PacificSource HEALTH PLANS

Provider Information Request

The information provided on this form is required for claims processing and directory information.
Please use additional forms for additional practice locations or practitioners/organizations.

☐ Credential New Provider ☐ Add Provider to Group ☐ Change Information ☐ Add Provider to Hospital-based Location[1]

CAQH # _____ ☐ Termination Date: ___ / ___ / ___ Reason: _____

Effective date at your organization Date: ___ / ___ / ___
Usually, PacificSource will assign the effective date of this change as the first of the month following notification for providers who are already in-network.

1. Provider Information (name as shown on CMS 1500 Field 31 OR UB box 1)

☐ Individual Practitioner ☐ Organizational Provider ☐ PCP ☐ Specialist

Name _____

NPI _____ Degree _____ Birth Date _____ ☐ Male ☐ Female

License No. _____ DEA No. _____

2. Practice Location Information (for patient visits and directory listing)

Practice Name (as it should appear in directories) _____

Address _____ City _____ State ____ Zip _____ County _____

Practitioner Specialty (as practicing at this location) _____

List this location in directories? Note: Hospital-based locations will not be listed. ☐ Yes ☐ No

Location NPI: _____ Tax ID No. (Attach IRS W9): _____

Contact Name _____ Contact Email _____

Practice Phone _____ Practice Fax _____

3. Billing Information (as billed on CMS 1500 Field 33 OR UB box 2)

☐ Same as Above

Billing Name (as it appears on claims) _____

Address _____ City _____ State ____ Zip _____ County _____

Billing Contact Name _____ Billing Contact Email _____

Billing Contact Phone _____ Billing Contact Fax _____

4. Summary of Changes/Notes

Form Completed By _____

Email _____ Phone _____

Hospital-based Provider: *Providers who practice exclusively in an in-patient setting. A credentialing application is not required.*

Return to: 828 Great Northern Blvd, Ste 101, Helena, MT 59601 | Fax to: (406) 422-1010 | Email to: MTProvNet@pacificsource.com

ORGANIZATIONAL PROVIDER
CREDENTIALING/RECREDENTIALING APPLICATION

Type of Facility:

INSTRUCTIONS

This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.
IPN maintains a program to select and re-evaluate all organizational providers (facilities/entities) that provide service within its delivery system. All organizational providers must successfully complete the process to be approved. The provider has the right to review information obtained in the process of evaluating the application exclusive of peer review information.

List ALL Organizational Provider NPIs you wish to credential. Include all applicable attachments for each NPI.
NOTE: IPN only credentials for the following Organizational Provider types. Refer to page 5 of this application for details.

- Hospital
- Ambulatory
- Medical Suppliers
- Rural Health Clinic (RHC)
- Behavioral Health/Mental Health Facility
- Custodial Care Specialties
- Federally Qualified Health Center (FQHC)
- Other

PLEASE INCLUDE THE FOLLOWING WITH YOUR APPLICATION

☐ Completed W-9
☐ Current Insurance face sheets which meet or exceed minimum limits acceptable by IPN:
  - Professional Liability $1,000,000 per occurrence $3,000,000 aggregate

☐ Listing of all locations
☐ Evidence of Credentialing Program (REQUIRED FOR ALL FACILITY TYPES)
☐ Complete the *Credentialing Program* section or provide Policy on Credentialing Program
☐ Policy on Seclusion & Restraint (REQUIRED FOR ALL FACILITY TYPES)
☐ Policy on Patient Visitation (Hospitals Only)
☐ Policy on Patient Safety which includes a description of evacuation process (Hospitals Only)
☐ Copy(s) of all Federal, State, and/or local professional licenses, certifications and/or registrations specifically required to operate as a health care facility.
☐ Copy(s) of all Federal, State, and/or local business licenses, certifications and/or registrations specifically required to operate as a health care facility.
☐ Copy(s) of all Accreditation Certificates and copy of most recent survey results (A list of Acceptable Certifying entities can be found on pages 6 & 7).
☐ Copy(s) of most recent CMS survey, including corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied, if no CMS exemption provision applies.
☐ IRS documents confirming the tax identification number and legal business name (e.g., CP 575).
☐ Description of credentialing and clinical staff privileging program for health care professionals.
☐ Identify the health care related organization(s) to which this application is being submitted in the space provided on page 4.
☐ Explanations provided in response to questions in the *Action History Questions* section of the application must be complete as they relate to dates, incident explanations and results, i.e., dismissal, judgment/settlement including amount and date of payment. Failure to provide the necessary information may be considered failure to meet credentialing criteria.

