

## PARTICIPATION AGREEMENT FOR MEDICAL GROUPS

**New Medical Group**     *Re-enrollment or Change of Information for Existing Group*

The undersigned group hereby volunteers to provide services to enrolled Project Access patients at no charge.

Medical Group Name \_\_\_\_\_

Address (street, city, state, zip) \_\_\_\_\_ (if multiple clinic sites, please indicate)

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_ Website URL (http://www.) \_\_\_\_\_

Sub Specialty or Focus of Practice \_\_\_\_\_ Bus Line #s \_\_\_\_\_

Office Manager (PAMC Contact) \_\_\_\_\_ Manager's Phone \_\_\_\_\_ Manager's Email \_\_\_\_\_

Primary Referral Coordinator/Scheduling Contact \_\_\_\_\_ Referral Phone \_\_\_\_\_ Referral Email \_\_\_\_\_

### Annual Commitment

It is understood that we are accepting "cases" or 'patients' and will provide these patients with medical care, procedures, treatments or surgery *that are medically necessary*. If a particular patient requires a great deal of time and resources, we may request PAMC to modify our commitment level.

**We will accept :**     **12**     **6**     **Other** \_\_\_\_\_ **patients (cases) per year/per physician.**

The average annual contribution is 12 cases for each medical sub-specialist or 6 cases for each primary care physician.

Project Access patients will be screened and pre-approved for hospital services (inpatient & outpatient) have an ID card, access to ancillary services such as labs, imaging, pharmacy, and specialty referrals.

**Hospital Privileges:** \_\_\_\_\_  
 \_\_\_\_\_

**Special Restrictions?** \_\_\_\_\_  
 \_\_\_\_\_

**Referred to PAMC by:** \_\_\_\_\_ (allow us to say thank you!)

Participation in the PAMC program is voluntary and may be terminated by either party, at any time, for any reason, upon written notice to the other. Unless you direct us otherwise, we will include your group on our "Thank You" webpage <http://www.projectaccessnow.org/multnomah-volunteers.html> with a link to your Group's own website.

**Please direct inquiries to:**

**Dani Leis, MA**  
 Program Manager  
 619 SW 11<sup>th</sup> Avenue Suite, 225, Portland, OR 97205  
 Office 503.517.2005 Fax 503.548.4849

Email [leis@coalitionclinics.org](mailto:leis@coalitionclinics.org)  
 Coalition Web <http://www.coalitionclinics.org>  
 Project Access Web <http://www.projectaccessnow.org/multnomah.html>

**PARTICIPATING GROUP PHYSICIANS**

CLINIC

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Please list all the participating physicians from your group here. You may use additional pages if necessary.

<b>Physician Name</b>	<b>Suffix</b>	<b>Sub-Specialty or Focus of Practice</b> <i>if different from main, i.e. Cardiology/Cardiac Surgery</i>
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2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

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18. \_\_\_\_\_

19. \_\_\_\_\_

20. \_\_\_\_\_