

**PARTICIPATING PRACTITIONER AGREEMENT
YALE-NEW HAVEN MEDICAL STAFF IPA, INC. (YNIPA”)**

**(C) THIRD SUPPLEMENT TO SECOND RIDER TO APPENDIX A
PRIVATE HEALTH CARE SYSTEMS, INC. (“PHCS”)**

WHEREAS, Private Health Care Systems, Inc. (“PHCS”) operates a preferred provider organization (“PPO”) through which PHCS offers health care services to PHCS Members, a representative Summary of Member Benefits being attached hereto as Exhibit 1; and

WHEREAS, PHCS has contracted with Yale-New Haven Physicians Corp. (“YPHO”) to arrange for the delivery of health care to Members of PHCS through YPHO’s provider network; and

WHEREAS, Practitioner desires to provide medical services to Members of PHCS; and

WHEREAS, in order to satisfy the contractual requirements of PHCS and/or the terms of the Participating Practitioner Agreement with respect to Practitioner’s delivering such services to PHCS Members, the Second Rider to Appendix A of the Participating Practitioner Agreement requires further supplementation;

NOW, THEREFORE, in consideration of the mutual promises exchanged herein, YNIPA and Practitioner hereby agree that the Second Rider to Appendix A of the Participating Practitioner Agreement shall be supplemented as follows:

- (1) Private Health Care Systems, Inc. shall be included in the term “Insurers”.
- (2) The compensation offered by PHCS for Covered Services rendered to Members pursuant to this arrangement is as set forth in Third Supplement to Second Rider to Appendix B of the YNIPA Participating Practitioner Agreement, attached. The party responsible to compensate Practitioner and the timing of compensation is as set forth in the Master Agreement between PHCS and YPHO. In no event shall Practitioner look to either YPHO or YNIPA for compensation under this agreement.

IN WITNESS WHEREOF, the parties have executed this Third Supplement to Second Rider to Appendix A.

PRACTITIONER:

YALE-NEW HAVEN HOSPITAL
MEDICAL STAFF IPA:

By:

Practitioner Signature

IPA Representative

Printed Name

Printed Name

Practitioner Specialty

Date

CT License Number

Tax ID Number

Group Tax ID Number (if applicable)

Date

Sign and Return this document along with your application package to:

Yale New Haven Community Medical Group
20 York Street, Hunter 4
New Haven, CT 06510
Fax: 203-688-5343

YALE-NEW HAVEN COMMUNITY MEDICAL GROUP

Private Health Care Systems, Inc. OPT-IN Form

I WILL

I WILL NOT

participate in the Yale-New Haven Community Medical Group contract with Private Health Care Systems, Inc.

Name _____

Signature _____

Date _____

Sign and Return this document along with your application package to:

Yale New Haven Community Medical Group
20 York Street, Hunter 4
New Haven, CT 06510
Fax: 203-688-5343