# Physician Election Form and Participation Agreement (Form B)

Kaleida Health's Initiative to Align Hospital and Physician Incentives ("Incentive Program") is described in the Physician Handbook, of which this form is a part. I have received and reviewed that Physician Handbook, and I wish to participate in this Incentive Program. I accept the terms, conditions and requirements of the Incentive Program as described in the Physician Handbook. I understand that those terms, conditions and requirements are essential provisions of this Participation Agreement, and I agree to be bound by them at all times during my participation in this Incentive Program.

_____ _____

Name *(please print)* NYS License #

To comply with Section II of the Physician Handbook, please indicate whether you admit patients to:

- ❑ Kaleida Health Only
- ❑ Kaleida Health and Other Hospital(s). Please list the names of the other hospital(s):

_____
_____
_____

**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[1]:
. ***(*Please note—PAYEE and Tax ID# MUST match*)**

- ❒ **MY GROUP—TAX ID # (GROUP): ____ _____**

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

Name of Group _____
Group Address _____
Group 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
Utilization Management
Telephone: 716.859.7262
Email: bmeade@kaleidahealth.org

_____ Date _____

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