



BEYOND MED PLANS INC.
PROVIDER AGREEMENT – REQUIREMENTS

This Provider Agreement Requirements (hereinafter "Agreement") is entered into this ___ day of _____, 20___, (hereinafter effective date) by and between Beyond Med Plans Inc. and its affiliates (hereinafter collectively "BMP") and _____ (hereinafter "Provider"). BMP and Provider may be referred to herein individually as a "Party" and collectively as the "Parties." Now, therefore the Parties do mutually covenant and agree as follows:

- 1. BMP is a discount plan organization network. Provider is a physician who is licensed to provide his/her/their advertised medical services in accordance with applicable law including any applicable medical personnel.
2. The Provider hereby agrees to provide to any and all BMP eligible members a discount off the Provider's registered fees as they relate to the corresponding medical services provided to the eligible BMP member. The recommended discount percentage is twenty percent (20%). Discounts are to be offered on a consistent basis.
3. The Provider, from time to time, may be asked by BMP, to confirm and/or update the Provider's fee schedule corresponding to all services that are provided to BMP members
4. All discounted fees towards services provided to BMP eligible members will be established at treatment planning/consultation visit or first medical service visit should they coincide. Should Provider's fee schedule increase during the course of a previously treatment planned/initiated medical service provided to a BMP eligible member, the discounted fee prior to the Provider fee schedule increase shall take precedence
5. The Provider hereby allows BMP the right to publish, advertise, and print Provider's name, contact information and medical specialty. This is done in an effort to promote Provider to BMP eligible members for the purpose of providing corresponding medical services aligned with the Provider's medical specialty to BMP eligible members.
6. The Provider agrees to have in full force and effect professional liability insurance in an amount not less than two hundred thousand dollars per claim and six hundred thousand dollars annual aggregate coverage and larger amounts as may be required by law OR any Professional Liability coverage as outlined by any and all state regulations.
7. The Provider agrees to adhere to all BMP rules and protocols as outlined in the Addendum.
8. This Agreement and the attachments hereto, constitute the entire understanding of the Parties and may be amended or modified only in writing signed and approved by the Parties, unless otherwise permitted herein. BMP may modify this Agreement upon thirty (30) days advance written notice to Provider. If Provider does not object in writing to BMP regarding the modification, Provider's silence shall constitute acceptance of such modification.

Products to be discounted: _____

Products to be discounted: _____

Discount % to be offered on above services: _____

Provider Office

BMP

Print Name

Print Name

Signature

Signature

Address

78 SW 7th Street, 07-151
Miami, FL 33130

Address

Please e-mail to:

Please complete the attached informational supplement prior to execution in order to process this Provider Agreement.



Provider Agreement – Information Supplement

For each onboarded provider and/or office address, please provide the following information.

Name: _____

Date of Birth: _____

Provider NPI or License #: _____ State of License (if applicable): _____

Office NPI (if applicable): _____

Office Address: _____

Name: _____

Date of Birth: _____

Provider NPI or License #: _____ State of License (if applicable): _____

Office NPI (if applicable): _____

Office Address: _____

Name: _____

Date of Birth: _____

Provider NPI or License #: _____ State of License (if applicable): _____

Office NPI (if applicable): _____

Office Address: _____

Please mark the box of the below services the Provider wishes to highlight as offered

