§15-143(C) PARTICIPATION AGREEMENT REVIEW FILING FORM

Name of Individual making this filing: _____
Your business email address _____
Your business telephone #: _____

Name of your Business Entity: _____
Business entity address: _____

What is the NAME of your Participation Agreement: _____

File No. 15-143(C) (For MIA Use)

Date Filing Stamped in: (For MIA Use)

YOU MUST COMPLETE THE FOLLOWING QUESTIONS AND INCLUDE THIS FORM WITH YOUR FILING IN ORDER FOR YOUR FILING TO BE COMPLETE:

1) Is the compensation arrangement described in this Participation Agreement between the health care practitioner and the health care entity -

   a. Fully funded or paid for by Medicare or Medicaid?

      _____Yes _____No

   b. Exempt under another provision found in §1-302(d)(1)-(11)?

      _____Yes _____No

If you answered **YES** to either (a) or (b) of Question #1, you are not required to file your Participation Agreement with the Maryland Insurance Commissioner. Please disregard the remainder of this Form and do not file your Agreement. If you answered **NO** to both (a) and (b) of Question #1, please complete this Form and file your Agreement.

2) On what **PAGE** and in what **SECTION** of the Participation Agreement are the payment/compensation provisions of this Participation Agreement located?

   Page(s)_____ Section(s) _____

3) I have attached a check for the $125 filing fee made payable to the Maryland Insurance Administration.

   _____Yes _____No (Your Form and Participation Agreement will be returned to you without review. Please re-file your form with the required filing fee.)

4) Please mail this completed Form and the filing fee to: Maryland Insurance Administration
   200 St. Paul Place, Suite 2700
   Baltimore, MD 21202
   Attn: Life & Health Unit, Form 15-143(c) Filing

Questions regarding this Form may be directed to Associate Commissioner Robert J. Morrow, Jr. at bob.morrow@maryland.gov