Managed billing

Managed billing credentialing guarantee: terms

If we do not get an eligible provider credentialed with their first commercial payer within 60 days, we pay you $200. These terms set out exactly what that means, who qualifies, when the clock runs, and how to claim.

Last updated June 2026.

1. Definitions

In these terms, the following words have the meanings set out below.

Credentialed

A provider is "credentialed" when their **first commercial payer approves enrollment**, meaning the point at which that payer has accepted the provider into its network or panel so the provider can begin billing that payer for covered services. Credentialing is measured by the first commercial payer approval, not by completion of paperwork, submission of an application, or approval by any later payer.

Commercial payer

A private, non-government health insurer or health plan. Government payers, including Medicare, Medicaid and Tricare, are not commercial payers and are excluded from this guarantee (see section 5).

Complete information packet

All information, documents, signatures and authorizations we request from the practice to begin and submit a credentialing application, provided accurately and in full. This typically includes provider identifiers (such as NPI), licensure and certification details, practice and location details, CAQH access or completion, and any payer-specific forms or authorizations we request. The packet is "complete" only when we have everything we have asked for and the information is accurate.

Business day

A day from Monday to Friday, excluding United States federal public holidays.

We, us, Carepatron

Carepatron and its managed billing service. For credentialing, Carepatron acts as the practice's agent only. Applications are made under the practice's own NPI, and Carepatron is never a signatory to the practice's payer agreements or bank accounts.

You, the practice, the provider

The Carepatron customer enrolled in managed billing, and each individual provider within that practice for whom we are performing new credentialing.

2. The promise

If an eligible provider's first commercial payer is not approved within 60 days of the clock start (defined in section 3), we will pay you $200 for that provider, subject to the eligibility rules, responsiveness condition, scope and exclusions in these terms.

Payout form. The $200 is provided as an **account credit applied against your Carepatron managed billing bill**. It is not a cash payment or cheque.

3. When the 60-day clock starts

The 60-day period runs from the date we receive a **complete and correct information packet** from the practice for the relevant provider. It does **not** run from your signup date, your subscription start date, or the date you first asked us to begin credentialing.

If information in the packet turns out to be missing, incomplete or inaccurate, the time needed to put it right does not count toward the 60 days (see section 6). The clock only counts time when we have everything we need, complete and correct.

4. Eligibility

Managed billing, and this guarantee, are offered to **US-based practices only**. The guarantee applies to **new credentialing only**, meaning providers who are starting commercial payer credentialing with Carepatron.

It does not apply to, and the clock does not run for:

- Re-credentialing of a provider who is already credentialed with the payer.
- Revalidations.
- Enrollments already in progress, whether started by the practice, a prior billing provider, or any third party, before we began work.

5. Eligible payers

The guarantee and the 60-day clock apply to **commercial payers only**.

All government and government-sponsored payers are excluded from the clock and from any payout. This includes, for example, Medicare, Medicaid, Tricare, and VA or CHAMPVA programs. Their processing timelines are set by the payer and are outside anyone's control. We will still perform government payer enrollment where it is part of your managed billing service, but it is not covered by this guarantee.

6. Your responsibilities and responsiveness

For us to deliver inside 60 days, we need timely, accurate input from the practice. The 60-day clock therefore counts days in our control:

- The clock **pauses** any time we are waiting on the practice, for example for requested information, documents, signatures, CAQH access or authorizations. It resumes only when we receive what we requested, complete and correct.
- You must return any item we request **complete and accurate within 7 business days**. An incomplete or incorrect submission does **not** satisfy this window: the clock remains paused until the missing or corrected information is received, and the days lost to correcting it are not counted against the 60 days.
- **Repeated failure** to provide complete and correct items within the window **voids the guarantee for the affected payer**.
- Information you provide must be accurate and current. Time lost to correcting inaccurate or incomplete information is not counted against the 60 days.

We will tell you what we need and when we are waiting on you, so the status of the clock is clear.

7. Amount and scope

- **$200 account credit per provider** whose first commercial payer is not approved within 60 days of the clock start.
- **No cap.** The guarantee applies to every eligible provider, with no limit on the number of providers covered or the total credit per practice.
- **One claim per provider.** The guarantee can be claimed once per eligible provider, for that provider's first commercial payer. It does not apply to additional or subsequent payers for the same provider.

The $200 account credit is your sole and exclusive remedy for a missed 60-day credentialing timeline.

8. Exclusions

The guarantee does not apply, and no payout is due, where the delay is outside our control or otherwise falls into the cases below. This includes:

- Payer backlogs, payer processing delays, payer audits, or any timeline set by the payer.
- Delays caused by the practice or provider, including late, incomplete or inaccurate information, missed signatures, or failure to respond within the window in section 6.
- Provider sanctions, licensure issues, disciplinary history, or other provider-specific factors affecting approval.
- Government payers (Medicare, Medicaid, Tricare), which are excluded from the clock under section 5.
- Re-credentialing, revalidations, and enrollments already in progress, which are excluded under section 4.
- Events outside our reasonable control, including outages of payer or CAQH systems, public health emergencies, or other force majeure events.

For clarity, the following are **out of scope** of managed billing and are never covered by this guarantee:

- Prior authorization.
- CPT or ICD code selection.
- Workers compensation, auto, or personal injury billing.
- Aged accounts receivable over 90 days.
- Payer rate negotiation.

Nothing in these terms is a promise of any approval timeline beyond the conditioned scope set out here. We do not guarantee that any payer will approve a provider.

9. How to claim and when it is paid

If an eligible provider's first commercial payer is not approved within the 60-day period (excluding any paused days under section 6), you can claim the $200 for that provider.

- **How to claim.** Contact your Carepatron managed billing team with the practice and provider details.
- **What we check.** We confirm the provider was eligible, the clock start date, the paused days, and that none of the exclusions in section 8 apply.
- **When it is paid.** Approved claims are applied as an account credit within 30 days of approval.

We may ask for reasonable information to verify a claim.

10. General

- **Changes to the offer.** We may modify or withdraw this guarantee at any time on a prospective basis. Changes do not affect eligible providers whose clock had already started under the version of these terms in effect at that time.
- **Governing law.** Managed billing is offered to US-based practices only. These terms are governed by the same law as your Carepatron managed billing agreement.
- **Void where prohibited.** This offer is void where prohibited or restricted by law.
- **Relationship to your agreement.** These terms are part of, and read together with, your Carepatron managed billing agreement. If there is any conflict between these terms and that agreement, the managed billing agreement prevails.
- **No agency for payer or bank relationships.** Payments from payers land in the practice's own bank account. Carepatron invoices its fee separately and is never a signatory to your payer agreements or bank accounts.