



Michael D. Maves, MD, MBA, Executive Vice President, CEO

May 1, 2007

Mr. Todd Breeden
Chief Operating Officer
TRPN
1620 Fifth Avenue
San Diego, CA 02101

Dear Mr. Breeden:

The American Medical Association (AMA) has received complaints from physicians across the country about the misleading nature of TRPN's solicitations to physicians (examples attached). This one-page document would appear to be a routine request for a W-9. Yet on closer inspection, it includes language that would bind physicians to a contract reducing the value of their services by 25%. Whether it is the intent of TRPN or not, the perception of physicians is that TRPN is seeking to trick physicians into signing a contract by disguising this document.

Alerts concerning TRPN's practices have been posted on the Web sites of several medical societies and complaints have been filed with state regulatory agencies. This gives you a sense of the level of suspicion these solicitations have created among physicians.

The purpose of this letter is to inform TRPN about the nature of the concerns raised and to urge TRPN to revise its practices to demonstrate a show of good faith in its relationships with physicians. Our concerns are as follows:

1. If TRPN is intending to create a network of participating physicians via a provider contract, this should be clearly and prominently stated at the top of the document. The document should be identified as a "Participating Provider Agreement" to appropriately alert recipients. Moreover, the essential terms of the proposed relationship to be reflected in a provider contract should be spelled out. The attached examples provided to the AMA do not meet these basic standards necessary to establish a valid and binding provider contract setting forth mutual obligations/benefits. Physicians should not be left wondering as to TRPN's intentions.
2. If TRPN feels that it is required, pursuant to IRS regulations governing withholding of federal income taxes on payments that TRPN is making to physicians, to offer those physicians an opportunity to provide Form W-9s to avoid being subject to backup withholding, this should be clearly stated--and a copy of the Form W-9 provided to the physician (or the physician directed to where a copy may be downloaded from the IRS Web site at no charge). It would not be appropriate to assert or imply that physicians are entering into any new or separate agreement with TRPN (or any other party) simply by reason of providing TRPN with a completed Form W-9, which is purely informational in any event. Apart from providing the information needed to complete Form W-9, it is not necessary or appropriate that TRPN seek a separate signature from a physician for this purpose.

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3. If TRPN believes that there is a legitimate basis to ask for physician confirmation/information regarding a specific patient circumstance or to confirm patient coverage eligibility for benefits provided by TRPN (or some other entity on whose behalf TRPN is acting, which should be made clear if that is the case), that basis should be indicated. If TRPN is making such a request in order that it comply with government regulations, the specific regulation should be cited. There should be no suggestion that a physician, in responding to such a confirmation/information request, is thereby deemed to have entered into any new or separate agreement with TRPN (or any other party). Again, physicians should not be left wondering about TRPN's intentions.
4. TRPN's sending of multiple recorded messages to physician offices stressing the urgency of an immediate return of documents, such as those attached, appears to be a "pressure" tactic intended to create confusion and doubt.

The AMA strongly urges TRPN to promptly address the concerns expressed above by working to establish positive physician relationships based on clarity and transparency of communications between TRPN and physicians.

Sincerely,



Michael D. Maves, MD, MBA

Attachments

cc: State Medical Associations
National Medical Specialty Societies
National Association of Insurance Commissioners
National Conference of Insurance Legislators

Please read this document carefully and to its entirety.

Internal Revenue Service Regulations require that payors maintain a current taxpayer identification number on file for all providers of services (see attached W-9 form).

THREE RIVERS PROVIDER NETWORK member payors have reported using your services. In order to assign the proper network identifier, authorize eligibility and distribute proper remittance we need to confirm that we have your correct information on file. If you are a group practice please attach a list of all participating providers and locations. If there are multiple parties please make copies and distribute. Sign and fax this authorization to:

006: HIPAA 45 CFR 162-Compliance/Eligibility/ Payment Authorization
This document is protected by the provisions of the federal HIPAA Privacy Rules 45 CFR and may include protected health information of one or more individuals. According to Federal Regulation under HIPAA 45 CFR- 162 providers of healthcare services are required to have a unique identifier. If you have received this in error, please notify us and return the document to us immediately.



