DISCLAIMER

The information contained in this document is based on the author's knowledge and years of experience in the hearing care industry. It should not be construed as a recommendation or advice in running your practice. All information should be evaluated with your own practice protocols and used as you deem appropriate in your business. Author presenter is not an attorney; any information in the presentation should not be considered professional advice.

FOCUS OF THIS SECTION OF THE PRESENTATION WILL BE ON CONTRACTING FOR REIMBURSEMENT OF HEARING AIDS AND OTHER LARGE TICKET HEARING RELATED DEVICES

SHOULD YOU PARTICIPATE IN EVERY INSURANCE/MANAGED CARE NETWORK OPPORTUNITY?

What do you need to know?
What do you need to do?
WHAT YOU NEED TO KNOW

WHOM DO YOU WANT TO CONTRACT?

- Know Your Market
  - Networks want to look attractive to employer groups, so they strive to offer a breadth and depth of providers.
  - As a provider, understanding your place in the market is one of the best negotiation tools at your disposal.
  - Which networks are the major players in your market.

- Know the Network Composition
  - Number of members the carrier has in your service area.
  - Name and volume of the large employer groups that use that particular payer.

WHAT YOU NEED TO KNOW

SELECT YOUR NETWORK PARTICIPATION BASED ON...

- Key Referral Sources
  - Who are your referral sources current or prospective?
  - Which networks do your referral sources participate?
  - Focus on these...

- Referrals you expect to get from the insurance companies.
  - Are preferred provider listings available to you?
  - Periodic communication to members?

- Local large employers contracted with the Network
  - Building a relationship with these large employers directly increases referrals
  - Participation in health fairs, newsletters etc..

WHAT YOU NEED TO KNOW

- Know Your Competition
  - Evaluate and understand the quality of provider networks and positioning yourself as a key addition.
  - Multiple facilities that can serve the network in multiple locations to eliminate travel for members.
  - Specific product or service that your competition doesn’t offer.
  - Positioning yourself against other practices of similar size requires a different approach than positioning yourself against a large national chain.

- Know Your Service Area
  - Is the network accepting new providers in your county?
  - If the network is closed, check back often... they will be replacing providers who have retired, closed or sold the business.

WHAT YOU NEED TO KNOW

- IS THE NETWORK INTERESTED IN YOUR BUSINESS

- Know Your Service Area
  - Is the network accepting new providers in your county?
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  - Evaluate and understand the quality of provider networks and positioning yourself as a key addition.
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- Know Your Service Area
  - Is the network accepting new providers in your county?
  - If the network is closed, check back often... they will be replacing providers who have retired, closed or sold the business.

WHAT YOU NEED TO KNOW

- WHICH CONTRACTS ARE THE BEST SUITED FOR YOUR FINANCIAL STRATEGY/GOALS?

- Understand Your Raw Costs and Profit Margin
  - Perform a cost analysis before accepting the fee schedule or negotiating a rate.
  - A provider must have the same base rate for a product to self-payers, insurance companies, and government payers.
  - Discounts you give the payers may vary depending on your contracts and agreements with the payers.
  - Negotiating a standard discount rate for all payers will simplify your claim billing and collecting process.
  - For both small and large providers, contracting with large national payers is typically the key to serving the patients in the payers service area.
  - Participating in networks is important; however, sometimes you have to walk away to save your business from reimbursement rates that will eventually bring a negative return.
WHAT YOU NEED TO KNOW
– WHICH CONTRACTS ARE THE BEST SUITED FOR YOUR FINANCIAL STRATEGY/GOALS?

Terms that Could Impact the Profitability of Your Business
Don’t sign a contract just to sign it: make sure to review and negotiate terms that are suitable for your business. Most terms are negotiable, much easier with the smaller local payers.

- **Timely filing**: Seek at least 120 days to submit a clean claim.
- **Access to other networks or products that are tied to this contract**: Be aware of other products this contract will service at the fees that you have negotiated.
- **Basic billing**: Negotiate into contract the billing rate to be your retail charge for the devices. Discounts negotiated should be off the retail charge.
- **Billing for upgrades**: Negotiate into contract the ability to bill patients for upgrades.
- **Termination terms**: Be aware of early termination penalties, the ability to terminate without cause, and the length of notice that is required to terminate the contract. Many contracts terminate on change of ownership; build in assignment clauses to support your eventual exit strategy.

