

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

**(D) FIFTH SUPPLEMENT TO SECOND RIDER TO APPENDIX A
UNITED HEALTHCARE (“UNITED”)**

WHEREAS, United HealthCare, which includes United HealthCare of New England, Inc., and The MetraHealth Insurance Company in Connecticut (together “United”) operates a preferred provider organization (“PPO”) through which United offers health care services to United Members; and

WHEREAS, United and YNH-Physicians Corp. (“YNH-PHO”) have signed a Letter of Agreement in April, 2000 (“LOA”) to arrange for the delivery of health care to Members of United through YNH-PHO’s provider network; and

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

WHEREAS, in order to satisfy the contractual requirements of United and/or the terms of the YNH-IPA Participating Practitioner Agreement with respect to Practitioner’s delivering such services to United 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, YNH-IPA and Practitioner hereby agree that the Second Rider to Appendix A of the Participating Practitioner Agreement shall be supplemented as follows:

1. United shall be included in the term “Insurers.”
2. The compensation offered by United for Covered Services rendered to Members pursuant to this arrangement is as set forth in the sample fee schedule attached hereto as Fifth Supplement to Second Rider to Appendix B of the YNH-IPA Participating Practitioner Agreement.

YNH-IPA may be responsible for credentialing under this arrangement. All other administrative functions and all payment responsibilities under this arrangement are with or through United. In no event shall Practitioner look to either YNH-PHO or YNH-IPA for compensation under this arrangement.

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

PRACTITIONER

YALE-NEW HOSPITAL HAVEN MEDICAL
STAFF IPA, INC.

By: _____
Practitioner Signature

By: _____
IPA Representative Signature

Practitioner Printed Name

IPA Representative Printed Name

Practitioner Specialty

Date

Connecticut 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

United Health Care OPT-IN Form

I WILL

I WILL NOT

participate in the Yale-New Haven Community Medical Group contract with United Health Care

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