

Credentialing Application Packet Instructions

In support of Washington State Senate Bill 5346 (An act relating to establishing streamlined and uniform administrative services for payors and providers) Coordinated Care requires communication of provider data materials using one of the two centralized single source to enter your provider data for purposes of credentialing:

- OneHealthPort (OHP) hosts the [ProviderSource](#)
- Council for Affordable Quality Healthcare ([CAQH](#))

Note: You will only see Coordinated Care listed after you are logged into your application.

This service is free to Practitioners entering their data. When you use this service to complete the [Washington Practitioner Application](#), please upload images of the documents identified below (Practitioner/Group). All other types (Ancillary/Clinic/Hospital) must supply documents separately with the appropriate application.

<input type="checkbox"/> Practitioner/Group	<input type="checkbox"/> Ancillary/Clinic	<input type="checkbox"/> Hospital
<input type="checkbox"/> Washington Practitioners Application Authorization and Release of Information (Signed and dated within the last 120 days from submission) <input type="checkbox"/> W-9 for each unique Tax ID <input type="checkbox"/> Provider Data Form (single practitioner) or Completed Roster (multiple practitioners) <input type="checkbox"/> Disclosure of Ownership and Control Interest Statement (Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individual practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls.) <input type="checkbox"/> NPI matches NPPES and NPIs used on the app are consistent throughout Documents to upload to CAQH or OHP: <input type="checkbox"/> Copy of Declaration Page of Professional Policy <input type="checkbox"/> Copy DEA Controlled Substance Registration (Current Year) <input type="checkbox"/> Board Certification Certificate (If applicable) <input type="checkbox"/> Education Certificate for Foreign Medical Graduates - ECFMG (If applicable)	<input type="checkbox"/> Hospital/Facility Provider Credentialing Application (one per Facility/Clinic/Ancillary Provider) <input type="checkbox"/> W-9 for each unique Tax ID <input type="checkbox"/> Disclosure of Ownership and Control Interest Statement (Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individual practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls.) <input type="checkbox"/> Copy of State Operational License <input type="checkbox"/> Other applicable State/Federal/Licensures (i.e. CLIA, DEA, Pharmacy, or Department of Health) <input type="checkbox"/> Copy of Accreditation/certification (by a nationally-recognized accrediting body, i.e. TJC/JCAHO) If not accredited by a nationally-recognized body, Site Evaluation Results by a government agency. <input type="checkbox"/> Copy of Current General Liability coverage (document showing the amounts and dates of coverage) <input type="checkbox"/> Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation) <input type="checkbox"/> NPI matches NPPES and NPIs used on the app are consistent throughout <input type="checkbox"/> Completed Practitioner/Location Roster	<input type="checkbox"/> Hospital/Facility Provider Credentialing Application (one per Hospital Provider) <input type="checkbox"/> W-9 for each unique Tax ID <input type="checkbox"/> Disclosure of Ownership and Control Interest Statement (Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individual practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls.) <input type="checkbox"/> Copy of State Operational License <input type="checkbox"/> Other applicable State/Federal/Licensures (i.e. CLIA, DEA, Pharmacy, or Department of Health) <input type="checkbox"/> Copy of Accreditation/certification (by a nationally-recognized accrediting body, i.e. TJC/JCAHO) If not accredited by a nationally-recognized body, Site Evaluation Results by a government agency. <input type="checkbox"/> Copy of Current General Liability coverage (document showing the amounts and dates of coverage) <input type="checkbox"/> Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation) <input type="checkbox"/> NPI matches NPPES and NPIs used on the app are consistent throughout <input type="checkbox"/> Completed Practitioner/Location Roster

Note: If you have already completed your application with CAQH or Provider Source, please ensure that you have authorized Coordinated Care to access your data. This can be done by calling CAQH at (888) 599-1771 or by logging into your account and adding Coordinated Care to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Coordinated Care. Please submit this and all documents via email as follows (unless otherwise instructed):

- For additions to existing contracts: CONTRACTING@coordinatedcarehealth.com
- For new contracts: CONTRACTING@coordinatedcarehealth.com

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.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
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 the "Name" line to avoid backup withholding. For individuals, this is 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.

Social security number									

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

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 ▶
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General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity,
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust, and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* on page 1.

What is FATCA reporting? The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulation section 301.7701-2(c)(2)(iii). Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Note. Check the appropriate box for the U.S. federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the U.S. federal tax classification in the space provided. If you are an LLC that is treated as a partnership for U.S. federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation, as appropriate. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for U.S. federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required U.S. federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the *Exemptions* box, any code(s) that may apply to you. See *Exempt payee code* and *Exemption from FATCA reporting code* on page 3.

