

Note: Print this Fee Discount Agreement on the medical service provider's or clinic's letterhead.

Fee Discount Agreement

Medical service provider or clinic

Provider or clinic name:	National Provider Identifier:	
Address:	Office contact:	
City/State/ZIP:	Phone:	Fax:

Insurer or self-insured employer

Company name:	Billing address: (if different than mailing address)
Representative:	City/State/ZIP:
Mailing address:	Phone:
City/State/ZIP:	Fax:

1. This agreement is effective from _____ through _____ .
2. This agreement only applies to patients being treated for Oregon workers' compensation claims.
3. The provider or clinic agrees to accept a discount rate of _____ % of the Oregon Medical Fee Schedule.
(Note: the discount rate may not exceed 10% of the fee schedule as calculated under OAR 436-009-0040.)
4. The insurer or employer may not direct patients to the provider or clinic, nor may the insurer or employer direct or manage the care a worker receives.
5. This agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties.
6. Either party may terminate this agreement by providing the other party 30 days written notice.
7. Other terms and conditions as follows:
 Check here if you include additional pages.

By signing this agreement, I certify that I understand the terms of this agreement and voluntarily agree to its terms.

Provider/clinic representative signature

Date

Insurer or self-insured employer representative signature

Date