ALIGN
SENIOR CARE

PROVIDER INFORMATION

PRACTICE NAME: _____

PRACTICE NPI: _____
(IF MORE THAN 1 PLEASE INCLUDE ROSTER OF PROVIDERS WHICH EACH GROUP NPI)

D/B/A, IF APPLICABLE: _____

SPECIALTY OF PROVIDERS: _____

LOCATION/S: **IF MORE THAN ONE LOCATION, PLEASE LIST ON EXCEL ROSTER**

STREET: _____

CITY: _____ **STATE:** _____

ZIP: _____ **OFFICE PHONE:** _____

REMITTANCE ADDRESS (BUSINESS OFFICE):

STREET: _____

CITY: _____ **STATE:** _____

ZIP: _____ **OFFICE PHONE:** _____

BUSINESS CONTACT/NOTIFICATIONS:

NAME/TITLE: _____

ADDRESS: _____

PHONE/EMAIL: _____

ARE YOUR PROVIDERS TAKING NEW PATIENTS? YES ☐ **NO** ☐

PROVIDERS:

NAME	NPI	CAQH #, IF APPLICABLE

PLEASE ATTACH LIST OR EXCEL ROSTER IF MORE THAN 5

PROVIDER INFORMATION

ENTITY/GROUP NAME: _____

D/B/A, *if applicable*: _____

NPI (*if various, include in roster*): _____

TIN (*if various, include in roster*): _____

REMITTANCE ADDRESS (BUSINESS OFFICE): *IF MULTIPLE, INCLUDE IN ROSTER

STREET: _____

CITY: _____ STATE:_____

ZIP: _____OFFICE PHONE: _____

BUSINESSCONTACT/NOTIFICATIONS:

NAME:

_____

TITLE:

_____

ADDRESS:

_____

PHONE/EMAIL:

_____

CREDENTIALING CONTACT (*Required unless group is delegated*):

NAME:

_____

TITLE:

_____

ADDRESS:

_____

PHONE/EMAIL: _____

IF THERE ARE MORE THAN 5 PROVIDERS, A ROSTER MUST BE ATTACHED THAT INCLUDES PROVIDER NAME, NPI, ALL SERVICING LOCATIONS, GROUP NPI, BILLING INFORMATION AND CAQH ID.

Provider Name	Specialty	Service Location(s)	NPI	CAQH ID

CREDENTIALING APPLICATION REQUIREMENTS

Before participating in the network, all providers must be credentialed. Providers can utilize a paper application or for easier processing, can provider their CAQH ID number.

Completing the CAQH application prior to beginning the credentialing process will ensure that providers are credentialed and in-network without delays. Providers cannot see members until credentialing is completed and a countersigned contract has been returned to your practice.

The credentialing process begins with an updated CAQH profile. Providers that do not have a CAQH profile, can register at www.caqh.org.

If there is already an established CAQH profile, confirm the profile status by logging into the CAQH portal.

Practitioners are required to submit a CAQH number and have updated CAQH applications prior to beginning the credentialing process.

andros (formerly known as CredSimple) is the AllyAlign Health Credentialing Verification Organization. **andros** will contact you via fax, email or phone to address incomplete or non-compliant applications.

Application Requirements **NOTE:** Incomplete or non-compliant applications will delay entrance into the network.	
Requirement	**What to check**
Recent CAQH profile	• CAQH profile must be attested to (signed) within the past 120 days
Updated Practitioner Information	• Credentialing contact information • Other licenses • Name of Board if Board Certified • DEA & State License Information *(including issuance and expiration dates*)
Minimum of 5 year work history and explanation of any gaps over 6 months	• Include 5 years of work history, or, if a provider has worked less than 5 years, work history should be completed from license issuance date • Add license issuance date • Provide a complete work history - any gaps in employment over 6 months require an explanation • Only fellowships are applicable towards work history gaps, additional training will not be counted
Answer all disclosure questions on CAQH profile	• Complete all disclosure questions on your CAQH profile. • Provide an explanation for any question answered positively.
Current malpractice coverage	• Practitioners must have current liability insurance coverage

Personal Information

Do not use any nicknames or initials unless they are part of your legal name.

