



**Physician Participation Agreement (Form B)**

The Kaleida Health Bundled Payment Shared Savings Program is intended to incentivize Practitioners to participate in the quality metrics identified below, in order to improve the quality, patient experience, and cost-effectiveness of care provided to applicable Medicare beneficiaries.

Quality metrics include:

1. Patient Satisfaction Scores (HCAHPS composite score for physician communication)
2. Quality (% 30 day readmission rates)
3. Patient Education Class Attendance (% of physician’s patients attending)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
NYS License #

**The following information is needed to make incentive payments to you, if you are eligible for such payments. Please indicate to whom any earned incentive payments shall be made payable, and where such payments should be sent. FAILURE TO COMPLETE THE FORM MAY RESULT IN A DELAY IN PAYMENT.**

I WOULD LIKE MY INCENTIVE PAYMENT TO BE MADE PAYABLE TO:

*(\*Please note—PAYEE and Tax ID# MUST match exactly)*

MY GROUP—TAX ID # (GROUP): \_\_\_\_\_

I WOULD LIKE MY INCENTIVE PAYMENT TO BE SENT TO THIS ADDRESS:

Name of Group \_\_\_\_\_

Group Address \_\_\_\_\_

Group City/State/Zip \_\_\_\_\_

**Physician Signature (required):** \_\_\_\_\_

**Date (required):** \_\_\_\_\_

**Email address (required):** \_\_\_\_\_

Please return completed Enrollment form to:

Patricia L. Vorpahl, VP Physician Services  
Larkin Building 726 Exchange Street, Suite 215  
Buffalo, New York 14210 Telephone: 716.859.8060  
Email: [pvorpahl@kaleidahealth.org](mailto:pvorpahl@kaleidahealth.org).

**For questions, contact:**  
Brian Meade, Sr. Director Utiliz. Mngt.  
Telephone: 716.859.7262  
Email: [Bmeade@kaleidahealth.org](mailto:Bmeade@kaleidahealth.org)