Quartz

GUNDERSEN HEALTH PLAN
A QUARTZ AFFILIATE

Physicians Plus
A QUARTZ AFFILIATE

Unity Health Insurance
A QUARTZ AFFILIATE

PROVIDER PARTICIPATION REQUEST FORM

Thank you for your interest in becoming a participating provider with Quartz. Your request will be evaluated for participation in all Quartz affiliate networks. In order to expedite the processing of your application, please do the following:

1. Complete the application in full. Please print clearly or fill out electronically and attach any additional information or brochures that may help in our evaluation of your facility and the services you provide.

2. Attach a copy of your W-9 form and provide the requested information specific to all facilities, practitioners and services (a W-9 form is attached for your convenience).

3. If applicable, provide: 1) evidence that you are Medicare and Medicaid eligible; and 2) evidence of licensure to operate according to State and Federal regulations.

PLEASE RETURN VIA:

E-mail: providercommunications@quartzbenefits.com

Facsimile: (608) 643-2564

Mail: **Quartz Health Solutions, Inc.**
Attn: Provider Relations Dept.
840 Carolina Street
Sauk City, WI 53583

SECTION I: BILLING INFORMATION *Please verify **all** information and complete **all** blank areas. Enter **N/A** if not applicable.*			
Legal Entity Name: ***(include d/b/a if applicable)***			
Ownership Type: ***(Sole Proprietor, LLC, SC, etc.)***		**Tax ID Number:**	
Mailing Street Address:			
Mailing City, State, Zip:			
Billing Address:			
Billing City, State, Zip:			
Phone Number:		**2nd Phone Number:**	
Fax Number:		**Website URL:**	

SECTION II: GENERAL INFORMATION *Please verify **all** information and complete **all** blank areas. Enter **N/A** if not applicable*	
Have you ever applied for or had a contract with Unity Health Plans Insurance Corporation, Quartz Health Solutions, Inc. (f/k/a SPWI TPA, Inc.), Gundersen Health Plan, Inc., Gundersen Health Plan Minnesota, or Physicians Plus Insurance Corporation?	☐ **Yes** ☐ **No**
If yes, under what name or group?	
Covered Service Area (City and Counties):	
Please list any Quartz network providers that currently refer to your office: (Gundersen/PPIC/Unity)	
Please provide a brief description regarding your facility and the services you currently provide:	
Does your facility have a restraint policy regarding patient restraints?	☐ **Yes** ☐ **No**
Is public transportation accessible to and from your facility?	☐ **Yes** ☐ **No**
Does your facility accommodate for people with physical disabilities (including exam rooms and equipment)?	☐ **Yes** ☐ **No**
Does your organization allow mid-level practitioners (e.g. nurse practitioners and/or physicians assistants) to be selected by patients as a Primary Care Physician? **Comments:**	☐ **Yes** ☐ **No**

SECTION III: CONTACT INFORMATION *Please verify **all** information and complete **all** blank areas. Enter **N/A** if not applicable*				
Contact Type	**Contact Name/Title (First and Last Name)**	**Phone Number**	**E-mail Address**	**Preferred Contact Method**
Primary Contact:				☐ Phone ☐ E-mail
Contract Signature:				☐ Phone ☐ E-mail
Agreement Notification:				☐ Phone ☐ E-mail
Billing:				☐ Phone ☐ E-mail
Provider Manual:				☐ Phone ☐ E-mail
Provider Updates/CMS Verifications:				☐ Phone ☐ E-mail
Compliance Representative				☐ Phone ☐ E-mail

SECTION IV: BEHAVIORAL HEALTH PROVIDER INFORMATION

Please complete the following if you are applying to join our network as a behavioral health provider.

A. Practice Type

	Group
	Individual

B. For Group Practice

1.	Does the practice have a Psychiatrist consulting on staff or referral arrangements with a Psychiatrist at another location?		Yes		No
2.	What are these arrangements and if there aren't any, what are the means for getting patients psychiatric care?				

C. Provider Information

Name	Degree	License

D. After Hours/Emergency Care and General Availability

Please describe your process for handling calls after hours for urgent and emergent patient situations:	
Number of hours/week in practice?	
Hours available (include evening/weekend hours):	

E. Treatment Information

Area(s) of specialization/interest (include special populations):	
Conditions treated:	
Methods/approaches used in treatment:	

F. Other Information

SECTION V: FACILITY CREDENTIALING FORM

Please update and/or verify the below information and complete columns to the right of each section.