Name (Last, First, Middle):			
Degree:			
Date of Birth:		Sex: ☐ Male	☐ Female:
SSN:			
Have You Ever Used Another Name?	☐ Yes	☐ No	

*If yes, please list all other names and dates of use below:

Other Name (Last, First, Middle):			
Home Address			
City/State/Zip:			
Home Phone:		Cell Phone:	
E-mail:		Fax:	
Preferred Method of Contact:	☐ Mail:	☐ E-mail	☐ Fax:
Place of Birth (City, State, Country):			
Citizenship:			
If Not an American Citizen, Status and Visa Number:			
Enter all non-English Languages You Speak:			

Primary Credentialing Contact

☐ **Check Here to Use The Office Manager And Address Of The Primary Practice Location As The Credentialing Information**					
Last Name:		First Name:		M:	
Address:		City		State	
Telephone:		Fax:			
E-mail Address:					

Professional Licenses

State License #	Issuing State	Issue Date	Expiration Date	Practicing In This State? (Y/N?)

Federal DEA Number:		DEA Issue Date:	
DEA State of Resignation:		DEA Expiration Date:	

CDS Certificate Number:		CDS Issue Date:	
CDS State of Resignation:		CDS Expiration Date:	

Medicare Number:			
Medicaid Number:		Medicaid State:	
National Provider ID (NPI) Number:			
USMLE Number:			
ECFMG Number (Non-U.S./Canadian Graduate Only):			
ECFMG Certificate Issue Date (Non-U.S./Canadian Graduate Only):			

Education and Training

Name of Undergraduate School:							
Address:				Suite/Building:			
City:		State:		Zip/Postal Code:		Country:	
Telephone:				Fax:			
Start Date (MM/YYYY):				End Date (MM/YYYY):			
Degree:							
Did you complete your undergraduate education at this school? ☐ Yes ☐ No							

List all training programs you attended. Use one section per institution:

Institution/Hospital Name (Use both lines if needed):

Affiliated Medical School:							
Address:				Suite/Building:			
City:		State:		Zip/Postal Code:		Country:	
Telephone:				Fax:			
Did you complete this training program at this institution? ☐ Yes ☐ No							

If not, please use the space below to explain:

List each department separately, if applicable.
List Internship/Residency, Fellowship, and other programs separately

Start Date (MM/YYYY):		End Date (MM/YYYY):	
Department/Specialty (Do not abbreviate):			
Name of Director:			
Telephone:		Fax:	
E-mail:			

Start Date (MM/YYYY):		End Date (MM/YYYY):	
Department/Specialty (Do not abbreviate):			
Name of Director:			
Telephone:		Fax:	
E-mail:			

Start Date (MM/YYYY):		End Date (MM/YYYY):	
Department/Specialty (Do not abbreviate):			
Name of Director:			
Telephone:		Fax:	
E-mail:			

Professional/Medical Specialty Information

Board Certification

Are You Board Certified?	☐ Yes	☐ No	
If yes, Please Indicate the Name of The Board			
Year Certified:		Expiration Date:	

If not Board Certified (select one)

☐ I have taken the exam, results pending for (enter Certifying Board Code):
☐ I intend to sit for an exam (MM/DD/YYYY):
☐ I do not intend to take a certifying board exam.

If you indicated that you did not intend to take a certifying board exam, please use the space below to explain. Otherwise leave this space blank.

Practice Location Information

Primary Practice Location

- *"General Correspondence"* refers to any correspondence that might be sent to the provider that does not solely relate to the credentialing or billing information

Currently practicing at this address?	☐ Yes	☐ No
If you indicated No, when is your expected start date?		

Physician Group/Practice name to appear in directory (do not abbreviate):

Group/Corporate name as it appears on W-9, if different from above (do not abbreviate):

Address:				Suite/Building:			
City:		State:		Zip/Postal Code:		Country:	
Send General Correspondence Here? ☐ Yes ☐ No							
Telephone:				Fax:			
Office e-mail address:							
Individual Tax ID:				Group Tax ID:			
Primary Tax ID (one only):				Use Individual Tax ID or Group Tax ID:			

Secondary Practice Location

Address:				Suite/Building:			
City:		State:		Zip/Postal Code:		Country:	

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for your convenience.
Do not write instructions such as "see above". These responses will require follow-up rejection.

