



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
CORDELL HULL BLDG.
425 5TH AVENUE NORTH
NASHVILLE TENNESSEE 37247

PHIL BREDESEN
GOVERNOR

KENNETH S. ROBINSON, M.D.
COMMISSIONER

August 18, 2005

Dear Provider:

This is to share information regarding a special safety net program available to oncologists who are serving individuals that were disenrolled from TennCare as a result of the current reforms. The State has developed this special program to encourage continuity of care for individuals who were receiving chemotherapy services at the time of their disenrollment or those diagnosed before termination that had a plan of care in place that included chemotherapy prior to the TennCare disenrollment.

Through this special safety net program, the Department of Health will make a \$1,500 one time only case rate payment per patient to participating oncologists for individuals who qualify for the program. In return, the participating oncologists will agree to continue to provide the current course of chemotherapy to these TennCare disenrollees and will not bill the patients for the services. We have structured this case rate in a way that should allow you to seek other assistance for these patients, such as pharmaceutical donations, and hope that you will do so. TennCare disenrollees who have other insurance including Medicare will not be eligible for these payments. The State will make the final decision on whether a patient is eligible for this special reimbursement under the safety net.

You can invoice us for the case rate at any time during the individual's treatment, however, since this is a limited program with a funding end date of December 31, 2005, all individual treatment invoices will need to be submitted by December 15, 2005. We will rely on the participating providers to notify us of a patient's participation

In order to participate in the program you will need to complete the following documents:

- Healthcare Safety Net- Cancer Treatment Letter of Agreement
- Authorization to Vendor
- W-9 Form

Please return the completed forms to:

Debra Lampley
Tennessee Department of Health
Health Services Administration
425 5th Avenue North
Cordell Hull Building, 4th floor
Nashville, TN 37247

Provider
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Invoices should be submitted using the Invoice for Case Rate form (attached) and should be sent to Debra Lampley at the address listed above. If you have any questions, please contact Debra Lampley at (615) 741-3703.

I would like to thank you in advance for your participation in this program and the assistance that you are providing to your patients who are losing their TennCare coverage.

A handwritten signature in black ink, appearing to be "A.W. Lampley", with a long horizontal flourish extending to the right. Below the main signature, the initials "AW" are written in a smaller, more legible script.

KSR/TCL

**Healthcare Safety Net – Cancer Treatment
Letter of Agreement
August 1, 2005 – December 31, 2005**

Whereas, the State is seeking to provide a special reimbursement to oncologists who are serving individuals who are being disenrolled from TennCare as a result of the current reforms:

I, _____, representing _____
(Print Full Name)

(Print Name of Business)

agree to continue to provide the current course of chemotherapy for patients who were under my (our) care and were receiving chemotherapy or had a treatment plan in place to begin chemotherapy at the time of their disenrollment from the TennCare program. Patients who have other insurance, including Medicare are not eligible for this special safety net program.

I agree to accept \$1,500 per patient (case rate) as payment in full for the chemotherapy services provided after the time of reform disenrollment. This payment is for the professional costs associated with chemotherapy services and should not disqualify my seeking pharmaceutical manufacturers' assistance in acquiring the necessary chemotherapy drugs for my patients. Payments made by TennCare MCOs for services provided prior to the individuals' reform disenrollment are not considered.

I agree to bill the Department of Health for the case rate using the attached form "Healthcare Safety Net – Cancer Treatment – Invoice for Case Rate". I understand that I may submit invoices at any time and that all treatment invoices will need to be submitted by December 15, 2005 since this is a limited program with a funding end date of December 31, 2005. I understand that the State will make the final decision on whether a patient is eligible for this special reimbursement under the safety net.

I understand this safety net will be in effect from August 1, 2005 – December 31, 2005.

I fully understand and agree with all of the above conditions evidenced by the information provided below and the execution of the "Authorization to Vendor" form and the provision of a W-9 form:

PROVIDER (TAXPAYER NAME): _____

BUSINESS NAME (If applicable): _____

PHYSICAL ADDRESS: _____

SIGNATURE: _____

TITLE: _____

DATE: _____

BILLING ADDRESS IF DIFFERENT FROM BUSINESS ADDRESS:

AUTHORIZATION TO VENDOR

STATE		VENDOR	
Department of Health		(Provider or Provider Group Name)	
PROGRAM:	Healthcare Safety Net – Cancer Treatment	FEIN/SSN:	
ALLOTMENT:	343.45	ADDRESS:	
COST CENTER:	Xx		
DPA #	DP-06-02186-00	PHONE:	
		FAX:	

SERVICE

ITEMS AUTHORIZED	SERVICE DATE(S)	UNITS AUTHORIZED	UNIT COST	AMOUNT AUTHORIZED
Chemotherapy Treatment for TennCare disenrollees	Services rendered August 1, 2005 through December 31, 2005	One case rate per TennCare disenrollee	\$1500 per TennCare disenrollee	As needed to cover one case rate per TennCare disenrollee receiving treatment

TERMS OF AUTHORIZATION

1. The Vendor agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of the authorized service or in the employment practices of the Vendor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.
2. The Vendor warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Vendor in connection with any work contemplated or performed relative to this Authorization.
3. The State may terminate this purchase without cause for any reason, and such termination shall not be deemed a breach of contract by the State.
4. The Vendor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Vendor, its employees, or any person acting for or on its or their behalf relating to this purchase. The Vendor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this purchase or otherwise enforce the obligations of the Vendor to the State.
5. Activities and records pursuant to this Authorization shall be subject to monitoring and evaluation by the State or duly appointed representatives.
6. The State is not responsible for the payment of services rendered without specific, written authorization.
7. The Vendor will submit an invoice in form and substance acceptable to the State to effect payment.

This Authorization To Vendor is issued to be effective August 1, 2005 and void after December 31, 2005.

AUTHORIZATION		ACCEPTANCE	
DATE:		DATE:	
[AUTHORIZATION SIGNATURE]		[ACCEPTANCE SIGNATURE]	
[NAME AND TITLE]		[NAME AND TITLE]	

SUBSTITUTE W-9 FORM
REQUEST FOR TAX PAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name _____ Phone Number _____

Business Name (if applicable) _____

Address _____

City _____ ZIP Code _____

2. Circle the most appropriate category below: (please circle only one)

- 1) Individual (not an actual business)
- 2) Joint account (two or more individuals)
- 3) Custodian account of a minor
- 4)
 - a. Revocable savings trust (grantor is also trustee)
 - b. So-called trust account that is not a legal or valid trust under state law
- 5) Sole proprietorship (using a social security number for the taxpayer ID)
- 6) Sole proprietorship (using a federal employer identification number for taxpayer ID)
- 7) A valid trust, estate, or pension trust
- 8) Corporation
- 9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
- 10) Partnership
- 11) A broker or registered nominee
- 12) Account with the US Department of Agriculture in the name of a public entity that receives agricultural program payments
- 13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c) 3 entities)

3. Fill in your taxpayer identification number below: (please complete only one)

- 1) If you circled number 1-5 above, fill in your Social Security Number.

_____ -- _____ -- _____

- 2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN)

_____ -- _____

4. Sign and date the form:

Certification - Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature _____ Date _____

Title (if applicable) _____