EAST BATON ROUGE PARISH
Filed Dec 18, 2020 8:40 AM
Deputy Clerk of Court
E-File Received Dec 17, 2020 11:08 AM
C-641928
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LOUISIANA HEALTH COOPERATIVE, INC. IN REHABILITATION (LAHC)
FINAL PROVIDER SETTLEMENT AND PAYMENT ACCEPTANCE AGREEMENT

LOUISIANA HEALTH COOPERATIVE

"PROVIDER" ENTITY NAME(S) INCLUDED IN THIS SETTLEMENT	TAX ID NUMBER

AGREED UPON FINAL SETTLEMENT PAYMENT TO YOU FOR OUTSTANDING CLAIMS WITH SERVICE DATES 2014 – 2015
$$$$$$$$$

I am the authorized corporate representative and/or owner of the provider entity(s) and Tax ID Number(s) shown above, collectively herein known as ("Provider") and entitled to collect the LAHC Settlement amount shown above on behalf of the Provider and all outstanding timely filed claims of the Provider are true and valid claims for the dates of service between 2014 and 2015.

I affirm that I am executing this LAHC Settlement Agreement on behalf of the Provider with full legal authority and the two witnesses shown below signed this document to verify my signature on behalf of the Provider.

On behalf of the Provider I recognize and agree that by signing below, the Provider forgives any and all uncollected amounts due from the Louisiana Heath Cooperative, Inc. in Rehabilitation ("LAHC"), including LAHC insureds, policyholders, subscribers, members and/or enrollees for patient responsibility amounts due or claimed to be due (such as deductibles, co-insurance and other amounts that are the patient's responsibility).

On behalf of the Provider I recognize and agree that by signing below, the Provider agrees to forego all collection activities as to same and waives all future claims against LAHC.

On behalf of the Provider I have confirmed the Louisiana Secretary of State (LA SOS) Business Filing page available on the LA SOS website for the Provider identified herein, which confirms my relationship as a legal representative to the Provider to which the LAHC payment is due. If a LA SOS Business Filing is not available for the Provider, I will provide proof of authority that I am the legal representative of the Provider.

By signing below, I and the Provider, hereby agree to all the terms and conditions of the LAHC Settlement Plan Agreement and General Release and the LAHC Settlement Plan Confidentiality and Non-Disclosure Agreement which can be found at http://www.ldi.la.gov/industry/financial-regulation/receivership/louisiana-health-cooperative on behalf of the Provider.

I agree to accept the amount shown above as Agreed Upon Final Settlement Payment made on behalf of the Provider as payment in full and final settlement of any and all claims as to LAHC.

Provider Acceptance and Instructions: (1) Sign, date, and fill-in as required below, including two witnesses. Once complete; (2) scan this page, along with one completed IRS Form W-9, and (3) email both documents to Philip@myLAHC.org. Once received, confirmed, and signed by the Receiver; a check will be mailed in the amount above to the name and address found on your IRS Form W-9.

☐ **Provider Completed IRS Form W-9 Attached (REQUIRED FOR PAYMENT)**

By:_____ _____
Provider Authorized Representative – Signature Date

Print: _____
Provider Authorized Representative – Print Full Name

Print: _____
Provider Authorized Representative – Print Title

Witness 1: _____ _____
Provider Witness 1 – Signature Date

Print: _____
Provider Witness 1 – Pint Full Name

Witness 2: _____ _____
Provider Witness 2 – Signature Date

Print: _____
Provider Witness 2 – Print Full Name

FOR LAHC USE ONLY

LAHC Receiver Approval for Payment:

By: _____ _____
Billy Bostick, Receiver Date