NOTICE

☐ The IPN Credentialing Department, or its designee, may do a site visit for any facility. Site visits may be done at the discretion of the IPN Credentialing Department whether or not the provider has accreditation status and or an existing site visit. Credentialing of a facility headquarters and or corporate location may incorporate satellite facilities owned and operated by the applying facility. IPN retains the right to individually credential and re-credential satellite facilities which may require independent compliance to IPN Policies and Procedures for credentialing and re-credentialing. This decision is at IPN's discretion.

☐ Every three years, IPN may confirm that the facility and or its satellite or mobile locations continue to be in good standing. This includes but is not limited to, state and federal regulatory bodies, malpractice insurance remains current and meets appropriate limits, most recent malpractice history for the three most recent and consecutive years and, if applicable, accreditation entities.

☐ The provider has the right to review submitted credentialing application information, be notified of any information that is substantially different from what is submitted, the right to correct erroneous information and the right, upon request, to be informed of the status of their application. The credentialing department will make every effort to provide status at the time of request and, if unable, will respond within three working days.

☐ IPN maintains a policy and procedure for health care providers and organizational providers (facilities) when denied network participation for reasons other than a failure to meet or maintain credentialing/recredentialing criteria. The policy and procedure is available by request from the IPN Credentialing Department.

☐ Complete the application in its entirety.
☐ Sign and date pages 11 & 13.
☐ Mail application to:

PacificSource Health Plans
Attn: Provider Network
828 Great Northern Blvd., Suite 101
Helena, MT 59601
Fax: (406) 422-1010
MTProvNet@pacificsource.com

ORGANIZATION INFORMATION *(Provide physical location information on the following page)*				
Corporate Identification Information (Controlling interest information required by CMS in order to comply with Federal Law)				
Legal Name of Organization: (Legal name listed with the IRS)				
DBA Name of Organization: (if applicable)				
Organization Owner:			Organization Administrator:	
Select all that apply	☐ Privately Owned ☐ Corporation ☐ Investor owned	☐ Government owned ☐ Partnership ☐ Limited Partnership	**Select one**	☐ For profit ☐ Non-profit
List any person that has direct or indirect ownership interest of 5% or more:				
In case of corporation or partnership, list the officers and directors or the partners:				
List any managing employees: *(Managing employees are individuals who exercise operational or managerial control over the entity or part thereof who directly or indirectly conduct the daily operations of this entity)*				

Mailing Address		
Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Phone:	Fax:	

Billing Address		
Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Phone:	Fax:	
Billing Contact Person:	Email:	

ORGANIZATION INFORMATION *(continued)* *(Provide physical location information on the following page)*							
Physical Location(s) Information: *(Include additional information relevant to this location on a separate sheet – provided at end of application)*							
Practice Location Name:							
Is this location Medicare Certified:	☐ Yes ☐ No			**Is this the primary address?**	☐ Yes ☐ No		
Federal TIN:		Long Term Care provider # (if applicable):					
NPI #:		Is this location wheelchair accessible? ☐ Yes ☐ No					
Site-specific Medicare #		Describe your service area (States, Counties, Cities, etc.):					
Site-specific Medicaid #							
Address Line 1:							
Address Line 2:							
City:	State:	Zip:	County:				
Phone:	Fax:	E-mail:					
Primary Contact Name:		Contact Title:					
Phone:	Fax:	E-mail:					
Please list any languages spoken by office personnel:							
Practice Limitations (e.g. age, gender, etc):							
Office Hours (Open to Close)							
M	**Tu**	**W**	**Th**	**F**	**Sat**	**Sun**	

Mailing/Correspondence Address *(This must be an address where provider can be contacted directly)*		
Check here ☐ if all correspondence can be directed to the practice location provided above.		
Mailing Address Line 1:		
Mailing Address Line 2:		
City:	State:	Zip:
Phone:	Email:	

