



Virginia Birth-Related Neurological Injury Compensation Program 2011 Participating Hospital Agreement

In consideration of the rights and benefits received from participation in the Virginia Birth-Related Neurological Injury Compensation Program, and as required by §38.2-5001 of the *Code of Virginia* for qualification as a "participating hospital" in the Program, the undersigned hospital hereby agrees:

(1) To participate with the Commissioner of Health, or his designee, in the development of a program to provide obstetrical care, including prenatal care, labor and delivery services and postpartum care, to patients eligible for Medical Assistance Services ("Medicaid") and to patients who are indigent and, upon approval of this program by the Commissioner of Health, to participate in its implementation (this agreement does not require participation in the Medicaid program); and

(2) To submit to review of its obstetrical service by the State Department of Health in the evaluation of claims submitted pursuant to §38.2-5004.

As to paragraph 1 above, the Commissioner of Health agrees to review the program described and, upon approval, provide for its implementation.

As to paragraph 2 above, the State Department of Health agrees to evaluate all claims submitted to it pursuant to §38.2-5004.

If payment is received by December 1, 2010 this agreement shall be effective from January 1, 2011 through December 31, 2011. For payments received after December 1, 2010, this agreement shall become effective 30 days after the Virginia Birth-Related Neurological Injury Compensation Program receives written notification from the hospital.

Authorized Signature

Executed on (Date)

Authorized Title and Printed Name

Telephone Number

Hospital Printed Name

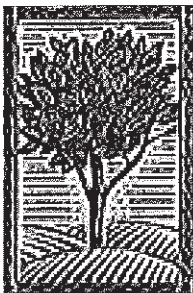
E-Mail



Commissioner of Health

Executed on (Date)

Please return this Agreement along with the Information Form and check for participation fee in the provided envelope.



**Virginia Birth-Related Neurological Injury Compensation Program
2011 Participating Hospital Information Form**

1. Enter total number of live births as reported in schedule 8.2 of your most recent Annual Historical Filing to Virginia Health Information (acting under contract with the Virginia Department of Health): _____ deliveries.
2. Multiply number of births by \$55.00 = _____.
3. Amount enclosed: \$ _____ (Maximum is \$200,000).
4. **PLEASE PRINT OR TYPE:**

Contact Name: _____

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

E-mail: _____

Federal Identification #: _____

Please return this form, participating contract and check to:
Virginia Birth-Related Neurological Injury Compensation Program
c/o SunTrust Bank
P.O. Box 91739
Richmond, VA 23291-1739
Phone 804-330-2471
Fax 804-330-3054