



PROVIDER

CREDENTIALING TIPS

To help streamline the credentialing process, we developed a tip sheet to help our providers complete the application and help identify common issues that cause delays in your application processing.

All areas of the application should be completed. For all areas that do not pertain to you, please indicate N/A under the respective area.

APPLICATION	NOTES/COMMENTS
II. Identifying information <ul style="list-style-type: none"> • Last Name, First Name M.I. • Other Names used • Birth Date • SSN# • Gender • Specialty • Subspecialties 	Please make sure these data elements are completed to the best of your ability. These elements are used as identifying information to conduct primary source verifications on your application. If any information is missing, it will delay your application until it has been completed.
III. Practice Information <ul style="list-style-type: none"> • Office Manager/Administrator (we will list this person as your main contact for obtaining Credentialing documents) • Name affiliated with TIN & TIN 	This applies to all locations where IEHP patients will be treated. *If you have multiple offices with different Tax ID#'s, we will require a copy of each W-9 for your credentialing file
IV. Premedical Education V. Medical/Professional Education <ul style="list-style-type: none"> • School Name • Degree • Graduation Date 	Please complete the following fields
VI. Internship/PGY1 VII. Residencies/Fellowships <ul style="list-style-type: none"> • Institution Name • Address, City, State ZIP • Type of Training • Specialty • Start Date (mm/yy) • End Date (mm/yy) • Successfully complete the program, Yes or No. 	If the facility is not an ACGME program, we would need to the address information, to verify your training with the school directly It is essential that the specialty and dates are reported accurately. Any discrepancies will be delay your application until it has been clarified If you did not successfully complete a training program, you must provide an explanation to support your response.
VII. Board Certification If not certified, describe your intent for certification, if any, and date of eligibility for certification on a separate sheet	The acceptable board certifications are recognized by the following organizations: <ul style="list-style-type: none"> • American Board of Medical Specialties (ABMS) • American Osteopathic Association (AOA) • American Board of Foot and Ankle Surgery (formerly the American Board of Podiatric Surgery) • American Board of Podiatric Orthopedics and Primary Podiatric Medicine • American Board of Multiple Specialties in Podiatry
X. Medical Licensure/Registration <ul style="list-style-type: none"> • California License Practice information • DEA Information • ECFMG Information (If applicable) • NPI 	State Licensures, DEA Certificates, and NPI registry information must reflect California addresses. DEA's with an exempt fee is only valid at the exempting institution. If the provider is not treating IEHP patients at that facility, the provider needs to obtain a paid status DEA. The NPI registry should list the provider's practice information Any discrepancies will delay the credentialing process until the issues are addressed



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APPLICATION	NOTES/COMMENTS
XII. Professional Liability	<p>Professional Liability information on the application must be supported with a copy of the insurance certificate (Binders and Declarations are not acceptable)</p> <p>Malpractice Insurance Face sheet should indicate the covered practice location, specialty coverage, policy coverage amounts, effective and termination date and should cover all locations the provider will be treating IEHP patients.</p> <p>If any information is missing from the certificate, the credentialing coordinator will attempt to verify this information with your insurance carrier directly</p>
XIII. Current Hospital and Other Institutional Affiliations Please include all hospitals and other institutional institutions the provider has current affiliations during the past 10 years (i.e. hospitals, surgery centers)	<p>If the practitioner does not have clinical privileges, the provider must provide a written statement delineating the inpatient coverage arrangement.</p> <p>If the provider is a PCP utilizing IEHP's Hospitalist program, they must identify which hospital and hospitalist they will be referring patients to on their application. These arrangements can be arranged with IEHP's Contracting Department</p> <p>Specialists (in the appropriate specialties) must have a formal inpatient coverage arrangement, which is subject to IEHP review and approval.</p>
X. Work History	<p>Please provide your work history activities for the past five (5) years. Any gaps of six (6) months or more must be explained on a separate page.</p> <p>Your work history activities must also include the start date you began at your current practice</p>
XVI. Attestation Questions If your answer is Yes to questions A through L, please provide full details on a separate sheet.	<p>Please be sure that all questions are answered. All responses will be compared to our findings through primary source verifications. If there is a discrepancy, it will delay your application until the issue(s) are addressed</p>
Provider Signatures and dates	<p>Stamped and typed signatures are not accepted and applications must have a current date.</p> <p>Any discrepancies, you will be contacted by a coordinator regarding the non-compliant pages for your review, to re-sign and re-date</p>

