**ACCOUNT SETUP AGREEMENT**

Rate Table

Provider:

LCAD ID:

Effective Date:

LGTC and Provider hereby agree to the following terms for invoicing and payment of claims and for the re-submittal of denied claims. Only services specifically scheduled through or by LGTC will be compensated.

**Regions: UHC MCD**

|  |  |
| --- | --- |
| **Level of Service** |  |
|  | **Base Rate** | **RPM** |
| **ALS** | $248.37 | $2.50 |
| **BLS** | $206.97 | $2.50 |

**Regions: Caresource MCR**

|  |  |
| --- | --- |
| **Level of Service** |  |
|  | **Base Rate** | **RPM 1-17 miles** | **RPM over 17 miles** |
| **ALS** | $261.44 | $11.55 | $7.70 |
| **BLS** | $217.86 | $11.55 | $7.70 |

Provider must perform transportation at the class of service as authorized by LGTC. LGTC will pay properly submitted uncontested invoices twice per month by check or electronic transfer within thirty days after submission. If a payment date falls on a weekend or holiday, payments will be made on the next working weekday.

**LOGISTICARE SOLUTIONS, LLC PROVIDER**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_