License/Accrediting Body	Indicate Yes, No or N/A	Number	Effective Date	Expiration Date
Facility State License	Yes ❒ No ❒ N/A ❒			
Medicare Certification	Yes ❒ No ❒ N/A ❒			
Medicaid Certification	Yes ❒ No ❒ N/A ❒			
The Joint Commission	Yes ❒ No ❒ N/A ❒			
AAAHC - Accreditation Association for Ambulatory Health Care	Yes ❒ No ❒ N/A ❒			
AAAASF - American Association for Accreditation of Ambulatory Surgical Facilities	Yes ❒ No ❒ N/A ❒			
ACHC - Accreditation Commission for Health Care	Yes ❒ No ❒ N/A ❒			
CARF - Commission on Accreditation of Rehabilitation Facilities	Yes ❒ No ❒ N/A ❒			
CHAP - Community Health Accreditation Program	Yes ❒ No ❒ N/A ❒			
COA - Council on Accreditation	Yes ❒ No ❒ N/A ❒			
DNV Healthcare - Det Norske Veritas Healthcare, Inc.	Yes ❒ No ❒ N/A ❒			
HFAP - Healthcare Facilities Accreditation Program	Yes ❒ No ❒ N/A ❒			

***Please attach copies of the following documents*:**

❒ Copy of the facility's state license
❒ Most recent State/CMS survey results and the cover letter stating acceptance of the plan of correction, if applicable
❒ Explanation regarding any loss or change of certification or accreditation status within the past three years.

For facilities without accreditation, Quartz Health Solutions, Inc. reserves the right to conduct an on-site visit of your facility.

SECTION VI: SERVICES

Please review each service listed and indicate the services provided by your facility.

BEHAVIORAL HEALTH SERVICES		BILLING NPI
☐	Mental Illness Adult– Inpatient Treatment	
☐	Mental Illness Child/Adolescent–Inpatient Treatment	
☐	Mental Illness Adult – Outpatient Treatment	
☐	Mental Illness Child/Adolescent – Outpatient Treatment	
☐	AODA Adult – Inpatient Treatment	
☐	AODA Adolescent – Inpatient Treatment	
☐	AODA Adult – Outpatient Treatment	
☐	AODA Adolescent – Outpatient Treatment	
☐	Other:	
EYE CLINICS SERVICES		**BILLING NPI**
☐	Ophthalmology Services	
☐	Optometry Services	
☐	Vision Care/Screening	
☐	Vision Supplies (Eye Glasses & Contacts)	
☐	Other:	
DIALYSIS		**BILLING NPI**
☐	Inpatient	
☐	Outpatient	
☐	Other:	
DURABLE MEDICAL EQUIPMENT SERVICES		**BILLING NPI**
☐	Apnea Monitors	
☐	BI-Pap	
☐	Bone Growth Stimulator	
☐	CPAP	
☐	DME/HME (standard wheelchair, hospital bed, etc.)	
☐	Oxygen Concentrator	
☐	Oxygen-Liquid	
☐	Photo Therapy	
☐	Respiratory DME	
☐	TENS Unit	
☐	Ventilators	
☐	Wound Vac	
☐	Other Specialty DME Items:	
HOME HEALTH SERVICES		**BILLING NPI**
☐	Durable Medical Equipment	
☐	Home Infusion	
☐	Home Health Services - Skilled	
☐	Home Health Services - Aid	
☐	Occupational Therapy	
☐	Physical Therapy	
☐	Speech Therapy	
☐	Other:	

NURSING HOME SERVICES		BILLING NPI
☐	Skilled Nursing Services	
☐	Other:	
PATHOLOGY SERVICES		**BILLING NPI**
☐	Pathology Services (Professional)	
☐	Pathology Services (Technical)	
☐	Other:	
PODIATRIC SERVICES		**BILLING NPI**
☐	Radiology – Diagnostic & Therapeutic	
☐	Podiatric Services	
☐	Other:	
PROSTHETICS/ORTHOTICS SERVICES		**BILLING NPI**
☐	Mastectomy Supplies	
☐	Orthotic Supplies	
☐	Prosthetic Supplies	
☐	Other:	
RADIOLOGY SERVICES		**BILLING NPI**
☐	Bone Density Measurement	
☐	CT (Professional)	
☐	MRI (Professional)	
☐	MRI (Technical)	
☐	Nuclear Medicine	
☐	Nuclear Medicine (Professional)	
☐	Open MRI	
☐	Radiation Oncology	
☐	Radiation Therapy	
☐	Radiology – General Services (Technical)	
☐	Radiology Services – Diagnostic & Therapeutic	
☐	Radiology Services – Mammography	
☐	Ultrasound	
☐	Vascular and Interventional Radiology	
☐	Other:	
SPORTS MEDICINE SERVICES		**BILLING NPI**
☐	Durable Medical Equipment (Dispensed In-house)	
☐	Occupational Therapy (Outpatient)	
☐	Physical Therapy (Outpatient)	
☐	Orthotic Supplies	
☐	Prosthetic Supplies	
☐	Radiology – Diagnostic & Therapeutic (In-house)	
☐	Orthopedic Surgery (Adult)	
☐	Orthopedic Surgery (Pediatric)	
☐	Other:	
OTHER SERVICES		**BILLING NPI**
☐	Anti-Hemophiliac Factor	