ADDENDUM A	NOTES/COMMENTS
I. Identifying information	Please indicate whether you intent to serve as a Primary Care Provider or Specialist and identify your practice type
III. Practice Information Allied Health Professionals	Please list ANY allied Health professionals (e.g. nurse practitioners, physician assistants, certified nurse midwives) you employ.
Age limitations	Please specify any age limitations for your practice
Office Hours	Please indicate the office hours for each of your office locations. <ul style="list-style-type: none"> PCP's are required to practice in each practice location for a minimum of twenty (20) hours, to receive membership assignment to that location
Continuity of Care	Please provide your written plan for continuity of care, if you do not have hospital privileges
Languages	Please provider languages spoken FLUENTLY by the Physician and/or Staff <ul style="list-style-type: none"> If Spanish is listed, IEHP will conduct a Language Competency audit to confirm if the office met the requirements to be listed as a Spanish site in our Provider Directory

ADDENDUM B	NOTES/COMMENTS
Professional Liability Action Explanation	Please complete the Addendum B for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you in which you were named in the past seven (7) years.



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ADDENDUM C	NOTES/COMMENTS
Confidential Questions – Health History	If you are a certified Worker’s Compensation Provider, please provide a copy of your OME Evaluator certificate
ADDENDUM D	NOTES/COMMENTS
Notice to Practitioners of Credentialing Rights/Responsibilities	Please complete, sign and date
ADDENDUM E	NOTES/COMMENTS
Primary Care Experience – Attestation	Applicable to General Practice and Obstetrics/Gynecology PCP’s only Please contact credentialing@iehp.org regarding additional information required for your specialty.
HIV/AIDS SPECIALIST FORM	NOTES/COMMENTS
Verification of Qualifications for HIV/AIDS Specialist	If you wish to be designated as a HIV/AIDS Specialist, please check all criterion that apply to you and provide the supporting documents
W-9	NOTES/COMMENTS
Tax Identification Number and Certification	Please provide a complete, signed and dated W-9 for each TIN you will be billing with for each IEHP member
AREAS OF EXPERTISE FORM	NOTES/COMMENTS
Behavioral Health Area(s) of Expertise Form	Applicable to Behavioral Health Provider’s only (i.e. Practitioners who specialize in Psychiatry, Psychology, Licensed Clinical Social Workers, Marriage Family Therapists)

California Participating Physician Application

This application is submitted to: _____, herein, this Healthcare Organization¹

I. INSTRUCTIONS:

This form should be typed 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. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: Home Fax Number: ()	E-Mail Address: Pager Number:	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security #:	Gender ¹ : <input type="checkbox"/> Male <input type="checkbox"/> Female	
Specialty:	Race/Ethnicity ² (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If Hospital Based):	
Primary Office Street Address:	City:	
	State:	ZIP:
Telephone Number:	Fax Number:	
Office Manager/Administrator:	Telephone Number: ()	
	Fax Number: ()	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

¹ As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

² This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ()	
	Fax Number: ()	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ()	
	Fax Number: ()	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		
IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)		
College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:
V. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)		
Medical School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
POSTGRADUATE TRAINING AND EXPERIENCE		
VI. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference This Section Number and Title)		
Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:
Type of Internship :		
Specialty:	From: (mm/yy)	To: (mm/yy)

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (eg. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? Yes No (If "No," please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? Yes No (If "No," please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? Yes No (If "No," please explain on separate sheet.)