Last Name:		First Name:		M:	
Address:		Suite/Building:			
City:		State:		Zip:	
Telephone:		Fax:			
E-mail Address:					

Office Hours

NOTE: After hours back-office telephone will be used only by the health plan and will not be published under any circumstances.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start							
End							

24/7 Phone Coverage? (If yes, please check one below ☐ Yes ☐ No	
Answering Service	
Voicemail with Instructions to call answering service	
Voicemail with other Instructions	

Languages

Non-English Language spoken by office personnel:

Interpreters available? Yes ☐ No ☐

Languages interpreted:

Covering Colleagues

If you have additional covering colleagues that are not partners at *THIS* location, use this section to fill in. Photocopy page as needed. Be certain to confirm "Primary Location" below each.

Last Name:		First Name:		M:	
Specialty:					

Last Name:		First Name:		M:	
Specialty:					

Last Name:		First Name:		M:	
Specialty:					

Hospital Affiliations

Do you have any hospital privileges? Yes ☐ No ☐					
Hospital Name					
Address:			Suite/Building:		
City:		State:		Zip:	
Telephone:				Fax:	
Department Name:					
Department Director's First Name and Last Name:					
Affiliation Start Date (MM/YYYY):		Affiliation End Date (MM/YYYY):			
Full, unrestricted privileges? Yes ☐ No ☐					
Are privileges temporary? Yes ☐ No ☐					
Admitting privilege status (e.g. non, full unrestricted, provisional, temporary):					
Please explain terminated affiliation:					

Do you have any hospital privileges? Yes ☐ No ☐					
Hospital Name					
Address:			Suite/Building:		
City:		State:		Zip:	
Telephone:				Fax:	
Department Name:					
Department Director's First Name and Last Name:					
Affiliation Start Date (MM/YYYY):		Affiliation End Date (MM/YYYY):			
Full, unrestricted privileges? Yes ☐ No ☐					
Are privileges temporary? Yes ☐ No ☐					
Admitting privilege status (e.g. non, full unrestricted, provisional, temporary):					
Please explain terminated affiliation:					

Professional Liability Insurance Carrier

Carrier or Self-Insured Name:					
Policy Number:					
Self-Insured? Yes ☐ No ☐					
Address:				Suite/Building:	
City:		State:		Zip:	
Telephone:				Fax:	
Original effective Date (MM/YYYY):			Effective Date (MM/YYYY):		
Expiration date (MM/YYYY)					
Type of coverage (Individual or Shared)					
Do you have unlimited coverage with this insurance carrier? Yes ☐ No ☐					
Amount of coverage per occurrence:			Amount of coverage per aggregate:		
Does the policy include tail coverage? Yes ☐ No ☐					

Work History

Include a chronological work history for the past 10 years

Are you currently on active military duty or military reserve? Yes ☐ No ☐

Work History

Practice/Employer Name:					
Address:				Suite/Building:	
City:		State:		Zip:	
Telephone:				Fax:	
Country:		Start Date (MM/YYYY):		End Date (MM/YYYY):	
Reason for departure:					

Work History

Practice/Employer Name:					
Address:				Suite/Building:	
City:		State:		Zip:	
Telephone:				Fax:	
Country:		Start Date (MM/YYYY):		End Date (MM/YYYY):	
Reason for departure:					

Work History

Practice/Employer Name:					
Address:			Suite/Building:		
City:		State:		Zip:	
Telephone:				Fax:	
Country:		Start Date (MM/YYYY):		End Date (MM/YYYY):	
Reason for departure:					

Gaps in Professional/Work History

Please explain any time periods or gaps in training or work history that have occurred since graduation from your professional school and are longer than three months in duration if required by the organization for which you are being credentialed.

Gap Start Date (MM/YYYY):		Gap End Date (MM/YYYY):	

Disclosure Questions

Answer all questions. For any "Yes" responses, please explain why in the space provided on page 19. If needed please explain on page (photocopy as needed.)