☐	Anesthetists	
☐	ECG Interpretation	
☐	Insulin Pump Therapy	
☐	Cardiac Outpatient Telemetry	
☐	Specialty Clinic	
☐	Urgent Care Services	
☐	Other:	
CLINIC SERVICES		**BILLING NPI**
☐	Allergy Services	
☐	Audiology – Hearing Screening	
☐	Audiology – Hearing Aids	
	Behavioral Health:	
☐	• Mental Illness Adult – Outpatient Treatment	
☐	• Mental Illness Child/Adolescent – Outpatient Treatment	
☐	• Alcoholism/Chemical Dependency Adult – Outpatient Treatment	
☐	• Alcoholism/Chemical Dependency Adolescent – Outpatient Treatment	
☐	Cardiology Services	
☐	Dental Services	
☐	Dermatology Services	
☐	Durable Medical Equipment	
☐	Endocrinology Services	
☐	Eye Glasses & Contacts	
☐	Family Practice	
☐	Gastroenterology Services	
☐	Hematology/Oncology Services	
☐	Infectious Disease Services	
☐	Internal Medicine Services	
☐	Laboratory Services	
☐	Nephrology Services	
☐	Neurology Services	
☐	Neurosurgery	
☐	Obstetrics & Gynecology	
☐	Occupational Health Services	
☐	Occupational Therapy (Outpatient)	
☐	Ophthalmology Services	
☐	Optometry Services	
☐	Oral/Maxillofacial Surgery	
☐	Orthopedics Services	
☐	Otolaryngology (ENT)	
☐	Pediatric Services	
☐	Physical Medicine & Rehabilitation	
☐	Physical Therapy (Outpatient)	
☐	Plastic & Reconstructive Surgery - General	
☐	Podiatric Services	
☐	Orthotic Supplies	
☐	Prosthetic Supplies	
☐	Pulmonary Medicine Services	
☐	Radiation Therapy	

☐	Radiology Services – Diagnostic & Therapeutic	
☐	Radiology Services – Mammography	
☐	Renal Dialysis	
☐	Rheumatology Services	
☐	Speech Therapy	
☐	Sports Medicine Services	
☐	Surgery - Outpatient or Ambulatory	
☐	Urgent Care Services	
☐	Urology Services	
☐	Other:	
HOSPITAL SERVICES		**BILLING NPI**
☐	Acute Inpatient Hospital Care	
	Behavioral Health:	
☐	• Mental Illness Adult– Inpatient Treatment	
☐	• Mental Illness Child/Adolescent–Inpatient Treatment	
☐	• Mental Illness Adult – Outpatient Treatment	
☐	• Mental Illness Child/Adolescent – Outpatient Treatment	
☐	• Alcoholism/Chemical Dependency Adult – Inpatient Treatment	
☐	• Alcoholism/Chemical Dependency Adolescent – Inpatient Treatment	
☐	• Alcoholism/Chemical Dependency Adult – Outpatient Treatment	
☐	• Alcoholism/Chemical Dependency Adolescent – Outpatient Treatment	
☐	Cardiology Services	
☐	Cardiac Surgery Program	
☐	Cardiac Catheterization Services	
☐	Critical Care Services – Intensive Care Units (ICU)	
☐	Durable Medical Equipment	
☐	Emergency & Trauma Center	
☐	Endocrinology Services	
☐	Gastroenterology Services	
☐	Hematology/Oncology Services	
☐	Home Health	
☐	Infectious Disease Services	
☐	Laboratory Services	
☐	Neonatal Intensive Care Unit	
☐	Neurology Services	
☐	Neurosurgery	
☐	Occupational Health Services	
☐	Occupational Therapy (Inpatient)	
☐	Occupational Therapy (Outpatient)	
☐	Orthopedic Surgery (Adult)	
☐	Orthopedic Surgery (Pediatric)	
☐	Otolaryngology (ENT)	
☐	Outpatient Infusion/Chemotherapy	
☐	Pediatric Services	
☐	Physical Medicine & Rehabilitation	
☐	Physical Therapy (Inpatient)	
☐	Physical Therapy (Outpatient)	
☐	Plastic & Reconstructive Surgery - General	