Exempt payee code. Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding:

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5 ²
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

- A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B—The United States or any of its agencies or instrumentalities
- C—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
- D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)
- E—A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)
- F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

- G—A real estate investment trust
- H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I—A common trust fund as defined in section 584(a)
- J—A bank as defined in section 581
- K—A broker
- L—A trust exempt from tax under section 664 or described in section 4947(a)(1)
- M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Coordinated Care within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity	
Name of Individual, Group Practice, or Disclosing Entity:	
DBA Name:	
Address:	
Federal Tax Identification Number:	Provider CAQH #:

Section I

<p><u>For individuals</u>, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.</p> <p><u>For entities</u>, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)</p>			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

<p>Are any of the individuals listed above related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)</p>	
Names	Type of relation

Section III

<p>Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)</p>			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)



Disclosure of Ownership And Control Interest Statement

Section IV

Has any person (individual or entity) who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? Yes No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors? Yes No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information above) as a Disclosing Entity? Yes No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature

Title (or indicate if authorized Agent)

Name (please print)

Date



Disclosure of Ownership And Control Interest Statement

Please return the completed form by fax to 1-877-644-4602, by email to contracting@coordinatedcarehealth.com or by mail to:

Coordinated Care
Attention: Provider Contracting
1145 Broadway, Suite 300
Tacoma, WA 98402

Hospital/Facility Provider Application

Instructions: In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each Legal Entity/TIN.
3. The Application must be signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. The original application with attachments should be attached to the Provider Agreement.
6. Fill-in the Tax ID# at the bottom of every page for reference purposes.

Attach the following to the completed application:

- State Operational License
- Other applicable State/Federal Licensures (e.g., CLIA, DEA, Pharmacy or Department of Health)
- Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO)
- If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency
- W-9
- Ownership and Disclosure Form
- For Medicare/Medicaid Plans (MMP), attach the MMP Directory Requirements form
- Other applicable State/Federal Licensures (See last page for list of state-required documents)

Initial Credentialing/ Assessment
 Re-Credentialing/ Re-Assessment
 Addition of new site to current contract

Legal Entity/TIN: _____

This application applies to the following **Provider Types:** (Choose all that apply)

<input type="checkbox"/> Adult Day Care Center; NPI:	<input type="checkbox"/> Clinic – Indian Health Center (IHC); NPI:	<input type="checkbox"/> Hospice; NPI:
<input type="checkbox"/> Adult Living Facility/Assisted Living Facility; NPI:	<input type="checkbox"/> Clinic – Rural Health Clinic (RHC); NPI:	<input type="checkbox"/> Hospital; NPI:
<input type="checkbox"/> Agency (Dept. of Health, State Health); NPI:	<input type="checkbox"/> Diagnostic Imaging Center; NPI:	<input type="checkbox"/> Skilled Nursing Facility; NPI:
<input type="checkbox"/> Ambulance; NPI:	<input type="checkbox"/> Dialysis; NPI:	<input type="checkbox"/> Skilled Nursing Facility; NPI:
<input type="checkbox"/> Assisted Long-Term Care Facility; NPI:	<input type="checkbox"/> Durable Medical Equipment; NPI:	<input type="checkbox"/> Surgical Center; NPI:
<input type="checkbox"/> Board of Health; NPI:	<input type="checkbox"/> Home & Community Based Services (HCBS); NPI:	<input type="checkbox"/> Urgent Care (Attached to Hospital); NPI:
<input type="checkbox"/> Clinic –Federally Qualified Health Center (FQHC); NPI:	<input type="checkbox"/> Home Health Agency; NPI:	<input type="checkbox"/> Urgent Care (Free Standing); NPI:

Contact Information:

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

Legal Entity Information (Name on Income Tax Return)

Tax ID Holder Name:	Federal Tax ID Number:
Legal/Tax Address (where you want the 1099 sent):	

Insurance Information

Carrier:	Amount of Coverage:	Dates:
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Billing Information

Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to:	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

Note: Each Provider Type/NPI listed on in the Provider Type Grid on Page 1, must have one service location.

Tax ID Number: _____

Complete for each Service Location that is part of this application. .

