Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Instructions for completing the

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY AGREEMENT WITH PARTICIPATING PHYSICIANS AND HEALTHCARE PROFESSIONALS

1. Review the information within this Agreement.
   (*The Agreement content follows these instructions.*).

2. Complete the required fields on pages 1 and 9 of this Agreement.
   - Please do not highlight, alter, cross-out any text or make any special markings of alterations to this Agreement. An Agreement received with any such marks/alterations will be returned to you and will delay the credentialing process.
   - This form is a fillable PDF. You may complete the required fields electronically and then save or print a copy for submission. To save a completed copy of this PDF, click *File*, and then click *Save As*. Then rename the file and select the appropriate location to save to your computer.

3. Print a copy of the completed Agreement and sign page 9**.**

4. Mail a copy of this completed and signed Agreement along with the other required information outlined in the ***Physician Checklist*** or the ***Other Health Care Professional Checklist*** to:

   Horizon BCBSNJ
   Credentialing & Recredentialing Department
   3 Penn Plaza East, PP-14C
   Newark, NJ 07105-2200

Upon completion of the credentialing process and your approval by our Credentials Committee, Horizon BCBSNJ will:

- Enter the effective date and countersign the Agreement.
- Return a copy of the countersigned Agreement to you for your records.

If you have questions, please call our dedicated Physician Services team at **1-800-624-1110**, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

Reset

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

Newark, New Jersey

AGREEMENT WITH PARTICIPATING PHYSICIANS AND HEALTHCARE PROFESSIONALS

This Agreement is between You and Horizon Healthcare Services, Inc., dba Horizon Blue Cross Blue Shield of New Jersey ("Horizon") and governs Your participation in the Horizon PPO professional network.

1. **Definitions**. As used in this Agreement:

   (a) "**Copayment**" means a specified dollar amount which a patient is responsible to pay for services

   (b) "**Coinsurance**" means a percent of the payment which a patient is responsible to pay for services.

   (c) "**Emergency**" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

   (d) "**Self-Insured Account**" means an employer group or other sponsor whose benefit program is administered and/or managed, but not fully underwritten, by Us or Our subsidiary or affiliate.

   (e) "**We**", "**Us**", and "**Our**" mean Horizon Healthcare Services, Inc., dba Horizon Blue Cross Blue Shield of New Jersey.

   (f) "**You**", "**Your**", and "**Yours**" mean the Participating Physician or Healthcare Professional.

2. **License/Specialty**. You agree that during the entire term of this contract You shall maintain a current, unrestricted valid license, certification, or registration to practice Your professional specialty in the State(s) where You practice. Your specialty is

   Click the arrow to the right, scroll and select your specialty ...

Please select your specialty from the drop-down menu.

Please include your name, the date, and the county in which your primary practice is located.

After printing a copy of the Agreement, sign here.

The Agreement will be returned to you if these fields are not completed.

nd Inquiries. We have a dedicated provider services toll-free telephone line
tives available to respond to questions or complaints You may have in
th Your relationship with Us under this contract. To access Provider Services,
1-800-624-1110 or such other telephone number or electronic means We
upply to You. Information concerning benefit plans, including coverage and
vailable through Provider Services as well as through newsletters and other
ns from Us.

Accepted and agreed at Newark, New Jersey.

Signed:

PHYSICIAN or HEALTHCARE PROFESSIONAL

Participating Physician's or Healthcare Professional's Signature

Print Name Above, Including Degree

Date

County

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

By:

Title:

Date:

Effective Date:

Please **DO NOT** complete the fields highlighted in red.

This information will be entered upon the completion of the credentialing process and your approval by our Credentials Committee.

Reset

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

Newark, New Jersey

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2. **License/Specialty**. You agree that during the entire term of this contract You shall maintain a current, unrestricted valid license, certification, or registration to practice Your professional specialty in the State(s) where You practice. Your specialty is

   Occupational Therapy

You also agree that You shall notify Us immediately in any of the following circumstances:

(a) Your professional license, certification, or registration to practice within Your specialty in any state;

(b) Your certification(s) to prescribe medication; or

(c) Your medical staff privileges at any hospital;

are voluntarily or involuntarily withdrawn, restricted temporarily or permanently, or suspended actively or stayed, or revoked for any reason.

