

WPS INTERNET WEBSITE USER AGREEMENT

Wisconsin Physicians Service Insurance Corporation, including its wholly-owned subsidiary, The EPIC Life Insurance Company (referred to collectively as "WPS"), and the undersigned health care provider ("Provider") agree that Provider is appointed as a non-exclusive user of the WPS Information System (the "System"). Provider is authorized to access WPS' designated Website via the Internet to view and receive eligibility and/or claims status information ("Information") and may use the Information to determine whether the patient is eligible for available benefits from WPS. Provider is authorized to submit health insurance claims electronically to WPS for processing and payment of available benefits. This appointment is conditioned upon the Provider fully agreeing to the terms and conditions set forth in the Agreement and meeting WPS' internal provider review standards, as determined by WPS.

1. Provider also agrees to use the Information only for the valid business purposes approved by WPS.
2. Provider agrees to establish and maintain rules and procedures so that the Information or any other information obtained from the System, shall not be used by Provider or Provider's officers, employees or agents, except in accordance with federal or state laws, including, but not limited to, the Health Insurance Portability and Accountability Act, the Freedom of Information Act and the confidentiality of records provisions of the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. §290dd-2). Provider agrees not to disclose any Information to any person or organization other than WPS, without the express written permission of the WPS customer or the customer's lawful representative. As a user, Provider must comply fully with all applicable federal, state, and local laws, including, but not limited to, laws requiring Provider to exercise due diligence to prevent unauthorized disclosure or improper use of the Information for any purpose not specifically intended by this System. The Provider is solely liable and responsible for its own acts and omissions and those of its employees, agents and officers while using this System; Provider understands and agrees WPS has no liability or responsibility whatsoever for Provider's acts and omissions.
3. This Agreement may be terminated at any time by either party to this Agreement by giving at least five (5) days advance written notice of such termination to the other party.
4. All required notices under this Agreement shall be sent by certified mail, postage prepaid and return receipt requested.

This signed Agreement or any question related to this Agreement shall be mailed to:

Electronic Data Services
Wisconsin Physicians Service Insurance Corporation
P.O. Box 8128
Madison, WI 53708-8128

If such notice is sent to the Provider, it will be addressed to the individual named, in the Provider signature blank below, and sent to the mailing address shown below for the Provider.

5. The contact person named on the WPS Internet Website Submitter Profile ("Site Administrator") is solely responsible for creating sub-user accounts. The Site Administrator is also responsible for updating and deleting accounts as necessary. Provider shall require that any sub-user abide by the terms of this Agreement and shall be responsible for use of the System and the Information by a sub-user.
6. This Agreement may not be modified or changed orally. All modifications must be made in writing and signed by the parties.
7. WPS reserves the right to deactivate any account that is inactive for six months or more.
8. The laws of the State of Wisconsin shall govern the interpretation and legal effect of this Agreement.
9. This Agreement shall be binding upon, and inure to the benefit of the successors, assigns and legal representatives of each of the parties. However, it shall not be assigned by either party without the written consent of the other party, which shall not be withheld unreasonably.

- 10. It is agreed that the relationship of the parties is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.
- 11. The System contains sensitive, confidential and proprietary medical benefit plan and financial information and must be protected against unauthorized disclosure, release, modification or other action. By entering into this Agreement, Provider agrees to treat said information as confidential and to preserve its confidentiality in accordance with applicable laws and WPS' rules and procedures for users of the System. Provider also understands and agrees that the Information is subject to change, the Information does change and that WPS relies on information provided by other sources not within WPS' control. As a result, WPS makes no warranty or guarantee concerning the accuracy or reliability of the content of any Information available at the WPS Website or other Internet Websites to which WPS' Website is linked.
- 12. Provider understands and agrees that its use of the System and the Information does not guarantee payment of benefits by WPS, or that any treatment, service or supply provided to any patient is covered by WPS. Provider further understands and agrees that WPS' claim processing decisions about payment can only be made by WPS when all necessary claim information is received and reviewed by WPS in accordance with all terms, conditions and provisions, including, but not limited to, exclusions of the applicable benefit plans.
- 13. By executing this Agreement below, Provider agrees to all terms and conditions of the Agreement.

_____ Provider's Name	_____ Full Name (First, MI, Last)
_____ Location/Department	_____ Title
_____ _____	_____ Signature of Provider or Authorized Officer
_____ Mailing Address	_____ Name
_____ Office Phone	_____ Date
_____ Fax Number	_____ For Wisconsin Physicians Service Insurance Corporation
_____ Provider's Status (Check one below)	_____ WPS Authorized Representative
<input type="checkbox"/> Corporation	_____ Name
<input type="checkbox"/> Partnership	_____ Date
<input type="checkbox"/> Sole proprietorship	
<input type="checkbox"/> Other (Identify)	

WPS INTERNET WEBSITE SUBMITTER PROFILE

Please complete and return this form along with the "WPS INTERNET WEBSITE USER AGREEMENT"

- Reason for Submission:
- New
 - Applies to only Certain Locations with the Same Site Administrator. Please attach a list if necessary
 - Change in Site Administrator

Note: If multiple locations exist and there will be a different Site Administrator at each location, one form will need to be completed for each applicable location.

TODAY'S DATE	
NAME OF YOUR PRACTICE	
TAX ID NUMBER	
EDI SUBMITTER NUMBER OR CLEARINGHOUSE NAME <i>(if filing claims electronically to WPS)</i>	

STREET ADDRESS	
CITY, STATE, ZIP CODE	
SITE ADMINISTRATOR NAME	
SITE ADMINISTRATOR EMAIL	
SITE ADMINISTRATOR PHONE	

FOR WPS USE ONLY
<p>You will be prompted to change the WPS Provider Corner user password when you sign on to the system for the first time. If you forget your password, contact WPS; confirmation of user identity will be required prior to issuing a new password.</p>
<p>WPS Provider Corner User Name _____</p>
<p>User Name and password control access to the processing system. You must have this information available each time you sign on to WPS Provider Corner.</p>
<p>Date Activated: _____</p>