WHAT YOU NEED TO KNOW
– YOUR OPERATIONAL STRATEGIES

• **Strategize your approach, minimize your risk**
  - Pick one or two insurance companies – some payer are easier to work with than others

• **Manage your cash flow**
  - Payers take 20-40 days to pay
  - You can only bill the insurance company after you dispense the aid

• **Resource requirements**
  - System - Will you bill electronically or on paper?
  - Who will manage the insurance contracting, credentialing and reimbursements?
  - Training for your staff
  - Should you outsource the insurance process?

WHAT YOU NEED TO KNOW
– BETTER NEGOTIATE CONTRACTS

- **Do your homework**: Understand your business, the competition, and the network position.
- **Complete a cost analysis**: Know your break-even point and the profit margin you need to create a successful position and a profitable practice.
- **Position your business for success**: Build your story and sell it to the network.
- **Read all of the contract terms**: Be prepared for “gotchas.”
- **Don’t undersell yourself**: Negotiate for more than what you need, and settle for what will allow you to make a profit.
- **Walk away**: Don’t be afraid to walk away when the deal won’t bring you the patient flow you are expecting or the revenue you need.

TO COMMON MISTAKES

1. Specify all lines of business or products and services covered under the contract
2. Do not agree to be bound by a compensation rate that is not specific and included in the contract
3. Do not agree to be bound by policies and procedures that have not been made available for review or included in the contract
4. Beware of “lesser of” language in the contract
5. Include in contract, provisions to ensure prompt and fair reimbursement
6. Do not ignore the “devil” in the definitions. Ex. Medically necessary, payer…
7. Restrict payer ability to make retroactive adjustments and allowing for recoupments from other claims without giving enough time to refund
8. Do not accept to indemnify too much while holding the payer harmless
9. Do not agree to payer making changes to reimbursement without agreement by both parties in writing. Failure to reach an agreement should not result in a termination of the contract.
10. Always include assignment and alignment options, as well as clear post-termination obligations
This AGREEMENT is entered into by and between _______________, Inc., a ______________ corporation, (“Network”) and ______________________, (“Physician”).

❖ When is the contract effective?
❖ Contract should be in the name of the company not the individual.

WHEREAS, the Network is developing a provider network consisting of physicians, institutional facilities, and providers of ancillary health; and

WHEREAS, Physician wishes to be a Participating Physician in Network.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree as follows:

❖ Make sure the contract clearly describes what product line(s) this contract is for.

Example - This Agreement applies only to Payer’s Commercial HMO, but not to Payer’s Medicare HMO.

I. DEFINITIONS

1.1 “Benefit Plan” means those health care services which are included as health care benefits pursuant to Member’s Benefit Plan.

❖ Make sure that Benefit Plans are only in those Product lines you have agreed to contract.

Example - Benefit Plans will be limited to Commercial HMO, and not Medicare HMO.

1.2 “Covered Services” means medical and other health care services that are covered under a Health Benefit Plan established by a Payer and which are deemed Medically Necessary by Payer or Network.

❖ Who is the Payer? Look for a definition of Payer.

1.3 “Emergency” means the sudden and unexpected onset of a condition or symptoms requiring medical or surgical care to screen and/or treat the Member, and which is secured immediately after the onset (or as soon thereafter as the care can be made available), and is of such immediate nature that the Member’s life or health might be jeopardized if he or she is not treated as soon as possible.

1.4 “Fee Schedule” means the maximum amount which Network will pay for a specific service.

❖ And what exactly is that? Ask and receive fee schedule before signing the contract.

1.5 “Medically Necessary” or “Medical Necessity” means those services or supplies which, under the terms and conditions of this Agreement, are determined to be: appropriate and necessary for the symptoms, diagnosis or treatment of the medical conditions of the Member; provided for the diagnosis or direct care and treatment of the medical condition of the Member; within standards of medical practice within the community; and not primarily for the convenience of the Member, the Member’s physician or another provider.

❖ Who determines “medically necessary”, is it the PCP, Audiologist or some other entity? Get specificity around “medical necessity”.