Service Location 1 of _____							
Group or Facility Name (to be displayed in the Directory)							
Tax ID Number: <input type="checkbox"/> Same as Legal Entity			Provider Type:			National Provider ID # (NPI):	
State License Number:			Medicaid Number:			Medicare Number:	
Service Location Address: <input type="checkbox"/> Same as Legal Entity							
Physical Street Address:			City, State, Zip:			County	
Main Switchboard Phone Number:			Service Location Fax Number			Email:	
Service Location Office Hours:							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5							
Service Location Handicap Access? <input type="checkbox"/> Yes <input type="checkbox"/> No		Service Location Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			ADA Compliant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list any Foreign Languages spoken at this location:							
Is your practice limited to certain ages? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If Yes, specify age restrictions:							
<input type="checkbox"/> None <input type="checkbox"/> 0-2 years <input type="checkbox"/> 0-12 years <input type="checkbox"/> 0-17 years <input type="checkbox"/> 0-20 years <input type="checkbox"/> 13+ years <input type="checkbox"/> Other _____ <input type="checkbox"/> 13-17 years <input type="checkbox"/> 13-20 years <input type="checkbox"/> 3+ years <input type="checkbox"/> 17+ years <input type="checkbox"/> 21+ years <input type="checkbox"/> 65+ years _____							
Billing Information for Service Location 1 of _____ :							
<input type="checkbox"/> Same as indicated on Page 2 (If different, complete below)							
Pay To Name (Issue check to): Note: May be different than name on the 1099.							
Pay To Address (Send remittance to):			City, State, Zip:			Phone Number:	
Billing Contact Name:			Billing Contact Email:			Fax Number:	
Insurance Information for Service Location 1 of _____ :							
<input type="checkbox"/> Same as indicated on Page 2 (If different, complete below)							
Carrier:			Amount of Coverage:			Dates:	

Tax ID Number: _____

Service Location 1 of _____ - Accreditation/Certification Type

Same as Legal Entity

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (AHCH)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 1 of _____ – Sanctions

Same as Legal Entity

If yes, to any question below, please explain on a separate sheet of paper.

Have there been any settled malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has an officer of your Organization ever been convicted of, pled guilty to, or pled “no lo contendere” to any felony including an act of violence, child abuse, or a sexual offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tax ID Number: _____

Complete for each Service Location that is part of this application. (Make additional copies as needed)

Additional Service Locations

Service Location _____ of _____							
Group or Facility Name (to be displayed in the Directory)							
Tax ID Number: <input type="checkbox"/> Same as Legal Entity			Provider Type:			National Provider ID # (NPI):	
State License Number:			Medicaid Number:			Medicare Number:	
Service Location Address: <input type="checkbox"/> Same as Legal Entity							
Physical Street Address:				City, State, Zip:		County	
Main Switchboard Phone Number:			Service Location Fax Number			Email:	
Service Location Office Hours:							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5							
Service Location Handicap Access? <input type="checkbox"/> Yes <input type="checkbox"/> No			Service Location Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			ADA Compliant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list any Foreign Languages spoken at this location:							
Is your practice limited to certain ages? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If Yes, specify age restrictions:							
<input type="checkbox"/> None <input type="checkbox"/> 0-2 years <input type="checkbox"/> 0-12 years <input type="checkbox"/> 0-17 years <input type="checkbox"/> 0-20 years <input type="checkbox"/> 13+ years <input type="checkbox"/> Other _____ <input type="checkbox"/> 13-17 years <input type="checkbox"/> 13-20 years <input type="checkbox"/> 3+ years <input type="checkbox"/> 17+ years <input type="checkbox"/> 21+ years <input type="checkbox"/> 65+ years _____							
Billing Information for Service Location _____ of _____:							
<input type="checkbox"/> Same as indicated on Page 2 (If different, complete below)							
Pay To Name (Issue check to): Note: May be different than name on the 1099.							
Pay To Address (Send remittance to):			City, State, Zip:			Phone Number:	
Billing Contact Name:			Billing Contact Email:			Fax Number:	
Insurance Information for Service Location _____ of _____:							
<input type="checkbox"/> Same as indicated on Page 2 (If different, complete below)							
Carrier:			Amount of Coverage:			Dates:	

Tax ID Number: _____

Additional Service Locations (continued) (Make additional copies as needed)

Service Location _____ of _____ - Accreditation/Certification Type

Same as Legal Entity

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (AHCH)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location _____ of _____ – Sanctions

Same as Legal Entity

If yes, to any question below, please explain on a separate sheet of paper.

Have there been any settled malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has an officer of your Organization ever been convicted of, pled guilty to, or pled “no lo contendere” to any felony including an act of violence, child abuse, or a sexual offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tax ID Number: _____

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current **Health Plan Name** provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to **Health Plan Name** Credentials Committee for their review and approval, and, absent such affirmative approval, **Health Plan Name** members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from **Health Plan Name**. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying **Health Plan Name** in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy **Health Plan Name** credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: _____ **Date:** _____
Print or type name

Signature of Provider or Authorizing Representative **Title**
A stamp signature is not acceptable

Tax ID Number: _____