Authorized Signature _____ Tax Identification Number _____ Date _____

Full Address _____ Phone _____ FAX _____

Card Certified N E-mail _____

(specialty)
This authorization allows you to self-credential and you shall provide such information to us upon request. There are no fee schedules and you shall bill members in accordance with your regular billing practices. This agreement will become effective upon the above date of signature and shall continue to effect for two years with automatic successive one year terms. The member's ID card contains all necessary billing information.

You agree to deliver health care services that meet all legal standards of care and within the standards of NCOA/JACHO. The rate used in conjunction with this Agreement for payment of services will be 75% of provider's total billed charges for covered services. Covered services includes any and all types of health services delivered by the provider. Members are responsible for any applicable co-payments, co-insurances or deductibles. Payments made and cashed by the provider shall be accepted as payment in full providing the total payment including the member's portion is not less than the contracted rate of 75% of total billed charges. For states with a mandated fee schedule, the provider will be paid 90% of the fee schedule. Payments shall be made within 45 days of receipt of a clean claim. TRPN has no responsibility to make payments on behalf of clients. Provider shall not balance bill the patient upon receipt of payment in full at the contracted rate. The parties agree that the above facsimile signature of the provider shall legally bind the parties to the terms and conditions of this Agreement. Either party may terminate this agreement with a 90 day prior written notice to the other party.

For more information contact us: Three Rivers Provider Network (800) 966-8776
Our mailing address is: THREE RIVERS PROVIDER NETWORK 1620 Fifth Avenue Ninth Floor, San Diego, CA 92101

If you have received this in error and wish to be removed from the list of eligible providers please return a blank copy of this form to us via fax at



Fax from : 2035622364

Please read this document carefully and in its entirety.

HIPAA 45 CFR 162-This document is protected by the provisions of the federal HIPAA Privacy Rules 45 CFR and may include protected health information of one or more individuals. According to Federal Regulation under HIPAA 45 CFR- 162 providers of healthcare services are required to have a national provider identifier number. Internal Revenue Service Regulations require that payors maintain a current taxpayer identification number on file for all providers of services (see attached W-9 form). If you have received this in error, please notify us and return the document to us immediately

THREE RIVERS PROVIDER NETWORK member/payors have reported using your services. In order to assign the proper network identifier, authorize eligibility, and verify participation, we need to confirm that we have your current authorization on file. If you are a group practice please attach a list of all participating providers and locations. If there are multiple parties please make copies and distribute. Sign and Fax this agreement to: (800) 318-0585.

You agree to deliver health care services that meet all legal standards of care and within the standards of NCQA/JACHO. The rate used in conjunction with this Agreement for payment of services will be 75% of provider's total billed charges for covered services. Covered services includes any and all types of health services delivered by the provider. Members are responsible for any applicable co-payments, co-insurance or deductibles. Payments made and cashed by the provider shall be accepted as payment in full providing the total payment including the member's portion is not less than the contracted rate of 75% of total billed charges. For states with a mandated fee schedule, the provider will be paid 90% of the fee schedule. Payments shall be made within 45 days of receipt of a clean claim. TRPN has no responsibility to make payments on behalf of clients. Provider shall not balance bill the patient upon receipt of payment in full at the contracted rate. The parties agree that the authorize facsimile signature of the provider shall legally bind the parties to the terms and conditions of this Agreement. Either party may terminate this agreement with a 90 day prior written notice to the other party.

This agreement allows you to self-credential and you shall provide such information to us upon request. There are no fee schedules and you shall bill members in accordance with your regular billing practices. This agreement will become effective upon the below date of signature and shall continue in effect for two years with automatic successive one year terms. The member's ID card contains all necessary billing information.

I have read, understand and agree to all the above terms and conditions.

_____ Name of Provider/Group	_____ Authorized Signature	_____ Tax Identification Number	_____ Date
_____ Full Address	() _____ Phone	() _____ PAX	
_____ (Specialty)	Board Certified	Y / N	E-mail _____

NPI Number, if available

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