You shall also notify Us immediately if You fail to maintain required medical malpractice insurance, are granted a leave of absence, resign from the medical staff of any hospital, are indicted or convicted of or plead guilty to a criminal offense regardless of the nature of the offense, or are subject to any disciplinary action by any governmental program, licensing, professional registration or certification authority, or hospital privileging authority. If You are licensed to practice medicine and surgery, You agree to maintain admitting hospital privileges as required under Our credentialing standards and to have a protocol or process to ensure availability to covered patients of Emergency or urgently needed services, either by Your office or another appropriate health care professional or provider.

3. **Policies/Credentialing/Access to Records/Non-Discrimination/Standards and Scope of Practice**. You agree that You will abide by Our policies and procedures as they exist today and as they may exist in the future. You agree that You will comply with Our applicable quality assurance program, provider complaint and grievance process, credentialing/recredentialing requirements, provider audit and risk adjustment programs, claim edit and processing procedures, and utilization review program. You agree to comply with the policies, rules and procedures of Horizon and its affiliates as set forth in the Participating Physician and Other Health Care Professional Office Manual that Horizon will provide to You which is incorporated herein by reference and made a part hereof. You agree to use the Council for Affordable Quality Healthcare (CAQH) system for submission of credentialing and recredentialing information, unless other arrangements are made with Us. You and We agree that patient information shall be kept confidential. You agree to allow Us to review and copy Covered Persons' records in Your office during regular business hours. You agree to provide Our employees, agents, representatives and designees, upon written request, with access to medical and business records relating to the provision of services to our covered patients during reasonable business hours for the purpose of ascertaining and verifying any information reflected therein or for such other administrative purposes of Horizon or as may be required for administration of health benefit plans. The information sought by Us or our agents, representatives or designees may include, without limitation, verification of covered services billed, review of prescription orders and review of physician records. Information will be furnished by You at no charge to the Covered Person or Horizon or their designees after receiving a written request from Horizon. You agree to permit any applicable State or Federal regulatory authorities to conduct on-site evaluations of Provider periodically in accordance with then current Federal and State laws and regulations. You agree not to discriminate in Your treatment of covered patients. You agree that You will use appropriate skill, knowledge and diligence, in accordance with prevailing standards of practice, to provide to Our covered patients, in a competent, professional and

ethical manner, medically appropriate professional services within Your professional license, certification or registration to practice, as recognized by the American Board of Medical Specialties or other entity, as provided in Our policies, and as reflected in active hospital privileging where required by Us. You expressly acknowledge and agree that, notwithstanding the scope of services You may be licensed, certified or registered to provide, We have the right to limit or restrict the covered services You may provide to Our covered patients through criteria adopted by Us and made known to You. You agree to maintain appropriate coverage for Your practice to assure availability of services on a 24 hour/7day week basis for Emergency and urgent services.

4. **Insurance**. You agree that throughout the term of this contract, You shall maintain, at Your cost and expense, professional liability insurance in an amount required by Horizon but in no event less than $1,000,000 per occurrence and $3,000,000 in the aggregate, and general liability insurance in an amount required by Horizon, but in no event less than $1,000,000, or a self-insurance or other arrangement acceptable to Horizon that provides at least the equivalent coverage. You agree to provide to Us, upon Our request, evidence that such insurance coverage is in force, and to immediately notify Us (not less than ten (10) days prior to cancellation of such coverage) in the event there is a change in the minimum amount or type of such coverage You maintain.

5. **Hold-Harmless/Allowance**. When You perform any professional services that are eligible under Our contracts or under contracts of Our subsidiaries or affiliates that We identify, You agree with Us that:

   (a) If the covered patient is enrolled in any of Our programs or the programs of Our identified subsidiaries or affiliates, You must accept Our allowance as payment in full for eligible services performed, even where the patient pays a portion of Our allowance as a deductible, Coinsurance or Copayment, or other amounts associated with exclusions or limitations contained in the covered patient's benefit plan. You agree that You will not bill the patient for any amount in excess of Our allowance for the eligible service, except for Copayments, Coinsurance or deductibles, or other amounts associated with exclusions or limitations contained in the covered patient's benefit plan. If the covered patient is enrolled in any of Our programs or the programs of Our subsidiaries or affiliates which allows for a payment in excess of Our allowance for eligible services, You will be advised by Us whether or not You may bill the patient an additional amount. This also applies when another Blue Cross and Blue Shield Plan makes a payment under reciprocity or hold harmless programs. Our allowance will be evaluated and may be revised periodically.

