

ROBERT WINTHER
PRESIDENT

MICHAEL PREVITERA
TREASURER



EDWARD M. FOX
EXECUTIVE DIRECTOR

RAY CONVERY
EXECUTIVE DIRECTOR

2980 Southampton Road, Philadelphia, PA 19154 | www.DVHCC.org | Phone: 215-676-7940 | Fax: 215-676-7941

MEMBERSHIP APPLICATION

All applications for membership and renewal of membership are subject to approval by the DVHCC Board of Directors and contingent upon receipt of a check for Seven Hundred Fifty (\$750.00) dollars representing the one-time initiation fee of Five Hundred (\$500.00) dollars and the first year's annual dues of Two Hundred Fifty (\$250.00) dollars. **Please make your check payable to the Delaware Valley Health Care Coalition, Inc.**

By completing this application, you hereby represent that you have the legal authority to bind your organization; and hereby agree as follows:

1. To adhere to the obligations of Members of the Delaware Valley Health Care Coalition, Inc. in conformance with the Articles of Incorporation, By-Laws, and their Amendments, as well as any and all Resolutions passed by the Board of Directors of the Coalition.
2. To pay all applicable utilization fees as determined by the Delaware Valley Health Care Coalition Board of Directors as set forth in all vendor contracts that our organization becomes signatory to and receives such benefits of while continuing to maintain membership in the Coalition.
3. Further, as a Member of this Coalition, our organization acknowledges and agrees that if our organization fails to maintain "good standing" membership in the Delaware Valley Health Care Coalition, Inc. and continues to receive any pricing, discounts, rebates and/or quality services set forth in any Umbrella contract and/or Member Agreement to which our organization is signatory, then the DVHCC has the right to charge our organization an "access fee" equivalent to the normal utilization fees owed under the vendor contract based upon our organizations' past year's utilization for so long as our organization continues to receive such Coalition-negotiated benefits.
4. Further, it is the understanding of our organization that the Coalition has the right and obligation to collect any access fee or utilization fees either directly from the Vendor or Member should the Vendor fail to properly collect the utilization fees and remit the same to the Delaware Valley Health Care Coalition.
5. As a Member of this Coalition, our organization acknowledges and agrees that in order to determine the vendor's compliance with the terms of the contract and affiliated Member Fund agreements, the Coalition has the authority to acquire from all vendors certain de-identified, summary information and reports, provided that the information is consistent and in compliance with the provisions of the "Privacy Rule" (set forth in 45 CFR Part 164) of HIPAA.

PLEASE COMPLETE FORM THOROUGHLY AND MAIL, FAX OR E-MAIL TO INFO@DVHCC.ORG

1. ORGANIZATION: _____

2. CONTACT PERSON: _____

a. CONTACT PERSON'S TITLE: _____

b. Is Contact a Third-Party Administrator? Y / N

If YES, Name of Firm: _____

3. ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

4. PHONE: _____ 5. CELL/ 2nd Phone: _____

6. E-MAIL: _____

7. FUND PARTICIPANTS

a. ACTIVE MEMBERS: _____ b. ACTIVE MEMBERS' DEPENDENTS: _____

c. RETIRED MEMBERS: _____ d. RETIRED MEMBERS' DEPENDENTS: _____

e. TOTAL # of PARTICIPANTS = _____

8. MEDICAL CARRIER: _____

INSURED or SELF-INSURED? _____

9. RETIREE MEDICAL CARRIER: _____

INSURED or SELF-INSURED? _____

10. PHARMACY BENEFIT MANAGER: _____

INSURED or SELF-INSURED? _____

11. DENTAL CARRIER: _____

INSURED or SELF-INSURED? _____

12. VISION CARRIER: _____

INSURED or SELF-INSURED? _____

18. FUTURE ISSUES YOU WOULD LIKE THE DVHCC TO ADDRESS:

19. DATE SUBMITTED ____/____/____