering Physician Date

Fax to: Texas Children's Health Plan