# EXHIBIT "M"
# to Third Amended Complaint

*U.S. ex rel. Williams v. Health Management Associates, Inc., Tenet Healthcare Corporation and Hispanic Medical Management d/b/a Clinica de la Mama, et al.*

# GEORGIA DEPARTMENT OF COMMUNITY HEALTH
# ELECTRONIC FUNDS TRANSFER AGREEMENT

**Providers who receive payment of claims under the Title XIX (Medicaid) program in Georgia must agree to the following terms and conditions:**

1. Legal Compliance. Provider shall abide by all federal and state laws governing the Medicaid program.

2. EFT Information. Provider will submit EFT information on form DMA-406 that includes the Payee, name of the bank, transit number, account number and a bank letter or voided check on the account to which funds will be transferred.

3. Non-Provider Payee. If the Payee indicated on this EFT Agreement is different from the enrolled Provider, Provider must submit to the Department an original signed and notarized Power of Attorney for Payee, DMA-253G. Designation of a payee other than Provider shall not relieve Provider of any liability for acceptance of medical assistance payments under the Medicaid program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments.

4. Acceptance of Funds. Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the Medicaid program within the meaning of the Official Code of Georgia Annotated, Section 49-4-146.1(b)(2). Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. Provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

5. Notice of Changes. Provider will notify the Department in writing at least ten (10) days in advance of any changes in Payee, Payee's name or address, or bank account name or number (supported by a bank letter or voided check on the new account).

6. Alternate Payment Methods. For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the Department may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by the Department. Payment by check will be made to the address for payments on record with the Department.

7. Incorporated Document. This EFT Agreement is incorporated into the Statement of Participation and shall not modify or eliminate any provision of the Statement of Participation (including applicable Policies and Procedures manuals of the Department) except as specifically provided herein.

8. Expiration or Termination of EFT. Violation of these terms may cause termination by the Department of EFT and/or the Statement of Participation. Expiration or termination of the Statement of Participation for any reason will terminate EFT automatically. The Department will give written notice of termination to Provider.

Payee Provider's Name: Spalding Regional Medical Center

Payee Provider's Georgia Medicaid Number: 00000866A

Bank Routing and Transit Number (9 digits): [redacted]

Bank Account Number: [redacted]

Signature of Provider or Authorized Representative of the Provider

Date: 3/15/07

**Return form to: ACS Provider Enrollment, P. O. Box 4000, McRae, GA 31055**

DMA 806
Rev. 05/06

0171220436 4

# GEORGIA DEPARTMENT OF COMMUNITY HEALTH
# ELECTRONIC FUNDS TRANSFER AGREEMENT

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Payee Provider's Name: Spalding Regional Hospital

Payee Provider's Georgia Medicaid Number: 000000866A

Bank Routing and Transit Number (9 digits): [redacted]

Bank Account Number: [redacted]

Signature of Provider or Authorized Representative of the Provider

Date: 06/27/07

**Return form to: ACS Provider Enrollment, P. O. Box 4000, McRae, GA 31055**

DMA 006
Rev. 07/06

817070907719

1126870000056

**Account Change Request 00056**

Rec'd 9/14/11
DCC 7104

# GEORGIA DEPARTMENT OF COMMUNITY HEALTH
# ELECTRONIC FUNDS TRANSFER AGREEMENT

Providers who receive payment of claims under the Title XIX (Medicaid) program in G[redacted] following terms and conditions:

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3. Non-Provider Payee. If the Payee indicated on the EFT Information form is different from the enrolled Provider, Provider must submit to the Department an original signed and notarized Power of Attorney for Payee. Designation of a payee other than Provider shall not relieve Provider of any liability for acceptance of medical assistance payments under the Medicaid program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments. Provider further acknowledges and agrees that only Payees who have agreed in writing to: 1) comply with all Department policies regarding the payment of medical assistance; and 2) be subject to the recoupment policies outlined in the Provider's Statement of Participation and as set forth in the Power of Attorney for Electronic Claims Submission, shall be deemed acceptable Payees.