   (b) If Your covered patient is enrolled under a fee schedule contract, You must accept Our payment for eligible services as payment in full if the subscriber's income makes him or her eligible for paid-in-full Service Benefits. If the patient is not eligible for Service Benefits, the combined payment from Us, from the patient or from any other source, shall equal Your usual or reasonable fee for the procedure performed. You will not submit a fee to Us that is higher than the fee actually accepted by You as payment in full for services performed.

(c) Any services to be performed will be discussed with, and approved by, the patient or subscriber before they are performed, whenever possible.

Where Our allowance or payment, coupled with the covered patient's deductible, Coinsurance or Copayments or other amounts associated with exclusions or limitations, as provided in the patient's benefit plan, is payment in full, You agree that in no event, including, but not limited to, non-payment, or payment that is other than You believe to be in accordance with this contract or is otherwise inadequate, Our insolvency, or breach of this contract, shall You bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered patient or person acting on behalf of the covered patient for services provided pursuant to this contract. This provision does not prohibit You from collecting Coinsurance, deductibles or Copayments or other amounts associated with exclusions or limitations, as specifically provided in the benefit plan. Nor does this provision prohibit You and a covered patient from agreeing to continue services solely at the expense of the covered patient, as long as You have clearly informed the covered patient that the health carrier may not cover or continue to cover a specific service or services. This provision shall survive the termination of this contract for any reason and supersedes any written or oral contrary agreement now or existing hereafter entered into between You and covered patients or persons acting on their behalf.

You agree that We (or Our subsidiary or affiliate) have no obligation to You for payment of services rendered to covered patients in Self-Insured Accounts beyond the extent to which funds are provided by the Self-Insured Account. However, in the event payment is not made to You for services provided under this contract to a covered patient of a Self-Insured Account, You may pursue any legal remedy available outside of this contract for collection of Your regular charges.

6. **Payment**. Our standard (current) allowance for your area of practice is available upon request. All payments will be made directly to You unless otherwise directed by operation of law. You may not charge patients in advance for eligible services. We reserve the right to require You to submit claims to Us according to Our electronic claims processing procedures. When You perform eligible services in a hospital or other health care facility You agree with Us that You will be paid for these services only if You do not receive payment from the hospital or other health care facility for these services. You agree to comply with Our billing and claims procedures and to submit claims within one hundred eighty (180) days of completion of the service, or within one hundred eighty (180) days of the last date of service of that course of treatment. You agree that We may adjust the payment to You to correct any overpayment, underpayment or payments made in error, and that We have the right to offset all such amounts from future payments to You or to require You to return excess amounts paid to You within ninety (90) days of written request for reimbursement, and You and We shall comply with all applicable laws and regulations as to any adjustment or offset. New Jersey law applicable to insured New Jersey plans (a) requires forty-five (45) calendar days notice of any adverse adjustment in payment, (b) requires that the offset be stayed pending internal appeal and state sponsored binding arbitration, and (c) limits adjustment to 18 months from the date of the first payment on the claim (for more information please refer to Your provider manual). You acknowledge Your understanding that this contract and Your provider billing number are personal to You and

are not transferable. You may not allow the use of Your provider billing number by another person or entity for any purpose other than for the purpose of billing for Your services on Your behalf. You further agree not to assign either Your provider billing number or this contract to another person or entity by operation of law or otherwise. You may qualify for a bonus or incentive payment under an incentive plan as may be offered by Horizon from time to time. In the event You disagree with Our determination of whether you qualify for a bonus or the amount of such bonus, You may appeal to Our Chief Operating Officer, or his/her designee, in writing within thirty (30) days of Your receipt of Our determination. To the extent that some portion of Our payment is tied to the occurrence or non-occurrence of a predetermined event, We will clearly specify such events to You in advance in writing and You shall have the right to receive an annual accounting of funds held in connection therewith.