SAMPLE MANAGED CARE AGREEMENT

I. DEFINITIONS (contd)
I. DEFINITIONS (contd)

1.6 “Member” means any person eligible to receive Covered Services and whose Benefit Plan has access to the Network. ❖

❖ Make sure that Member is only in those Product lines you have agreed to contract.

1.7 “Participating Hospital” means a duly licensed hospital which has entered into an agreement with Network to provide Covered Services to Members.

1.8 “Participating Physician” means a physician who has entered into an agreement with Network to provide Covered Services to Members.

1.9 “Payer” means an organization, firm, or governmental entity, including but not limited to a self-insured employer, employer coalition, health insurance purchasing cooperative, insurer, health maintenance organization or preferred provider organization, that has contracted with Network to arrange for the provision of health care services to its members. ❖

❖ The Payer and the Network may not be the same. The Payer may pay the Network to access providers in the Network - the Payer is obligated to pay the claim not the Network.

❖ Payers are required to comply with all requirements and responsibilities described in this Agreement, and Network is responsible for reimbursements if they fail to comply with such requirements.

❖ Network agrees to provide a quarterly list of contracted Payers.

1.10 “Primary Care Physician” means a Participating Physician who is designated by the Network as a provider of primary care services, and who is primarily responsible for managing and coordination the overall health care needs of the Member.

1.11 “Physician Manual” means the manual which has been prepared by Network and sets forth all policies and procedures governing Physician’s participation in Network. ❖

❖ Make sure you get a copy of this and read it.

1.12 “Specialty Care Physician” means a Participating Physician who is designated by the Network as a provider of specialty services other than primary care services.

1.13 “Utilization Review/Quality Assurance Plan” or “UR/QA Plan” means the program or programs adopted by the Network, and carried out by Participating Providers with Network which authorizes and monitors the utilization of Providers offered to Members. ❖


❖ Determine which services need preauthorization and notification and who can request authorizations – PCP, SCP or both. Are retro-authorizations considered for medical necessity?

I. DEFINITIONS (contd) Additional definitions to be included

What are the important definitions missing from the list?

❖ “Clean Claim” means a claim for payment for a Covered Service that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors but does not include a claim under review for medical necessity.

❖ “Claim” means a bill submitted by Physician to Network for Physician services provided to a Member using a billing form containing equivalent information. Billed amount is the retail price of the product or service.

❖ “Non-Covered Services” – specify products, services and codes not covered.
II. PHYSICIAN RESPONSIBILITIES

2.1 Physician agrees to provide to Members those Covered Services to the same extent and availability, and with the same degree of care, as Physician normally provides such services to the general community.

2.2 Physician shall maintain reasonable office hours in a location convenient to Members, and agrees to be accessible to Members either personally or by arranging for coverage by another Participating Physician or by another qualified physician approved by Network. Physician shall assist Network in ensuring that the covering physician complies with the UR/QA plans established by Network and by Payer, and that he complies with the compensation terms of this Agreement.

2.3 If Physician arranges with either a participating or non-participating Physician to cover Members for him/her in his/her absence, it will be the Physician’s responsibility to ascertain that the covering Physician will:
   (a) accept compensation from Network as full payment for covered services in accordance with the applicable Network compensation schedule
   (b) not bill the Member directly except for any applicable copayment, coinsurance, or deductibles;
   (c) obtain approval as designated by Network, prior to all non-emergency hospitalizations and non-emergency referrals of Members; and
   (d) comply with all Network rules, protocols, procedures, and programs.

This provision makes it the Physician’s responsibility to educate non-participating covering physicians.

2.4 Physician shall maintain adequate medical records for Members and shall retain and preserve such records for the full period of time required by state and federal law. Physician and Network shall maintain the confidentiality of Members' medical records in accordance with all applicable laws and regulations. Subject to such requirements, the Physician will make the Member's medical records readily available to any Participating Physician or other health professional who needs the records in order to treat the Member, and upon reasonable request, shall make the records available for review by Network, Payer, or their designee for quality assurance/utilization purposes or for other reasonable and necessary purposes.

Network will reimburse Physician the cost of preparing, copying, and delivering records.

2.5 Network or its designee shall have the right to inspect and audit, any of the Physician’s accounting, administrative, medical records and operations.