LICENSURE

1. Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing restrictions or certification board?

Yes ☐ No ☐

2. Has there been any challenge to your licensure, registration or certification?

Yes ☐ No ☐

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

Yes ☐ No ☐

4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

Yes ☐ No ☐

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organization such as IPAs PHOs)?

Yes ☐ No ☐

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

Yes ☐ No ☐

7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

8. Have any of your board certifications or eligibility ever been revoked?

Yes ☐ No ☐

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

Yes ☐ No ☐

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certification(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?

Yes ☐ No ☐

Medicare, Medicaid or other Governmental Program Participation

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted regarding participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?

Yes ☐ No ☐

Other Sanctions or Investigations

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, and act of violence child abuse or sexual offense or sexual misconduct?

Yes ☐ No ☐

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or healthcare Integrity and Protection Data Bank?

Yes ☐ No ☐

14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

Yes ☐ No ☐

15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?

Yes ☐ No ☐

16. Are you currently being investigated, or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?

Yes ☐ No ☐

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

Yes ☐ No ☐

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?

Yes ☐ No ☐

MALPRACTICE CLAIMS HISTORY

19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, please provide information for each case.
If you answered "Yes" to question 19, you must provide and explanation on the Supplemental Disclosure Question Explanation for on

Yes ☐ No ☐

CRIMINAL/CIVIL HISTORY

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

Yes ☐ No ☐

21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor, (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or sexual offense or sexual misconduct?

Yes ☐ No ☐

22. Have you ever been court-martialed for actions related to your duties as a medical professional?

Yes ☐ No ☐

ABILITY TO PERFORM JOB

23. Are your currently engaged in the illegal use of drugs? ("Currently" means defined as sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It ". does not include the use of a drug taken under the supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription-controlled substances.)

Yes ☐ No ☐

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

Yes ☐ No ☐

25. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

Yes ☐ No ☐

26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

Yes ☐ No ☐

Standard Authorization, Attestation and Release
(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter referred to as "Participation") at or with each healthcare organization on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity), and any of the Entity's affiliated entities, I am required to provide competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently, I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups, responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information", as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release, and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s) or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and release, all references to the Entity, its Agent9s), and/or third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing process and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or grounds for my termination of Participation at or with the Entity. I agree that information obtain in accordance with the provisions of the Authorization, Attestation and release is not and will not be a violation of my privacy.

I certify that all the information provided by me in my application is current, true, correct, accurate, and complete to the best of my knowledge and belief and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to

provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff and organization and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization Attestation and Release shall be as effective as the original.

Signature: _____

Name (please print): _____

Date of Signature: _____

Disclosure Questions Supplemental Form

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

Malpractice Claims Explanation Supplement Form

Use this form to report any "Yes" response to Disclosure question #19. If you need additional space to explain a Yes response, photocopy this page and submit as instructed.

Date of Occurrence:		Date claim was filed:			
Status of claim (NOTE: if case is pending, select open, if closed indicate closed:					
If settled, enter date claim was settled:					
Professional Liability Carrier involved:					
Address:			Suite/Building:		
City:		State:		Zip:	
Telephone:					
Policy Number:					
Amount of Award settlement:					

Please indicate the method of resolution:

Dismissed: Yes ☐ No ☐	
Settled: Yes ☐ No ☐	
Mediation: Yes ☐ No ☐	
Arbitration: Yes ☐ No ☐	
Judgement for Defendant(s): Yes ☐ No ☐	
Judgment for plaintiff(s): Yes ☐ No ☐	

Description of allegations:	

Please indicate if you were the primary defendant or co-defendant?	
Number of other defendants (if any):	
Your involvement in case (attending, consulting, etc.):	

Description of alleged injury to patient:

Did the alleged injury result in death? Yes ☐ No ☐
To the best of your knowledge, is the case included in the National Practitioner Data Bank? (NPDB) Yes ☐ No ☐

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

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

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

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

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

☐☐☐ - ☐☐ - ☐☐☐☐

or

Employer identification number

☐☐ - ☐☐☐☐☐☐☐

Part II Certification

Certification Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.