PRIMARY CONTRACTED SPECIALTY *(If each location offers different services, please indicate this on a separate sheet or attachment)* *(If there are multiple primary CONTRACTED specialties, check ALL that apply)*	
Hospital: # of beds_____ ☐ General Acute Care ☐ Psychiatric ☐ Rehabilitation ☐ Critical Access	**Behavioral Health Facilities: # of beds_____** ☐ Inpatient ☐ Residential ☐ Ambulatory
Ambulatory: ☐ Ambulatory Surgery Center ☐ Dialysis Center ☐ Ambulance ☐ Air Ambulance ☐ Diagnostic Imaging – *Radiology*	**Custodial Care Specialties:** ☐ Skilled Nursing Facility # of beds_____ ☐ Home Health Agency ☐ Hospice Care ☐ In Home Supportive Care
Other: ☐ IV Home Infusion Therapy ☐ Laboratory ☐ Collection Site ☐ Independent Diagnostic Testing (IDTF) ☐ Diabetes Management & Education ☐ Sleep Disorder Center ☐ Public Health or Welfare ☐ Crisis Center	**Medical Suppliers:** ☐ Durable Medical Equipment ☐ DME – Sleep Supplies ☐ Prosthetic/Orthotic Supplier
☐ Federally Qualified Health Center (FQHC)	☐ Rural Health Clinic (RHC)

Scope of Services			
Select all that apply *(attach accreditation and/or certification or licensure for each service)*	☐ Acute Care ☐ Ambulance ☐ Anesthesiology ☐ Emergency Department (Level I, II, III, IV, V) ☐ Birthing Center ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Radiology ☐ CT Scan ☐ Echocardiography ☐ Mammography ☐ Magnetic Resonance Imaging (MRI) ☐ Nuclear Medicine	☐ Nuclear Cardiology ☐ PET ☐ Dialysis ☐ Lithotripsy ☐ Laboratory/Pathology ☐ Skilled Nursing ☐ Outpatient Surgery ☐ Hospice ☐ Infusion Therapy ☐ Home Health ☐ Adult Day Care ☐ Home Companion Care ☐ Homemaker Services ☐ Incontinent Supplies	☐ Home Environment Consultant ☐ Home Rehab Services ☐ Personal Care Aide ☐ Social Worker ☐ Pharmacy ☐ Phlebotomy ☐ Bereavement Counseling ☐ Sleep Study Services ☐ Telemedicine
Other Specialty:		**Taxonomy:**	
Specialty Designation Notes:			
***Attach a roster of all providers, with credentials, who will offer services to patients seen at this facility.*			

CERTIFICATION AND ACCREDITATION

(Attach a copy of the most recent accreditation certificate for each accrediting body)

Is this provider accredited by a national accreditation organization? ☐ Yes ☐ No ☐ Pending

If Yes, please complete the following:

☐ **Medicare Certification (CMS)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **The Joint Commission (TJC)** Date of original certification: _____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **American Association Accreditation of Ambulatory Surgery Facilities (AAAASF)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Accreditation Association for Ambulatory Health Care (AAAHC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Community Health Accreditation Program (CHAP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Accreditation Commission for Health Care (ACHC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **AOA's Healthcare Facilities Accreditation Program (AOA-HFAP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Association of Ambulatory Surgery Centers (AAASC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **American Academy of Orthotics & Prosthetics (AAO&P)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Board for Certification in Orthotics & Prosthetics (ABCOP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **American College of Radiology (ACR)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Diabetes Association (ADA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Board of Certification/Accreditation International (BCIA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Commission on Accreditation of Rehabilitation Facilities (CARF)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____

CERTIFICATION AND ACCREDITATION *(continued)* *(Attach a copy of the most recent accreditation certificate for each accrediting body)*	
☐ **National Committee for Quality Assurance (NCQA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **College of American Pathologists (CAP)** Date of original certification: _____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Det Norske Veritas (DNV)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Healthcare Quality Association on Accreditation (HQAA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **National Association of Boards of Pharmacy (NABP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Academy of Sleep Medicine (AASM)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **The Compliance Team (TCT)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Prescription Drug Plan Sponsor (URAC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Department of Health and Welfare Quality Assurance Rev (BLTC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Academy of Craniofacial Pain (AACP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Commission on Accreditation of Ambulance Services (CAAS)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Commission on Accreditation of Medical Transportation Services (CAMTS)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
***IPN only accepts accreditation by CMS considered bodies. This list is subject to change.*	