This provision allows the Payer to inspect any of your financial records.

Any review will be limited to Members and Covered Services. Payer shall contact Physician at least fifteen (15) days in advance of any review to schedule a mutual agreeable time for the review.

Network may not request or have any access to Physician’s non-public financial data, records, or information, which they feel to be confidential.

2.6 Physician represents that the information provided in the network application is correct. In addition, Physician warrants that he is
   (a) licensed to practice medicine or osteopathy in the State(s) of
   (b) has met all qualifications and standards for appointment to the medical staff of at least one Participating;
   (c) will have and maintain, where appropriate, a current and unrestricted narcotics number issued the Drug Enforcement Administration (“DEA”); and
   (d) has specialized training in the area in which he practices.

Watch the State location referenced in the contract.
II. PHYSICIAN RESPONSIBILITIES

2.7 Physician shall report any reportable occurrences including, but are not limited to, any action, investigation, or proceeding initiated or taken by any professional society or organization, by any facility, by any medical group or practice, by any licensure or certification agency, by any reimbursement entity or managed care organization, or by any similar entity or organization, to revoke, suspend, restrict, or otherwise adversely affect his privileges, license, certification, or professional standing or membership. The Physician agrees to notify the Network immediately of any suspension, reduction, or termination of his liability insurance, or of any lawsuit filed against him alleging malpractice or negligence and requesting damages in excess of $__________.

2.8 Physician shall provide and maintain professional liability insurance, in amounts of $__________ per claim and $__________ annual aggregate during this Agreement. Do you have this coverage? Usually $1m/claim and $3m/aggregate

2.9 Physician agrees that Network shall not be responsible for any claims, actions, liability or damages arising out of the acts or omissions of Physician or the acts or omissions of any non-participating physician who covers Members for the Physician. This provision only protects the Network.

2.10 The Physician agrees to cooperate with marketing programs established or approved by Network, and agrees to allow the Network and Payers to list the Physician’s name, specialty, address, telephone number, willingness to accept additional Members, and other relevant information in Participating Provider directories and similar informational materials.

IV. UTILIZATION REVIEW, QUALITY MANAGEMENT AND ADMINISTRATION

4.1 The Network will establish criteria and goals for establishing and monitoring the Medical Necessity, appropriateness, and quality of services provided by Participating Providers.

4.2 Physician agrees to cooperate with all Network rules, protocols, procedures, and programs in establishing and monitoring the Medical Necessity, quality management, benefit management, denials of admissions or continued stay, or other programs that may be established to manage the cost and utilization of medical services.

4.3 Physician agrees to refer Members to other Participating Providers when he/she is unable to provide the required services and when consistent with sound medical judgment.

Physician will use his/her best efforts to refer Members...
IV. UTILIZATION REVIEW, QA MANAGEMENT AND ADMIN

4.6 Physician shall comply with all determinations rendered by the UR/QA Plan program.

- Nothing in this Agreement shall be construed to interfere with or affect in any way the exercise of the independent medical judgment of Physician or Physician’s employees in rendering health care services to Members. Specifically, but not in limitation, the Physician or Physician’s employees shall be permitted to communicate with Members concerning (i) all matters necessary or appropriate for the delivery of health care services, (ii) treatment alternatives regardless of the provisions or limitations of coverage, and (iii) the reimbursement arrangements under which the Physician is compensated.

V. COMPENSATION

5.1 For Covered Services provided to Members, Physician shall be compensated in accordance with Exhibit A.

- Is there a fee schedule in Exhibit A?
- Get a copy of the fee schedule or reimbursement schedule before signing the contract.

5.2 Physician agrees to look solely to Network for payment for Covered Services.

- Limits options available to patients to upgrade.
- Physician has the right to bill Member for all non-covered services. No contractual discount will apply.
- Physician has the right to bill Member for all upgrades to the hearing devices beyond the basic device covered by the network, if Member opts to upgrade. No contractual discount will apply.

5.3 Network may offset overpayments against future payments to Physician.

- Accounting nightmare!!!
- Network agrees that recovery of overpayments will not be taken from future payments, but will be billed to Physician with appropriate documentation to substantiate the recovery.
- Network will notify Physician within fifteen (15) calendar days of receipt of claim, of any claim denied or pended for review/audit.
- Network must identify and notify the Physician of suspected overpayments no later than 180 days from the date Health Plan made the payment to the Physician to be eligible to recover such amounts.

