



**PHYSICIAN ACKNOWLEDGEMENT OF
PHYSICIAN ORGANIZATION PARTICIPATION
MEDICARE ADVANTAGE AGREEMENT**

The undersigned physician hereby certifies as follows:

1. I am a member in good standing of West Michigan Physicians Network.
2. I am duly licensed to practice medicine in the State of Michigan.
3. All information provided to Priority Health with respect to my qualifications is accurate and complete.
4. I agree that Priority Health together with authorized regulatory agencies may inspect, review and copy records or reports in my possession concerning services provided to Members.
5. I agree to comply with Priority Health’s quality assurance activities.
6. I agree to look solely to Priority Health for payment of services rendered pursuant to the Agreement (as defined below). I further agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member, with respect to Covered Services provided to a Member, except to the extent that the applicable Plan specifies a copayment or deductible or as permitted under the Coordination of Benefits Act. I further agree not to maintain any action at law or in equity against a Member to collect sums that are owed to me under the terms of the Agreement, even if Priority Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of the Agreement. This section will survive termination of the Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. The parties do not intend this section to apply to the collection of sums that are owed to me for services provided after the Agreement has terminated, except as otherwise provided in the Agreement, or to services that are not Covered Services or to copayments, coinsurance or deductibles. I further agree that this provision supersedes any oral or written agreement hereinafter entered into between me and a Member or a person acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of the Agreement.
7. I agree to all of the terms and conditions of the Physician Organization Participation Agreement – Medicare Advantage between Priority Health and Group (the “Agreement”). Capitalized terms used herein and not otherwise defined carry the meanings given them in the Agreement.

Date: _____

By: _____

<p>Return form by mail or fax to:</p> <p>WMPN 21 Michigan NE Suite 650 Grand Rapids, MI 49503</p> <p>WMPN Fax: (616) 391-3934</p>
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Print Name: _____

UPIN: _____