BY SIGNING THIS AGREEMENT, PROVIDER IS CERTIFYING THAT ALL ABA SUPERVISORS, ASSISTANT BEHAVIOR ANALYSTS, AND BEHAVIOR TECHNICIANS EMPLOYED BY OR CONTRACTED WITH PROVIDER MEETS THE AUTISM CARE DEMONSTRATION REQUIREMENTS IN ADDENDUM G-2 CONTAINED HEREIN.

EFFECTIVE DATE. This Agreement is effective on _____

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement on the effective date specified above.

PROVIDER NAME *(Individual, Group or Facility)*	**MANAGED HEALTH NETWORK, INC. AND AFFILIATES**
_____	
Notices: All notices shall be addressed as follows: Address:	Address:
_____	P.O. Box 10086
_____	San Rafael, CA 94912
E-mail: _____	Professional.Relations@MHN.com
TEL: ( ) _____	
FAX: ( ) _____	FAX: (415) 257-1467
_____ (Authorized Signature)	_____ (Authorized Signature)
_____ (Print Name)	Stephanie English
Title:_____	Title: Vice President, Provider Networks
Date: _____	Date: _____
Federal Tax ID#: _____	
NPI #: _____	

Signature Above is binding for all applicable lines of business defined in the Addenda of this Agreement.
Attn Provider Groups: Roster of Individual Practitioners included under this Agreement must be attached for participation.

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