4. Acceptance of Funds. Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the Medicaid program within the meaning of the Official Code of Georgia Annotated, Section 49-4-146.1 (b)(2). Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. Provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

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Payee Provider's Name: Spalding Regional Medical Center

Georgia Medicaid Payee Provider Number (if issued): [redacted]

Bank Routing and Transit Number (9 digits): [redacted]

Bank Account Number: [redacted]

Signature of Provider or Facility Administrator: [signature]

Date: June 29, 2011

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# GEORGIA DEPARTMENT OF COMMUNITY HEALTH
# ELECTRONIC FUNDS TRANSFER AGREEMENT

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8. Expiration or Termination of EFT. Violation of these terms may cause termination by the Department of EFT and/or the Statement of Participation. Expiration or termination of the Statement of Participation for any reason will terminate EFT automatically. The Department will give written notice of termination to Provider.

Payee Provider's Name: Sylvan Grove Hospital

Payee Provider's Georgia Medicaid Number: [redacted]

Bank Routing and Transit Number (9 digits): [redacted]

Bank Account Number: [redacted]

Jamara Da
Signature of Provider or Authorized Representative of the Provider

06/27/07
Date

**Return form to: ACS Provider Enrollment, P. O. Box 4000, McRae, GA 31055**

DMA 006
Rev. 07/06

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## GEORGIA DEPARTMENT OF COMMUNITY HEALTH
## ELECTRONIC FUNDS TRANSFER AGREEMENT

Providers who receive payment of claims under the Title XIX (Medicaid) program in Georgia must agree to the following terms and conditions:

1. Legal Compliance. The provider shall abide by all federal and state laws governing the Medicaid program.

2. EFT Information. The provider will submit EFT information below that includes the payee, name of the bank, transit number, account number and a bank letter or voided check on the account to which funds will be transferred.

3. Non-Provider Payee. If the payee indicated below is different from the enrolled provider, the provider must submit to DCH an original signed and notarized Power of Attorney for Payee. Designation of a payee other than the provider shall not relieve the provider of any liability for acceptance of medical assistance payments under the Medicaid program. The provider acknowledges and agrees that the payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to the provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments.

4. Acceptance of Funds. The provider agrees that evidence of credit to the proper account by the payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the Medicaid program within the meaning of the Official Code of Georgia Annotated, Section 49-4-146.1(b)(2). The provider certifies by such acceptance that the provider presented the claims for the services shown on the Remittance Advice issued by DCH, and that the services were rendered by or under the supervision of the provider. The provider understands that payment will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

5. Notice of Changes. The provider will notify DCH in writing at least 10 days in advance of any changes in payee, payee's name or address, or bank account name or number (supported by a bank letter or voided check on the new account).

6. Alternate Payment Methods. For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), DCH may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by DCH. Payment by check will be made to the address for payments on record with DCH.

7. Incorporated Document. This Electronic Funds Transfer Agreement is incorporated into the Statement of Participation and shall not modify or eliminate any provision of the Statement of Participation (including applicable policy and procedures manuals of DCH) except as specifically provided herein.

8. Expiration or Termination of EFT. Violation of these terms may cause termination by DCH of EFT and/or the Statement of Participation. Expiration or termination of the Statement of Participation for any reason will terminate EFT automatically. DCH will give written notice of termination to the provider.

**Provider Name:** Monroe HMA Inc d/b/a Walton Regional Medical Center

**Payee Name:** Monroe HMA Inc d/b/a Walton Regional Medical Center

**Provider Medicaid Number:** 000206774

**Bank Receiving Deposit:** The National Bank of Walton County

**Bank Routing and Transit No.:** [redacted]
(Nine digit code assigned by the American Bankers Association)

**Provider Bank Account No.:** [redacted]
(Maximum 17 digits)

**Provider's Signature or Signature of Authorized Representative of Provider**

**Title** CEO

DMA-006
Rev. 04/03

[redacted]