VIII. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date Certified/Recertified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above? Yes No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)
 (Attach additional sheets if necessary. Reference This Section Number and Title)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

California State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:	Expiration Date:	
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):	Date Issued:	Valid Through:
Medicare UPIN / National Physician Identifier (NPI):	MediCal/Medicaid Number:	

XI. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held.
 (Attach additional sheets if necessary. Reference This Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	State: ZIP:
Per Claim Amount \$	Aggregate Amount: \$	Expiration Date:

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:	State: ZIP:	
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:	State: ZIP:	

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

Name and Mailing Address of Other Hospital/Institution:		City:
		State: ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of Other Hospital/Institution:		City:
		State: ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Telephone Number: ()
Mailing Address:		City:
		State: ZIP:
Name of Reference:	Specialty:	Telephone Number: ()
Mailing Address:		City:
		State: ZIP:
Name of Reference:	Specialty:	Telephone Number: ()
Mailing Address:		City:
		State: ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number: ()
		Fax Number: ()
Mailing Address:		City:
		State: ZIP:
From: (mm/yy)	To: (mm/yy)	

Name of Practice /Employer:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:	City:		
	State:	ZIP:	
From: (mm/yy)	To: (mm/yy)		
Name of Practice /Employer:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:	City:		
	State:	ZIP:	
From: (mm/yy)	To: (mm/yy)		

XVI. ATTESTATION QUESTIONS

Please answer the following questions “yes” or “no”. If your answer to questions A through L is “yes” or if your answer to M & N is “no”, please provide full details on reverse or on a separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes <input type="checkbox"/> No <input type="checkbox"/>
F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
H. Have you ever been convicted of any crime (other than a minor traffic violation)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
I. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
J. Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice or unable to perform those essential functions without a direct threat to the health and safety of others? If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.	Yes <input type="checkbox"/> No <input type="checkbox"/>
K. Have any judgements been entered against you or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
L. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged) or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	Yes <input type="checkbox"/> No <input type="checkbox"/>
M. Is your professional liability insurance valid and current?	Yes <input type="checkbox"/> No <input type="checkbox"/>
N. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ **Date:** _____
 (Stamped Signature Is Not Acceptable) (Not Acceptable If Not Dated)

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state² laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 8 and 9.

Print Name Here _____

Physician Signature _____ Date: _____

(Stamped Signature Is Not Acceptable)

² The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

<p>Addenda Submitting (Please check the following):</p> <p><input type="checkbox"/> Addendum A - Health Plan and IPA/Medical Group</p> <p><input type="checkbox"/> Addendum B - Professional Liability Action Explanation</p>	<p><i>This Application and Addenda A and B were created and are endorsed by:</i></p> <ul style="list-style-type: none"> • American Medical Group Association - (310/430-1191 x223) • California Association of Health Plans - (916/552-2910) • California Healthcare Association - (916/552-7574) • California Medical Association - (415/882-5166) • National IPA Coalition - (510/267/1999) • The Medical Quality Commission - (310/936-1100 x230)
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Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Reapplication nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the health care organization from which it was provided.

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to: _____, herein, this Healthcare Organization³

I. IDENTIFYING INFORMATION		
Last Name:	First:	Middle:
Medical Group (s) / IPA(s) Affiliation:		
Do you intend to serve as a primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you intend to serve as a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list specialty(s)) _____		
Please check all that apply:		
<input type="checkbox"/> Solo Practice	<input type="checkbox"/> Single Practice	
<input type="checkbox"/> Group Practice	<input type="checkbox"/> Multi Specialty	
II. BILLING INFORMATION		
Billing Company:		
Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
III. PRACTICE INFORMATION		
Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please list:		
Name:	Type of Provider:	License Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
If you are a Physician Assistant Supervisor, please include State License Number: _____		
Do you personally employ any physicians (do not include physicians that are employed by the medical group)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please list:		
Name:	California Medical License Number:	
_____	_____	
_____	_____	
Please list any clinical services you perform that are not typically associated with your specialty: _____		
Please list any clinical services you do not perform that are typically associated with your specialty: _____		

¹ As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

Is your practice limited to certain ages: Yes No
 If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? Yes No

Do you participate in EDI (electronic data interchange)? Yes No

If so, which Network? _____

Do you use a practice management system/software: Yes No

If so, which one? _____

What type of anesthesia do you provide in your group/office?
 Local Regional Conscious Sedation General None Other (please specify)

Has your office received any of the following accreditations, certifications or licensures?

- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- California Department of Health Services Licensure
- Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- Medicare Certification
- The Medical Quality Commission (TMQC)
- Other _____

IV. OFFICE HOURS – Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number: ()	Fax Number: ()
Mailing Address:	City:	
	State:	ZIP:
Covering Physician's Name:	Telephone Number: ()	
Covering Physician's Name:	Telephone Number: ()	
Covering Physician's Name:	Telephone Number: ()	
Covering Physician's Name:	Telephone Number: ()	

If you do not have hospital privileges, please provide written plan for continuity of care:

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:

Fluently by Staff:

VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #

Billing Name:

Type of Service Provided:

Do you have a CLIA certificate?

Yes

No

Do you have a CLIA waiver?

Yes

No

Certificate Number:

Certificate Expiration Date:

VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member of applicant.

Organization Name	Applicant	Member
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the information in this document and any attached documents is true and correct.

Print Name Here : _____

Physician Signature _____ Date _____

(Stamped signature is Not Acceptable)

California Participating Physician Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to: _____, herein, this Healthcare Organization⁴

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past **seven (7)** years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Patient Last Name:	First	Middle:
Street Address:	City:	
	State:	Zip

II. CASE INFORMATION

City County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of Patient:	Age of Patient:
Location of Incident: <input type="checkbox"/> Hospital <input type="checkbox"/> My Office <input type="checkbox"/> Other doctor's office <input type="checkbox"/> Surgery Center <input type="checkbox"/> Other (please specify) _____			
Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc):			
Allegation:			
Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization: _____ _____ _____			
If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization: Name: _____ Phone Number: _____ Name: _____ Phone Number: _____			

¹ As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

California Participating Physician Application

Addendum C

This Addendum is submitted to: _____, herein, this Healthcare Organization⁵

SECTION A		CONFIDENTIAL QUESTIONS – HEALTH HISTORY	
1.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? If yes, please describe any accommodations that could reasonable be made to facilitate your performance of such functions without risk of compliance	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Are you a certified Worker’s Compensation provider?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Are you a reservist? If yes, what branch of the military? Anticipated date of separation from reserve duty? ____ / ____ / ____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	Medicaid/Medi-Cal#		

I attest to the fact that all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute a cause for denial of participation of cause for summary dismissal.

Print Name Here: _____

Physician Signature _____ Date _____
(Stamped signature is Not Acceptable)

¹ As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

California Participating Physician Application

Addendum D

Notice to Practitioners of Credentialing Rights/Responsibilities

I. Right of Review

As an applicant for credentialing/recredentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure. You have a right to be informed, upon request, of the status of your credentialing application; and the right to correct erroneous information submitted by another party, provided the information is not peer-review protected.

You may request to review such information at any time by sending a written request via fax or letter to Credentialing Department at: P.O. Box 1800, Rancho Cucamonga, CA 91729-1800, fax number (909) 890-5756. Following receipt of your request, you will be contacted by the Credentialing Department, within five (5) working days in order to arrange a date and time for review of the information in the Credentialing Department.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained by primary sources varies significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to Inland Empire Health Plan by primary sources, you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) days of notification of discrepancy.

Upon receipt of your notification, Inland Empire Health Plan will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter or fax. You will be requested to provide proof of correction by the primary source to the Credentialing Department via letter or fax as cited above within ten (10) days. Subsequently, a second reverification of primary source information will be performed by Inland Empire Health Plan. If, after ten (10) working days, primary source information remains inconsistent and in dispute, you will be subject to adverse action up to administrative termination from Inland Empire Health Plan.