5.4 Physician acknowledges that the coverage provided and the authorization(s) required for maximum benefits, for particular Covered Services may vary under different Health Benefit Plans. Under certain Health Benefit Plans no coverage is available if the Covered Service has not been preauthorized. Physician agrees to consult the Physician’s office manual, Member services and other Network materials in order to determine if a Covered Service is covered, and if so, to obtain the necessary authorization(s) in order for the Covered Service to receive the maximum benefit.

- Identify plans that require pre-authorization.
V. COMPENSATION

5.5 If Physician bills Network, such bill must be submitted no later than ninety (90) days after the date of service. Network shall not be obligated to pay any such bills submitted after the ninety (90) day period.

❖ Note timely filing period
- Negotiate 120 days when possible
- Complete claims that are not paid within thirty days will be paid at Physician’s billed charges.

❖ Negotiate 120 days when possible

VI. TERM AND TERMINATION

6.1 This Agreement shall be effective as of ________, 20___, and shall continue for a term of three (3) years from that date. Unless otherwise terminated as set forth below, the Agreement shall automatically be renewed for subsequent one-year terms. Renegotiations of Agreement shall only take place ninety days prior to the end of the term of the Agreement.

❖ Watch the term of the contract and when you can renegotiate.

6.2. Either party may terminate this Agreement, with or without cause, at any time upon one hundred and eighty (180) days’ prior written notice to the other party.

6.3. Either party shall have the right to terminate this Agreement upon thirty (30) days’ prior written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement.

❖ Make sure the time frame for notice and cure is understood.

6.4 In addition, Network may terminate this Agreement immediately upon (i) the revocation, suspension, or restriction of Physician’s license to practice medicine; (ii) the revocation, suspension, or restriction of Physician’s license, certification, registration, permit or approval required for the lawful and reasonable conduct of his practice and the provision of Covered Services to Members; (iii) Physician’s failure to maintain general and professional liability insurance as required under this Agreement; (iv) revocation, suspension, or restriction of Physician’s medical staff appointment or the necessary clinical privileges required to provide Covered Services at a Participating Hospital or any other hospital; (v) Network’s determination that any Member would be endangered or impaired by the continuation of this Agreement.

6.5 In the event of any material changes in laws affecting the structure of the Network, or affecting the provision or reimbursement of health care services similar to those provided hereunder, the parties agree to negotiate in good faith to amend this Agreement to conform with applicable law. In the event that such changes adversely affect either party, such party may terminate this Agreement upon sixty (60) days written notice if the parties are unable to renegotiate the Agreement on mutually agreeable terms within such 60-day period.

❖ Specify that termination will not result from the change of ownership of the Physician either via a sale of the practice or other reasons. The agreement will be assigned to the new owners within 30 days of notification of the change. All providers credentialed will continue to remain credentialed under the contract after assignment unless the Network is notified of termination of provider.
VI. TERM AND TERMINATION
6.6 In the event of termination of this Agreement, Network and Physician shall use their best efforts to arrange for an orderly transition of patient care, consistent with appropriate medical standards, for Members who have been or are at the time under the care of Physician, to the care of another physician selected by Member or Payer, but for no longer than (1) one year. Such services shall be provided according to this Agreement.

❖ This provision states that even though you have terminated the Agreement you may still be receiving the reimbursement for a year.

❖ Upon termination of this Agreement Physician shall continue to provide Covered Services to Members then inpatients of the Physician and entitled to services pursuant to Health Benefit Plans until such Members are (i) discharged or transferred consistent with sound medical practice, or (ii) thirty (30) calendar days from the effective date of termination.

VII. MISCELLANEOUS
This section usually contains various standard miscellaneous items that may not need negotiation, but a read through is definitely required. Occasionally, the following will appear in this section:

❖ Physician may not assign this Agreement without Network’s prior written consent.

❖ Get this removed from the miscellaneous section, it has already been addressed in the Termination section.