☐	Pulmonary Medicine Services	
☐	Radiation Oncology Services	
☐	Radiology Services – Diagnostic & Therapeutic	
☐	Radiology Services - Mammography	
☐	Rheumatology Services	
☐	Speech Therapy (Outpatient)	
☐	Surgery – Outpatient or Ambulatory	
☐	Surgery (General)	
☐	**Transplant Program:**	
☐	• Heart Transplant	
☐	• Heart/Lung Transplant	
☐	• Kidney Transplant	
☐	• Liver Transplant	
☐	• Lung Transplant	
☐	• Pancreas Transplant	
☐	Swing Bed – (Skilled Nursing Services)	
☐	Urgent Care Services	
☐	Urology	
☐	Vascular Surgery	
☐	Other:	

SECTION VII: LANGUAGES

Please list below all languages spoken by the employees of your facility.

SECTION VIII: ATTESTATION

I hereby verify that the information provided herein is current, correct and complete as of the date of my signature below and that, at a minimum, the staff are legally and professionally qualified for the positions they hold and that there are no state or federal sanctions against this facility. As an administrative representative of this facility, I have the authority to sign on behalf of the organization.

Signature Title Date

QUARTZ CONTRACT IMPLEMENTATION FORM

Billing and Facility Information

Contact Information (for information regarding claims, address changes, and/or practitioner changes):

Contact Name:			
Contact Address:			
Contact Telephone Number:		Contact Fax Number:	
Contact Email Address:			

Credentialing Recipient:

Contact Name:			
Contact Address:			
Contact Telephone Number:		Contact Fax Number:	
Contact Email Address:			

Service Site Locations:

1.	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:	Phone Number:			Fax Number:			
	Clinic National Provider Identification (NPI) Number:							
	Billing National Provider Identification (NPI) Number:							
	Swing Bed Facility? ☐ Yes ☐ No		Essential Community Provider Type:					
	Total # of Beds:		☐	Federally Qualified Health Center Provider		☐	Ryan White Provider	
	# of Certified Medicare Beds:		☐	Indian Health Provider		☐	Other ECP Provider	
	# of ICU/CCU Beds:		☐	Family Planning Provider		☐	Hospital Provider	
	On Call/After Hours Coverage? ☐ Yes ☐ No		Regular Office Hours:					

2.	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:	Phone Number:			Fax Number:			
	Clinic National Provider Identification (NPI) Number:							
	Billing National Provider Identification (NPI) Number:							
	Swing Bed Facility? ☐ Yes ☐ No		Essential Community Provider Type:					
	Total # of Beds:		☐	Federally Qualified Health Center Provider		☐	Ryan White Provider	
	# of Certified Medicare Beds:		☐	Indian Health Provider		☐	Other ECP Provider	
	# of ICU/CCU Beds:		☐	Family Planning Provider		☐	Hospital Provider	
	On Call/After Hours Coverage? ☐ Yes ☐ No		Regular Office Hours:					

QUARTZ CONTRACT IMPLEMENTATION FORM

Billing and Facility Information

Service Site Locations Cont'd:

3.	Location/Clinic:									
	Street Address:			City:		State:		Zip + 4:		
	Billing Address:			City:		State:		Zip + 4:		
	County:		Phone Number:			Fax Number:				
	Clinic National Provider Identification (NPI) Number:									
	Billing National Provider Identification (NPI) Number:									
	Swing Bed Facility?	☐ Yes ☐ No		Essential Community Provider Type:						
	Total # of Beds:			☐	Federally Qualified Health Center Provider		☐	Ryan White Provider		
	# of Certified Medicare Beds:			☐	Indian Health Provider		☐	Other ECP Provider		
	# of ICU/CCU Beds:			☐	Family Planning Provider		☐	Hospital Provider		
	On Call/After Hours Coverage? ☐ Yes ☐ No			Regular Office Hours:						

