Physician Participation Agreement (Form A)

The Kaleida Health Bundled Payment Shared Savings Program is intended to incentivize Practitioners to participate in the quality metrics identified below, in order to improve the quality, patient experience and cost-effectiveness of care provided to applicable Medicare beneficiaries.

Quality metrics include:

1. Patient Satisfaction Scores (HCAHPS composite score for physician communication)
2. Quality (% 30 day readmission rates)
3. Engagement (Attendance at individual or group meeting with BPCI staff)

_____ _____

Name *(please print)* NYS License #

The following information is needed to make incentive payments to you, if you are eligible for such payments. Please indicate to whom any earned incentive payments shall be made payable, and where such payments should be sent. FAILURE TO COMPLETE THE FORM MAY RESULT IN A DELAY IN PAYMENT.

I WOULD LIKE MY INCENTIVE PAYMENT TO BE MADE PAYABLE TO:
. ***(*Please note—PAYEE Social Security# MUST match exactly*)**

❒ **MYSELF — SOCIAL SECURITY NUMBER: _____**

I WOULD LIKE MY INCENTIVE PAYMENT TO BE SENT TO THIS ADDRESS:

Name_____
Home Address _____
Home City/State/Zip _____

Physician Signature (required): _____
Date (required): _____
Email address (required): _____

Please return completed Enrollment form to:

Patricia L. Vorpahl, VP Physician Services
Larkin Building 726 Exchange Street, Suite 215
Buffalo, New York 14210 Telephone: 716.859.8060
Email: pvorpahl@kaleidahealth.org.

For questions, contact:
Brian Meade, Senior Director
Telephone: 716.859.7262
Email: BMeade@kaleidahealth.org

Form Updated 10/2/17