Has the provider ever been denied accreditation? ☐ Yes ☐ No
If yes, please explain:

LICENSURE *(Attach a copy of all licenses)*					
☐ Please check here if this location does not require a license by an appropriate State agency.					
License Type:		**State:**		**Number:**	
Issue Date:		**Expiration Date:**			
Current Survey Date:					
License Type:		**State:**		**Number:**	
Issue Date:		**Expiration Date:**			
Current Survey Date:					
License Type:		**State:**		**Number:**	
Issue Date:		**Expiration Date:**			
Current Survey Date:					

Has your licensure ever been revoked or otherwise limited? ☐ Yes ☐ No
If yes, please explain:

REGISTRATION(S) AND CERTIFICATE(S) *(Attach a copy of all that apply)*					
DEA Number:		**Issue Date:**		**Expiration Date:**	
CS/CDS Number:		**Issue Date:**		**Expiration Date:**	
CLIA Number:		**Issue Date:**		**Expiration Date:**	
Lab Registration *(if applicable)*:		**Issue Date:**		**Expiration Date:**	
Other Registration(s)/Certificate(s):					

CURRENT INSURANCE COVERAGE *(Attach a copy of liability insurance face sheet)*			
Commercial General Liability Insurance *(Complete all information below or provide copy of policy face sheet)*			
☐ Check here if your facility is not insured. (Attach explanation)			
Coverage Type: ☐ Claims Based	☐ Occurrence Based	☐ Tail Coverage	☐ Umbrella
Carrier Name:		Policy #:	
Carrier Address:			
City:	State:	Zip:	
Effective Date:		Expiration Date:	
Per Incident: $		Aggregate: $	

CREDENTIALING PROGRAM		
Credentialing Contact Person:	Title:	
Phone:	Fax:	Email:

1. Do you verify the credentials of all licensed and non-licensed staff that you employ? ☐ Yes ☐ No
For YES: How frequently is this verified?
For YES: Please check method(s) of verification for **licensed** staff: ☐ Online directly with the appropriate State Board ☐ Obtaining a current copy of the license ☐ Other_____
For YES: Please check method(s) of verification for **non-licensed** staff: ☐ Background check agency ☐ Previous employer(s) ☐ Other_____
2. Do you ensure that each of the LICENSED staff practicing at your facility renews his/her State License before it expires? ☐ Yes ☐ No
3. Do you perform background checks on all staff before hiring? ☐ Yes ☐ No
For YES: Please check all method(s) utilized: ☐ Federal and/or State Criminal Background Check(s) ☐ Background Check agency ☐ Search a State 'Misconduct Registry' or equivalent ☐ Other_____
4. Are subcontractors required to carry individual medical malpractice/professional liability insurance? ☐ Yes ☐ No
For YES: What amounts?
5. If you use Telemedicine, do you verify licensure of the individual providers? ☐ Yes ☐ No
For YES: How often?
6. Is there 24 hour health provider coverage in the facility? ☐ Yes ☐ No
For YES: What type of provider?
7. Are inpatient services available? (non-hospital only) ☐ Yes ☐ No ☐ N/A
For NO: Do you have written agreements with local hospitals for immediate acceptance of patients that require care? ☐ Yes ☐ No
For YES: List hospital(s):
8. Does the facility have a licensed Anesthesiologist or CRNA? ☐ Yes ☐ No ☐ N/A
9. Is a physician and Anesthesiologist/CRNA required to remain present during surgical procedures? ☐ Yes ☐ No ☐ N/A
10. Are RN's available for patient care at all times in the operating and recovery rooms? ☐ Yes ☐ No ☐ N/A

DME Only:
1. Is this a Dental Office? ☐ Yes ☐ No ☐ N/A
2. Do you provide dental sleep medicine oral appliances for patients with sleep apnea? ☐ Yes ☐ No ☐ N/A
3. Is there a physician advisor at each location? ☐ Yes ☐ No
4. Do you require patients provide orders from a medical doctor prior to accessing these services? ☐ Yes ☐ No ☐ N/A
5. Are the providers at your facility members of the American Board of Dental Sleep Medicine or the American Academy of Craniofacial Pain? If so, please attach certificates. ☐ ABODSM ☐ AACP