4.	Location/Clinic:									
	Street Address:			City:		State:		Zip + 4:		
	Billing Address:			City:		State:		Zip + 4:		
	County:		Phone Number:			Fax Number:				
	Clinic National Provider Identification (NPI) Number:									
	Billing National Provider Identification (NPI) Number:									
	Swing Bed Facility?	☐ Yes ☐ No		Essential Community Provider Type:						
	Total # of Beds:			☐	Federally Qualified Health Center Provider		☐	Ryan White Provider		
	# of Certified Medicare Beds:			☐	Indian Health Provider		☐	Other ECP Provider		
	# of ICU/CCU Beds:			☐	Family Planning Provider		☐	Hospital Provider		
	On Call/After Hours Coverage? ☐ Yes ☐ No			Regular Office Hours:						

5.	Location/Clinic:									
	Street Address:			City:		State:		Zip + 4:		
	Billing Address:			City:		State:		Zip + 4:		
	County:		Phone Number:			Fax Number:				
	Clinic National Provider Identification (NPI) Number:									
	Billing National Provider Identification (NPI) Number:									
	Swing Bed Facility?	☐ Yes ☐ No		Essential Community Provider Type:						
	Total # of Beds:			☐	Federally Qualified Health Center Provider		☐	Ryan White Provider		
	# of Certified Medicare Beds:			☐	Indian Health Provider		☐	Other ECP Provider		
	# of ICU/CCU Beds:			☐	Family Planning Provider		☐	Hospital Provider		
	On Call/After Hours Coverage? ☐ Yes ☐ No			Regular Office Hours:						

QUARTZ CONTRACT IMPLEMENTATION FORM

Practitioner Information

Practitioner Name (First, MI, Last):				DOB:	
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No		Taxonomy:	
Has Practitioner completed Cultural Competency Training?	☐ Yes ☐ No	Practitioner E-mail:			
Available for patients to choose as their PCP? ☐ Yes ☐ No			Is this provider employed by your organization? ☐ Yes ☐ No		
Gender:	☐ Male ☐ Female	Area(s) of Specialty:			
Race:	☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:				
In-Training/Non-Licensed?	☐ Yes ☐ No	Languages Spoken:		American Sign Language: ☐ Yes ☐ No	
Credentials/Degree:		Please List Hospital Affiliations:			
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No		
Medicaid #:		Certified? ☐ Yes ☐ No			
Comments:					

Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:

Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

Practitioner Name (First, MI, Last):				DOB:	
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No		Taxonomy:	
Has Practitioner completed Cultural Competency Training?	☐ Yes ☐ No	Practitioner E-mail:			
Available for patients to choose as their PCP? ☐ Yes ☐ No		Is this provider employed by your organization? ☐ Yes ☐ No			
Gender:	☐ Male ☐ Female	Area(s) of Specialty:			
Race:	☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:				
Credentials/Degree:		Languages Spoken:		American Sign Language: ☐ Yes ☐ No	
In-Training/Non-Licensed? ☐ Yes ☐ No		Please List Hospital Affiliations:			
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No		
Medicaid #:		Certified? ☐ Yes ☐ No			
Comments:					

Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:

Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

Quartz Provider Participation Request Form

Practitioner Name (First, MI, Last):		DOB:	
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No	Taxonomy:
Has Practitioner completed Cultural Competency Training? ☐ Yes ☐ No		Practitioner E-mail:	
Available for patients to choose as their PCP? ☐ Yes ☐ No		Is this provider employed by your organization? ☐ Yes ☐ No	
Gender: ☐ Male ☐ Female	Area(s) of Specialty:		
Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:			
Credentials/Degree:	Languages Spoken:	American Sign Language: ☐ Yes ☐ No	
In-Training/Non-Licensed? ☐ Yes ☐ No	Please List Hospital Affiliations:		
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No
Medicaid #:		Certified? ☐ Yes ☐ No	
Comments:			

Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:

Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

Practitioner Name (First, MI, Last):		DOB:	
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No	Taxonomy:
Has Practitioner completed Cultural Competency Training? ☐ Yes ☐ No		Practitioner E-mail:	
Available for patients to choose as their PCP? ☐ Yes ☐ No		Is this provider employed by your organization? ☐ Yes ☐ No	
Gender: ☐ Male ☐ Female	Area(s) of Specialty:		
Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:			
Credentials/Degree:	Languages Spoken:	American Sign Language: ☐ Yes ☐ No	
In-Training/Non-Licensed? ☐ Yes ☐ No	Please List Hospital Affiliations:		
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No
Medicaid #:		Certified? ☐ Yes ☐ No	
Comments:			

Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:

Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

**This page may be copied if you have additional practitioner information to provide.*

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.