Print Name Here: _____

Physician Signature _____ Date _____
(Stamped signature is Not Acceptable)

Addendum E
General Practice Providers & Obstetrics/Gynecology PCP's only
Primary Care Experience – Attestation

Please indicate below the age of the patients for whom you have provided primary care services to in the last five (5) years. In order for a category to apply, it must represent at least 20% of your average practice and you must be familiar with and routinely follow standard preventative services, such as CHDP and the American Academy of Pediatrics (AAP), both for Pediatrics only, and the United States Preventative Task Force (USPTF). Please check all those that apply:

- Pediatrics (0 to 18 years of age)
- Pediatrics (0 to 21 years of age)
- Adults (14 years of age and above)
- Adults (18 years of age and above)
- Adults (21 years of age and above)
- Ob/Gyn PCP (14 years and above, restricted to females)
- If you desire age limits different from above, please specify:

NOTE: If your desire age limits different from above, you will not receive member auto-assignment.

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial of participation or dismissal from participation with Inland Empire Health Plan (IEHP).

Physician's Name: _____

Physician's Signature: _____ Date: _____

(Stamped signature is not acceptable)

Verification of Qualifications *for* HIV/AIDS PHYSICIAN SPECIALIST

Health plans and healthcare organizations must implement regulations related to AB2168 (Ch. 426, 2000). This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS-34-01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

Please check ANY and ALL of the criteria listed below that apply to you.

- No, I do not wish to be designated as an HIV/AIDS Specialist
- Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:
- I am credentialed as a "HIV Specialist" by the American Academy of HIV Medicine (attached AAHIVM Certification);

OR
 - I am Board Certified in Infectious Disease **AND** in the preceding **twelve (12)** months have clinically managed a minimum of **twenty-five (25)** HIV patients **and** have successfully completed **fifteen (15)** hours of category 1 continuing medical education (CME) in HIV medicine, **five (5)** hours of which was related to antiretroviral therapy;

OR
 - In the past **twenty-four (24)** months, I have provided clinical management of **twenty (20)** patients; **and** in the past **twelve (12)** months completed board certification in Infectious Disease

OR
 - In the past **twenty-four (24)** months I have provided clinical management to **twenty (20)** HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV Medicine;

OR
 - In the past **twenty-four (24)** months I have clinically managed at least 20 HIV patients and in the past **twelve (12)** months have completed 15 hours of category of 1 CME in HIV Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine (attach copies of the CME credits and Exam verification)

I attest that, to the best of my knowledge, the above information can be supported by documentation, if required.

Name of Practitioner (Please print): _____

Date: _____

Practitioner's Signature: _____

License No: _____

Office Telephone: _____

Office Fax: _____

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.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% 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* above.

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

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. 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 line 2.

e. **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 Regulations under 2612.7701-2(c)(2)(ii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should 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 line 1. 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 line 2. "Business name/disregarded entity name." 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.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 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 U.S. commonwealth or possession, 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 U.S. commonwealth or possession
- 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 reportable under section 6045(f), 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 requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

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 U.S. commonwealth or possession, 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 Regulations 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 Regulations 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

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

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 this page), 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 SSA 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 line 1 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) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ 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 Regulations section 1.671-4(b)(2)(i)(A))	The grantor ⁴

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 Regulations 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 2.

*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, 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 (TIGTA) 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.



Behavioral Health Areas of Expertise Form

Provider Name: _____
Last First M

License Number: _____ PhD/PsyD LMFT LCSW Psychiatric Mental Health NP

Patient Population- Indicate the age range that apply to each below.