Acupuncture All Services <input type="checkbox"/>	Acupuncture <input type="checkbox"/> Cupping <input type="checkbox"/> Heat and Cold Therapy <input type="checkbox"/> Laser Acupuncture <input type="checkbox"/> Other: _____
Bariatric Services All Services <input type="checkbox"/>	Gastric Bypass <input type="checkbox"/> Gastric Sleeve <input type="checkbox"/> Gastric Clip <input type="checkbox"/> Banding <input type="checkbox"/> Stomach Reduction <input type="checkbox"/> Hernia Repair (if applicable) <input type="checkbox"/> Other: _____
Chiropractic All Services <input type="checkbox"/>	Chiropractic <input type="checkbox"/> Adjustments <input type="checkbox"/> Imaging <input type="checkbox"/> Corrective Exercises <input type="checkbox"/> Other: _____
Dermatology All Services <input type="checkbox"/>	Acne Treatments <input type="checkbox"/> Anti-Aging Treatments <input type="checkbox"/> Botox <input type="checkbox"/> Dermal Fillers <input type="checkbox"/> Scar / Mole / Tag Removal <input type="checkbox"/> Skin Cancer Screening <input type="checkbox"/> Skin Rejuvenation <input type="checkbox"/> Tattoo Removal <input type="checkbox"/> Other: _____
Fertility All Services <input type="checkbox"/>	Donor Egg Programs <input type="checkbox"/> Genetic Testing <input type="checkbox"/> In Vitro Fertilization (IVF) <input type="checkbox"/> Intrauterine Insemination (IUI) <input type="checkbox"/> Other: _____
Hair Restoration All Services <input type="checkbox"/>	Hair Transplants <input type="checkbox"/> Hair Loss Treatments <input type="checkbox"/> Platelet-Rich Plasma <input type="checkbox"/> Hair Extensions <input type="checkbox"/> Follicular Unit Transplant <input type="checkbox"/> Folliculate Unit Extraction <input type="checkbox"/> Other: _____
Health & Wellness	Anti-Aging <input type="checkbox"/> Cryo Therapy <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> IV Therapy <input type="checkbox"/> Vitamin Infusions <input type="checkbox"/> Non-Surgical Weight Loss Program <input type="checkbox"/> Dietary Counseling <input type="checkbox"/>
Massage Services Massage <input type="checkbox"/>	Specific Services: _____
Medical Marijuana All Services <input type="checkbox"/>	Medical Marijuana Certification <input type="checkbox"/> Other: _____
Med Spa All Services <input type="checkbox"/>	Bodysculpting (Emsculpt) <input type="checkbox"/> Botox <input type="checkbox"/> Chemical Peels <input type="checkbox"/> Coolsculpting <input type="checkbox"/> Facials <input type="checkbox"/> Fillers & Injectables <input type="checkbox"/> Hair Loss Restoration <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Microneedling <input type="checkbox"/> Skin Rejuvenation <input type="checkbox"/> Skin Tightening <input type="checkbox"/> Vein Therapy <input type="checkbox"/> Other: _____
Mental Wellness	Counseling Services <input type="checkbox"/> Family Counseling <input type="checkbox"/> Rehabilitation <input type="checkbox"/>
Physical Therapy	Occupational Therapy <input type="checkbox"/> Pain Management <input type="checkbox"/>
Plastic Surgery All Services <input type="checkbox"/>	Breast Augmentation <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Breast Lift <input type="checkbox"/> Rhinoplasty <input type="checkbox"/> Facelift and Neck <input type="checkbox"/> Liposuction <input type="checkbox"/> Tummy Tuck <input type="checkbox"/> Body Contouring <input type="checkbox"/> Dermal Fillers <input type="checkbox"/> Scar / Mole / Tag Removal <input type="checkbox"/> Buttox Lift <input type="checkbox"/> Hair Replacement or Transplantation <input type="checkbox"/> Botox <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Vaginal Rejuvenation <input type="checkbox"/> Dermabrasian <input type="checkbox"/> Arm Lifts <input type="checkbox"/> Other: _____
Surgical Vision All Services <input type="checkbox"/>	LASIK eye surgery <input type="checkbox"/> LASEK eye surgery <input type="checkbox"/> Epi-LASIK <input type="checkbox"/> PRK <input type="checkbox"/> Other: _____
Veterinary Services All Services <input type="checkbox"/>	Medical Exams and Check-Ups <input type="checkbox"/> Neuter and Spay <input type="checkbox"/> Orthopedics <input type="checkbox"/> Surgeries <input type="checkbox"/> Bloodwork <input type="checkbox"/> Urine/Stool Testing <input type="checkbox"/> Teeth Cleaning <input type="checkbox"/> Other: _____