7. **Term of Agreement and Your Right to Terminate**. This contract shall become effective on the effective date indicated below and the initial term of this contract shall be for one (1) year commencing immediately thereafter. Horizon and You agree that this contract shall automatically renew on each annual anniversary date unless either party provides ninety (90) days advance written notice of its intention not to renew to the other party. If this contract expires, or is terminated or not renewed, You must continue to provide services to covered patients as provided in section 10.

   In addition, You may cancel this contract at any time by giving at least thirty (30) days' written notice, however, Your cancellation shall not apply to any subscription certificate in force until the first date thereafter on which the subscription certificate may properly be terminated by Horizon, even if We should cease to transact business as a health services corporation by vote of Our Board of Directors, by court order, by legislative act, or by order of any judicial, administrative or legislative authority. You recognize that subscription certificates may be terminated at any time, since premiums are required to be paid to keep the certificate in force. Your compliance with the obligations to continue to provide services to covered patients as provided in section 10 shall be deemed to be compliance with the requirements of this paragraph.

8. **Our Right to Terminate Without Cause**. We may cancel this contract by giving 90 days' written notice at any time, unless Our medical director determines that You represent an imminent danger to a covered patient or the public health, safety or welfare, in which case We may cancel this contract immediately. If we cancel this contract under this section, except for imminent danger or non-renewal, We will provide You with notice of Your right to request a hearing within thirty (30) days of the date of notice of termination, and the procedure therefor, and notice of Your right to obtain the reason for the termination (if not stated in the notice). If so requested by You, We will provide the reason(s) for termination in writing (if not stated in the notice) and hold a hearing, in accordance with applicable statute or regulation within thirty (30) days of the date of Our receipt of Your request. Your participation in the hearing process shall not be deemed to be an abrogation of Your legal rights.

9. **Our Right to Terminate With Cause**. We may terminate this contract immediately for breach of contract, including breach of our policies and procedures, or if We determine that You have committed fraud, or if Our medical director determines that You represent an imminent danger to a covered person's or the public health, safety or welfare. You agree that breach of contract or breach of our policies and procedures shall include, but is not limited to: a revocation, active or stayed suspension or restriction placed on Your professional license, certification, or registration; Your failure to maintain required medical malpractice insurance; You being subject to a disciplinary action by a governmental program, licensing, professional registration or certification authority, or hospital privileging authority; You having restrictions placed on Your CDS or DEA certificates; Us having reasonable suspicion that You have committed fraud against Us; Your failure to meet or maintain credentialing/recredentialing criteria; Your being convicted of or pleading guilty to a criminal offense.

10. **Your Obligations On Termination or Non-Renewal**. You shall promptly provide to Us a listing of Our covered patients under Your care upon Our request, if either party gives notice of termination or non-renewal of this contract, so that We can notify them of the termination or non-renewal. Termination or non-renewal shall not release You from Your obligation to complete treatment of covered patients then receiving treatment. In addition, in the event that this contract is terminated by either party, expires or is not renewed, You shall provide covered services to covered patients under the terms of this contract for a period of four (4) months from the effective date of termination, expiration or non-renewal, unless a longer period is required as follows: (a) in the case of pregnancy, through post-partum evaluation up to six weeks after delivery; (b) in the case of post-operative care, for a period of up to six (6) months; (c) in the case of oncological treatment, for a period of up to one (1) year; and (d) in the case of psychiatric treatment for a period of up to one year. During this period, You will be compensated for such services in accordance with the terms of this contract. During this period, You shall: accept as payment in full the allowance or payment in effect as of the date prior to the start of this period; abide by all the terms and conditions of this contract, including without limitation the hold-harmless provision (see section 5); adhere to Our applicable quality assurance requirements and provide Us with necessary medical information related to such care; otherwise adhere to Our policies, rules and procedures, subject to applicable appeal rights, including but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by Us. Your obligations regarding confidentiality and access to medical records shall survive the termination or non-renewal of this contract.