PATIENT VISITATION - *HOSPITAL*
Does your facility have written *policies and procedures regarding the visitation rights of patients **(**CMS-3228**)?** ☐ Yes ☐ No ☐ N/A
For YES: Provide policy and procedure for *visitation rights of patients.*
***Policy must include:* • *Identifying any clinically necessary or reasonable restriction or limitation the hospital may need to place on such rights, and* • *The reasons for the clinical restriction or limitation.*

RESTRAINT AND SECLUSION
Does your facility have a policy and procedure related to the use of seclusion and restraint as required under the Code of Federal Regulations CFR, 438.100 section V *"be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation."* ☐ Yes ☐ No
For YES: Provide policy and procedure for *restraint and seclusion.*

ACTION HISTORY QUESTIONS	
Please respond to the following questions *YES* or *NO*. If your answer to any of the following questions is *YES* provide a detailed explanation, as specified in each question, on a separate sheet. Sign and date each additional sheet. *****Modification to the wording or format will invalidate the application.***	
1. Has this provider, under any current or former name or business identity, ever had any felony convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?	☐ Yes ☐ No
2. Has this provider, under any current or former name or business identity, ever had any felony convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
3. Has this provider, under any current or former name or business identity, ever had any felony convictions under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201?	☐ Yes ☐ No
4. Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
5. Has this provider ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	☐ Yes ☐ No
6. Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended?	☐ Yes ☐ No
7. Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?	☐ Yes ☐ No
8. Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	☐ Yes ☐ No
9. Has this provider, under any current or former name or business identity, ever had the malpractice insurance terminated or revoked except by request or consent?	☐ Yes ☐ No
10. Has this provider, under any current or former name or business identity, ever had or currently have pending, any legal actions excluding medical malpractice?	☐ Yes ☐ No

Printed Name of Authorized Representative

Signature of Authorized Representative

Authorized Representative's Title

Date Signed

AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this application, it is agreed and understood that:

1. As a representative of the health care provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions indicated in this application is upon the contracted provider or its representative.
2. I further understand and acknowledge that IPN, or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the HIPDB reporting and information as required by law as a part of the verification and credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated and all professional liability insurers with which the provider(s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with IPN or designated agent.
4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of IPN or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to IPN's cycle of recredentialing provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with IPN or its respective agent(s).
6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of IPN or its respective agent(s) before initiating judicial action.
7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.
8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with IPN.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as an IPN Participating Provider or cause for summary dismissal from IPN or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with IPN and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by IPN.

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

***This provider complies with all Federal, State and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).*

Printed Name of Authorized Representative	Signature of Authorized Representative
Authorized Representative's Title	Date Signed

As the authorized representative for the following provider(s)/supplier(s), I grant permission for the release of information related to licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions for the following provider(s)/supplier(s):

Facility Name	City, State
Facility Name	City, State

ADDITIONAL LOCATIONS OR SPECIALTIES

(if applicable)

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

LIST OF ADDITIONAL LOCATIONS ON FILE WITH IPN

Organizational Provider Credentialing Application Addendum

Please supply description(s) for restraint and seclusion action and credentialing and clinical staff privileging below. *If copies or descriptions for each of these polices are attached to this application, this page can be left blank.* **THIS PAGE MUST BE COMPLETED OR POLICIES PROVIDED. "NA" IS NOT ACCEPTED.**

Restraint and Seclusion Action

If restraint and/or seclusion of an individual visiting our location were to become necessary, the healthcare professional(s) working for our organization would (*please check one*):

☐ Contact local law enforcement authorities for intervention/assistance.
☐ Other (*Provide a description below if there is another plan of action for restraint and seclusion and a policy has not been provided.*)

Credentialing and Clinical Staff Privileging

When a licensed professional is hired at this facility, who ensures they are licensed upon hire and that their license stays current?

What other screening activities are done to ensure the person is competent for the position they hold?

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

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 of the person whose name is entered on line 1. 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: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its 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.) See instructions.

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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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 for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

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, *later.*