NOW YOU KNOW HOW YOUR CONTRACT SHOULD BE SET UP... HOW DO YOU APPLY IT IN YOUR PRACTICE?
OPERATIONAL SET UP CONSIDERATION

- Do your retail prices support the billing rates according to your contracts?
- Do the discount categories set up in your software align with the contracts specs?
- Do you and your staff know what the allowed amounts are for each of the contracts?
- Do you and your staff understand how to handle upgrades and non-covered items in your billing?

CALCULATING PATIENT BENEFITS

Scenario 1:
You’ve tested Mr X; it appears that he would benefit from a pair of hearing aids. Mr X wants top of the line hearing aids and he can afford it.
He has United Health insurance. Verification of his benefits shows that he has a deductible of $1,000 to meet and his co-insurance is 20% after that.
You already know that your United contract is 50% of billed with a maximum allowed amount of $5,000.
What will the insurance company pay and how much would you have to collect from the patient for a top of the line HA – retail price $12,000; price after insurance discount is $6,000.

Scenario 2:
You’ve tested Ms A; it appears that she would benefit from a pair of hearing aids. Ms A expects no out of pocket expense since she knows her insurance pays 100%.
She has United Health insurance. Verification of her benefits shows that the deductible has been met and her co-insurance is 0% after that.
You already know that your United contract is 50% of billed with a maximum allowed amount of $5,000.
What would you dispense the patient to meet her needs and satisfy the insurance contract and requirements?
Scenario 3:
You’ve tested Ms B; it appears that she would benefit from a pair of hearing aids. Ms B expects no out of pocket expense since she thinks her insurance pays 100%, and she has already met her deductible.
She has Blue Cross Blue Shield insurance. Verification of her benefits shows that the deductible has been met and her co-insurance is 0% after that.
You already know that your BCBS contract is subject to a fee schedule; max reimbursement on a pair of BTE is $2,464.
What would you dispense the patient to meet her needs and satisfy the insurance contract and requirements?

Scenario 4:
You’ve tested Dr Z; it appears that he would benefit from a pair of hearing aids. Dr Z wants top of the line hearing aids but he really does not want much out of pocket because his insurance told him that they cover 100%.
He has Aetna insurance. Verification of his benefits shows that he has a deductible of $1,000 to meet and his co-insurance is 0% after that.
You already know that your Aetna contract is subject to a fee schedule. The max they pay for a binaural BTE is $998.
What would be your course of action?
WHAT SHOULD YOU BE AWARE OF WHEN CREDENTIALING YOUR PROVIDERS?

- Medicare will only credential Audiologists
- When credentialing your Audiologist, make sure they are tied to your Tax ID, your NPI and the facility address where they will be practicing
- Credentialed Providers can accept patient without a contract with the insurance company; reimbursements will be out-of-network. They will be considered non-participating (non-par) Providers
- It is wise to begin credentialing your Providers at the same time you begin the application process for a new contract with an Insurance Company
- Credentialing will be a much easier process if your Audiologists have CAQH numbers

CHECKLIST FOR CREDENTIALING

- COMPLETED application, SIGNED AND DATED*
- If you have CAQH ID #, there is no need to complete xxx application.
- CURRENT Curriculum Vitae/Work History (Must include Month/Year). If gap exceeds 6 months, please include an explanation.
- CURRENT Copy of State License(s).
- CURRENT Copy of DEA Certificate.
- CURRENT Copy of CDS Certificate (if applicable).
- CURRENT Copy of Malpractice Insurance Face Sheet Written explanation of any Malpractice occurrences within the last 5 years.
- Copy of Board Certification Letter verifying Board eligibility.
- Completed W-9 Form for each tax identification number.
- Statement of Collaboration, if applicable.
- Sub-Specialty documentation (if applicable).
- Signed and dated Provider Network Participation Agreement and applicable addendums (2 original copies of each)

RESOURCES FOR CREDENTIALING

We encourage you to submit an application, attestation and authorization form using the Council for Affordable Quality Health Care (CAQH) Universal Credentialing DataSource application at http://www.caqh.org

Credentialing applications will be by state for some insurance companies.

- BLUE CROSS BLUE SHIELD
  http://www.bcbsnc.com/content/providers/application/instructions.htm

- UNITED HEALTH CARE
  https://www.uhc.com/provider

- CIGNA
  https://www.cigna.com/health/professionals/join-our-network
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