    The requirements stated above shall apply only to those of Our covered patients who were existing patients to whom You provided care within the twelve (12) months period immediately preceding the effective date of termination, expiration or non-renewal of this contract, as long as You inform all other covered persons who were not existing patients (to whom You did not provide care within the twelve (12) months period immediately preceding the effective date of termination, expiration or non-renewal of this contract) that You are not a participating provider prior to providing services. If an appointment was made by such other covered patient prior to the effective date of the termination, expiration or non-renewal of this contract, You agree to inform such other covered person prior to the appointment date that You are no longer a participating provider.

11. **Your Freedom to Communicate With Patients**. In no event shall We terminate this contract or penalize You solely because You have advocated on behalf of a covered patient in seeking appropriate, medically necessary health care services, filed a complaint against Us, or appealed Our decision. Nothing in this contract shall be construed to impose obligations or responsibilities upon You which require You to violate the law or rules governing Your licensure, certification or registration to practice Your specialty. Nothing in this contract shall provide financial incentive to You to withhold covered health care services that are medically necessary. Nothing in this contract shall be construed to require You to recommend any procedure or course of treatment which You deem professionally unacceptable. You agree You are responsible for the quality and type of health care services You provide to covered patients. You are free to communicate openly with a patient about all diagnostic testing and treatment options, including alternative medications. This contract is not intended to infringe on Your freedom of choice in accepting a patient.

12. **Electronic Communications**. We may require that communications pursuant to this contract, such as the provider manual, policies, rules, procedures, verification of eligibility, claims submission, claims payment inquiries/verification, and credentialing/recredentialing be done by electronic means.

13. **Confidentiality**. You agree that, except as required by law and for the purposes of carrying out this contract, You will keep confidential all information relating to the compensation and compensation methodology under this contract, and any information regarding Our (or Our subsidiaries' or affiliates') business activities, which are not otherwise available to the general public, without Our prior written consent. You also agree that all information and materials provided to You pursuant to this contract which are not otherwise available to the general public shall remain the property of Us (or our subsidiary or affiliate), including but not limited to provider manuals and operations manuals. You agree not to disclose any of such information or materials except where such disclosure may be required to perform Your obligations under this contract or as may otherwise be required by law.

14. **Entire Agreement**. This contract supersedes all prior agreements between You and Us except that neither this contract nor any amendment to this contract shall constitute an amendment to, or supersede, any agreement You may have with Us or Our subsidiaries or affiliates to participate in Our or Our subsidiaries' or affiliates' other provider networks, such as Our managed care provider network.

15. **Blue Cross Blue Shield Association**. You hereby expressly acknowledge Your understanding that this contract constitutes a contract between You and Us, that We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Us to use the Blue Cross and/or Blue Shield Service Mark in the State of New Jersey, and that We are not contracting as the agent of the Association. You further acknowledge and agree that You have not entered into this contract based upon representations by any person other than Us and that no person, entity, or organization other than Us shall be held accountable or liable to You for any of Our obligations to You created under this contract. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this contract.

16. **Your Providing Services to Other Blue Cross and Blue Shield Plan Members**. Unless You provide services outside the State of New Jersey, in the absence of a separate agreement with any entity referenced in this paragraph, the terms of this contract shall be applicable to services provided to individuals having their health insurance benefits underwritten or administered by any Blue Cross and/Blue Shield company and their affiliated subsidiaries that are licensed by the Blue Cross Blue Shield Association to use the words "Blue Cross" and/or "Blue Shield" and all Blue Cross and Blue Shield symbols, trademarks and service marks presently existing or hereafter established.

17. **Amendment; Assignment**. This contract may be amended by Us upon sixty (60) days advance written notice. You may exercise Your right to terminate this contract as provided in section 7 if You do not accept Our amendment. We may assign this contract to an entity who controls, is controlled by or is under common control with Us. You may not assign, delegate or transfer, in whole or in part, any rights or obligations under this contract without Our prior written consent.

