



SeaCare Health Services

A Community Health Care Partnership

SeaCare Health Services Provider Letter of Agreement

As a participating SeaCare Health Services (SHS) provider:

- Reimbursement Schedule:** I agree to accept SHS participants into my practice, treating them as I would any other patient. I agree to accept, as payment in full, the following reimbursement schedule* (depending on the patient's assigned category, determined by SHS):
 - Brief visits or consultations (generally, up to 30 minutes) \$10
 - Complex visits or consultations (over 30 minutes) \$15
 - In-office procedures, based on relative value scale pro-rated to a maximum of \$75

**I understand that SHS may adjust the payment schedule as needed and will notify my office in advance of any such change. Charges for services rendered more than one year previously are considered donated.*
- Lab work:** Donated by LabDaq (CORE's lab), LabCorp, and Quest, except for some unusual tests that have to be sent out. SHS will work with patients to apply for assistance from labs for uncovered tests. Labs done in providers' offices are not reimbursed and are considered donated services.
- X-rays/other diagnostic tests:** SHS Care Coordinators will work with patients to access free and reduced-cost programs at Exeter Hospital and Portsmouth Regional Hospital. X-rays, etc. done in providers' offices are not reimbursed and are considered donated services.
- Immunizations:** Immunizations for children are not reimbursed because the state supplies them for free.
- Hospital Care:** SHS is an outpatient program. However, many providers donate hospital services in addition to those provided on an outpatient basis.
 - Check here if you DO NOT wish to donate your hospital services.
- I agree to permit SHS to verify my status* in good standing on the medical staff at either Exeter Hospital or Portsmouth Regional Hospital (*or that of the supervising physician, for mid-level providers).
- SHS has my permission to list my name as a participating provider in public "thank you" notices.
- This agreement may be terminated by either party with 30 days notice.

Name (Please Print Clearly) _____

Specialty _____

Name of Practice _____

Office Address _____

City, State, Zip _____

Phone _____

Fax _____

Signature _____

Date _____

**Please sign and return to SeaCare Health Services (fax: 603-772-8120)
or to Wendy Gladstone, MD at her Exeter Hospital medical staff mailbox.**