Accepting New Patients: Yes No

Pediatric Ages:

Adolescents Ages:

Adult Ages:

Geriatric Adult Ages:

Psychiatrist: Board Certification(s):

General Child and Adolescents Psychosomatic Medicine Addiction Medicine Geriatric N/A

Individual Therapy- Select all that apply below:

- | | |
|---|---|
| <input type="checkbox"/> 12 Step Recovery | <input type="checkbox"/> HIV/ AIDS Issues |
| <input type="checkbox"/> Non- 12 Step Recovery | <input type="checkbox"/> Life Transitions Issues |
| <input type="checkbox"/> Addiction: Chemical | <input type="checkbox"/> Maternal Mental Health |
| <input type="checkbox"/> Addiction: Non-Chemical | <input type="checkbox"/> Men's Issues |
| <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Military related PTSD |
| <input type="checkbox"/> Adoption Issues | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Adult Children of Alcoholics | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Personality Disorder |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Psychological Testing- Intellectual |
| <input type="checkbox"/> Behavioral/ Conduct Disorder | <input type="checkbox"/> Psychological Testing- Personality |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Psychological Testing- Projective |
| <input type="checkbox"/> Cancer Survivor | <input type="checkbox"/> Psychotic/ Schizophrenic Mood Disorder |
| <input type="checkbox"/> Christian Counseling | <input type="checkbox"/> Reactive Attachment Disorder |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Clinical Hypnosis | <input type="checkbox"/> Sexual/ Physical Abuse Perpetrators |
| <input type="checkbox"/> Codependency | <input type="checkbox"/> Sleep/ Wake Disorder |
| <input type="checkbox"/> Disability Related Mental Health Issues | <input type="checkbox"/> Somatoform Disorder |
| <input type="checkbox"/> Disruptive, Impulse Control & Conduct Disorder | <input type="checkbox"/> Stres Management |
| <input type="checkbox"/> Eating Disorder Spectrum | <input type="checkbox"/> Substance/ Addictive Disorder- Naltrexone |
| <input type="checkbox"/> EMDR - Certified | <input type="checkbox"/> Substance/ Addictive Disorder- Suboxone |
| <input type="checkbox"/> Factitious Disorder | <input type="checkbox"/> Substance/ Addictive Disorder- Vivitrol |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Gender Dysphoria | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Grief/ Loss | |

Group Therapy- Select all that apply below:

- | | |
|---|---|
| <input type="checkbox"/> 12 Step Recovery | <input type="checkbox"/> Mood Disorders |
| <input type="checkbox"/> Non- 12 Step Recovery | <input type="checkbox"/> Men's Issue |
| <input type="checkbox"/> Addiction: Non-Chemical | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Sexual/ Physical Abuse |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Social Skills |
| <input type="checkbox"/> CBT | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Grief/ Loss | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Medication Education Group | |

Signature:

Print Full Name:

Provider's Signature:

Date:



QUESTIONNAIRE FOR:
PROVIDERS FOR TRANSGENDER MEMBERS

IEHP is interested in identifying Providers who have experience and interest in providing high quality care to Transgender Members. Please complete the following survey.

NPI:
LAST NAME: FIRST NAME:
SPECIALTY: EMAIL:
PHONE: FAX:

1. Are you willing to be listed in our Provider Directory as a provider available to our Transgender Members?

- Yes No, (You may stop survey)

2. Please assess your ability in providing high quality care to Transgender Members:

- Advanced Moderate Minimal No experience (Move to Question 6)

3. What services do you provide to Transgender patients? (Select all that apply)

- Hormone Treatment Mental Health Services Integrated mental and physical health service model
Procedures (surgical, office-based) and what type:
Other

4. Approximately how many Transgender patients have you serviced in the past twelve (12) months?

- None 1-2 3-9 10-25 Over 25

5. How long have you been providing care to Transgender patients?

- Under 1 year 1-5 years 5-9 years Over 10 years

6. What training, if any, have you received to treat Transgender patients? (Select all that apply)

- CME events. Please list organization that provided CME:
Member of World Professional Association for Transgender Health (WPATH)?
Transgender certifications through WPATH?
None Other:

7. What clinical practices guidelines/resources do you use in providing transgender care? (Select all that apply)

- WPATH Standards of Care
UCSF Center of Excellence for Transgender Health - Guidelines for the Primary and Gender - Affirming Care of Transgender and Non-Binary People
Endocrine Society Clinical Practice Guidelines None
Other, please list:

