

Exhibit A
PROVIDER INVESTMENT

I.	ANNUAL SERVICE FEE	PROVIDER
	A. FIRST YEAR	\$00.00
	B. SUBSEQUENT YEARS	\$99.00
II.	APPLICATION FEE	
	A. ESTABLISH CONNECTION AND MAPPING	\$00.00
III.	PER TRANSACTIONS	
	A. BATCH TRANSACTIONS – FLAT RATE	
	1. CLAIMS	
	A. COMMERCIAL	
	B. STATE PAYERS (Medicare, Medicaid, Blue Shield)	\$99.00 per month per provider
	C. PRINT & MAIL	\$.50

MINIMUM REQUIREMENT FEE:

**IF PROVIDER IS SENDING LESS THAN \$10.00 A MONTH OF
*QUALIFYING CLAIMS, AN AUTOMATIC CHARGE OF \$10.00 WILL BE ASSESSED. THIS FEE WILL
NOT BE ADDED TO THE CLAIMS PER TRANSACTION FEE SENT DURING ANY PARTICULAR MONTH.
THE PROVIDER’S CHARGE FOR ANY PARTICULAR MONTH WILL THEN BE ONLY THE \$10.00**

***QUALIFYING CLAIMS ARE ALL CLAIMS SUBMITTED DURING ANY PARTICULAR MONTH.**

- VII. SYSTEM SUPPORT**
- **YEARLY UPGRADES AND REVISIONS OF THE BULLETING BOARD SERVICES (BBS).**
 - **TOLL FREE CLAIM SUBMISSION LINE FOR LONG DISTANCE CALLERS.**
 - **TOLL FREE CUSTOMER SUPPORT LINE FOR CLAIM QUESTIONS.**

- VIII. NOTES**
- **QHA RESERVES THE RIGHT TO CORRECT ANY MISTAKES MADE IN THE PREPARATION OF THIS CONTRACT.**
 - **THIS CONTRACT DOES NOT INCLUDE APPLICABLE SALES TAX OR FREIGHT ON ITEMS SUBJECT TO SUCH.**
 - **ALL PRICES ARE SUBJECT TO CHANGE UPON THIRTY (30) DAYS WRITTEN NOTICE BY EITHER PARTY.**

**By signing below, the parties agree to all of the terms and conditions set forth above.
This contract is not valid until signed by an authorized QHA representative.**

Provider

Quantum Health Automation

Name: _____
Signature: _____
Title: _____
Date: _____

Name: _____
Signature: _____
Title: _____
Date: _____