Provider: Providence Hospital
TIN: 63-0288861
Effective: 05/15/2019

6801 Airport Boulevard
Mobile, AL 36608
(251)633-1000

Hospital agrees to accept the following rates as payment in full for services provided:

I. Inpatient Services: PROVIDER will be reimbursed at a rate equal to 80% of the State of Alabama Department of Labor (DOL) fee schedule pursuant to the negotiated participating agreement between the State of Alabama Department of Labor (DOL) and the individual Hospital in effect at the date of discharge. The calculation for the AlaMed inpatient rate shall be inclusive of all methods of calculation in the Hospital's inpatient state fee schedule, including but not limited to the Stop Loss provisions in the even the state fee schedule includes as Stop Loss.

Medical devises listed under revenue codes 274. 275, 276, or 278 shall be paid additional at cost plus 15% and Hospital shall furnish the invoice with the bill.

II. Outpatient Services not provided in paragraphs III or IV: A rate equal to 85% of the rate extended to the State of Alabama Department of Labor (DOL) pursuant to the negotiated participating agreement between the State of Alabama Department of Labor (DOL) and the individual Hospital in effect at the date of discharge

Medical devices listed under revenue codes 274. 275, 276, or 278 shall be paid additional at cost plus 15% and Hospital shall furnish the invoice with the bill.

III. Wound Care and Hyperbaric Oxygen Therapy: For all services regarding wound care and hyperbaric oxygen therapy services, treatment, supplies, expenses or other charges, PROVIDER will be reimbursed at a rate of 55% of billed charges.

IV. Inpatient/Outpatient Diagnostic Services: For all services, treatments, supplies, expenses, or other charges, PROVIDER agrees to accept the following rates as payment in full:

Description	Reimbursement
MRI	
MRI, without contrast	$600.00
MRI, with contrast	$675.00
MRI, with/without contrast	$750.00
CT	
CT, without contrast	$550.00
CT, with contrast	$625.00
CT, with/without contrast	$700.00

V. Emergency Room Services: PROVIDER agrees to a global reimbursement fee of $1,400.00 per visit to include all charges related to Hospital services, including but not limited to: E.R., diagnostics, lab, and other charges. Charges made by physician are not included, as they are billed directly by other parties.

VI. Stop Loss: When total charges exceed $30,000, reimbursement will convert to 80% of the State of Alabama Department of Labor (DOL) Stop Loss rate.

VII. Physician Services: PROVIDER will be reimbursed for the lesser of billed charges or a rate equal to 103% of Blue Cross Blue Shield of Alabama Preferred Medical Doctor (PMD) fee schedule when billed by the Hospital.

*Note: To calculate the AlaMed rate, first calculate the state rate and then apply the applicable discount.