18. **Notice**. Notice required to be given pursuant to this Agreement by Physician or Healthcare Professional to Horizon shall be in writing and shall be sent by United States mail, certified, return receipt requested, postage prepaid, or via Federal Express or other similar professional overnight courier to:

Network Relations
Horizon Healthcare Services, Inc.
3 Penn Plaza East, PP-14J
Newark, NJ 07105-2200

Notice required to be given pursuant to this Agreement by Horizon to Physician or Healthcare Professional shall be sent either: (1) via the Company website, (2) electronically via email or fax mail, or (3) sent by United States mail, certified, return receipt requested, postage prepaid, via Federal Express or other similar professional overnight courier to:

Provider:
Address: Your mailing address on file with Horizon
Email: Your email on file with Horizon
Fax: Your fax number on file with Horizon

or such other address as the Parties shall designate in writing.

For purposes of this Agreement notices shall become effective on the day of receipt, counting the day of actual receipt of the notice as the first day of notice.

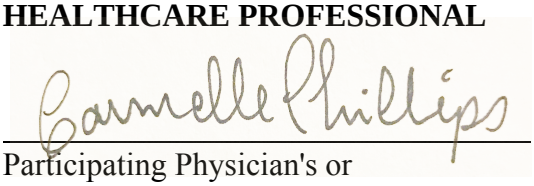
19. **Conformity to Law**. Any provision of this contract in conflict with any applicable federal or state law shall be construed and applied to conform to the requirements of all applicable federal and state law.

20. **Complaints and Inquiries**. We have a dedicated provider services toll-free telephone line and representatives available to respond to questions or complaints You may have in connection with Your relationship with Us under this contract. To access Provider Services, You may call **1-800-624-1110** or such other telephone number or electronic means We subsequently supply to You. Information concerning benefit plans, including coverage and eligibility, is available through Provider Services as well as through newsletters and other communications from Us.

Accepted and agreed at Newark, New Jersey:

Signed:

PHYSICIAN or HEALTHCARE PROFESSIONAL



Participating Physician's or Healthcare Professional's Signature

Carmelle Dorothy Phillips, OT

Print Name Above, Including Degree

07/10/2023

Date

Morris

County

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

By: _____

Title: _____

Date: _____

Effective Date: _____

APPENDIX

PROVIDER CLAIM PAYMENT APPEAL PROCESS

If You have a dispute with Horizon relating to the payment of a claim (except for utilization management determinations and except for certain claims described below):

(a) You may file an appeal in writing within 90 calendar days of receipt of the claim determination, for services rendered on, or after, July 11, 2006. The appeal shall be submitted on the Health Care Provider Application to Appeal a Claims Determination Form, including all supporting information. The form may be found at www.state.nj.us/dobi or www.horizonblue.com/providers and shall be submitted to:

Appeals Department
Horizon BCBSNJ
P.O. Box 10129
Newark, NJ 07101-3129

(b) Horizon's decision will be communicated to You in writing on or before 30 calendar days following receipt of an appeal form. If a favorable determination is made, Horizon will make payment within 30 calendar days of the notification along with 12% interest accrued from the date the appeal was received by Horizon. If a decision is not communicated to You within 30 calendar days, or if You disagree with Horizon's decision, You may refer the dispute to external arbitration.

(c) You may initiate an arbitration proceeding within 90 calendar days of receipt of the internal appeal decision, by completing an application and payment of arbitration fees. To be eligible for this second level arbitration appeals process, Your dispute must be in the amount of $1,000 or more. You may aggregate claims (by carrier and covered person or by carrier and CPT code) in order to reach the $1,000 minimum. The independent arbitrator's decision is binding and will be issued on or before 30 calendar days following receipt of the required documentation. Payment will be issued within 10 business days of the arbitrator's decision. The application and additional information may be found at www.njpicpa.maximus.com.

The provider claim payment appeal and arbitration process is not available for appeal of utilization management determinations and is only available for claims for services rendered to members covered by insured health plans delivered or issued for delivery in the State of New Jersey; it may not be available where not required under New Jersey law or regulation.

For further detail on the provider claim payment appeal process or arbitration process, please refer to the provider manual, Horizon's website, or call the Horizon Appeals Department at **1-800-624-1110** or such other telephone number or electronic means subsequently supplied to You.

The provider claim payment appeal and arbitration process is automatically subject to change as a result of any change to regulation or law (legislative or judicial) on the subject.