



Asuris Northwest Health Practitioner Credentialing Application

Asuris contracts with physicians, dentists and other health care professionals to form provider networks essential for the delivery of health care services to our members.

Asuris requires all providers to meet criteria prior to contracting, and remain in compliance with criteria at all times. Please refer to the *Practitioner Credentialing Criteria for Participation and Termination* for details.

You will receive an email confirmation once you have passed successful credentialing. You will receive another email when your agreement documents are available online for viewing or signature. This email will contain instructions for accessing the online documents securely through the eContracting Center. Your effective date will be the first day of the month in which the contract was signed.

NOTE: If you practice at a clinic that has an Asuris Participating Medical Group Agreement, we will add you to the group's agreement and no additional documents need to be signed. Your effective date will be the first day of the month in which credentials were approved.

To begin the credentialing verification process, please:

1. Provide the email address and name of the individual who is responsible for reviewing and electronically signing the agreement documents:

All agreement documents are sent electronically. Please fill out the following information to receive your documents electronically. Not completing this portion will delay processing of your documents.	
First Name:	
Last Name:	
Email:	

2. Complete this application online in its entirety and print it.
3. Sign pages 11, 13 and 14 and return them along with any required supporting documentation to Asuris via one of the following methods:
 - a. Email: Sign and scan pages 11, 13 and 14. Use the Submit Form by Email button to create an email. Attach the signed, scanned pages and supporting documentation to the email and send to **asuris_credentialing@asuris.com**. Your email should have three attachments: The completed application, pages 11, 13 and 14 which have been signed and supporting documentation.
 - b. Fax: Use the Print and Fax button to print your completed application. Sign pages 11, 13 and 14 and fax the entire application together with supporting documentation to the appropriate number below:
 - Medical: (888) 335-3002
 - Dental: 1 (800) 331-3505
4. Retain the printed application for your records.

You have the right to review information submitted in support of your credentialing application. To learn more about the credentialing process and eContracting, visit the Welcome Center at **www.asuris.com/provider/welcome**. If you have questions about the process or the status of your application, please contact our Credentialing Department at 1 (888) 258-3435 or by email at **asuris_credentialing@asuris.com**.

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- ❖ Keep an **unsigned** and **undated** copy of the application on file for future requests. When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- ❖ Please sign and date pages 11 and 13 .
- ❖ Please document any YES responses on the Attestation Question page.
- ❖ Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.
- ❖ Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. 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.* **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number: ()	Pager Number: ()	Cell Phone Number: ()	E-Mail Address:
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Languages Fluently Spoken by Practitioner:
Have you ever voluntarily opted-out of Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty primarily practicing:		Sub specialties primarily practicing:	

Other Professional Interests in Practice, Research, etc.:

3. PRACTICE INFORMATION CHECK ALL THAT APPLY

Effective Date at Primary Practice location (MM/YY) _____

Practice Setting
Clinic/Group Solo Practice Home Based Hospital Based Primary Care Site Urgent Care Other

Practitioner Profile
 PCP Specialist Check if you are both PCP & OB OB in your practice Yes No Deliveries Yes No

Name of Practice / Affiliation or Clinic Name: Department Name (if hospital based):

Primary Office Street Address: City:
 State: Zip Code: Org. NPI#:

Patient Appointment Telephone Number: () Fax Number: ()

Mailing Address: (if different from above)

Billing Address: (if different from above)

Practice Website

Office Manager / Administrator Name: Administration Telephone Number: ()

E-mail Address: Fax Number: ()

Credentialing Contact (if different from above): Telephone Number: ()

E-mail Address: Fax Number: ()

Name Affiliated with Tax ID Number: Federal Tax ID Number:

Is the office wheelchair accessible? Yes No

Are you accepting new patients? Yes No
 Have you limited your practice in any way (e.g. 18 years or older?)
Yes No If yes, please explain:

 Do you currently supervise ARNP's or PA's? Yes No
 If yes, please provide the name and specialty below:

 Please list languages fluently spoken by office staff:

Office Hours
 Monday: _____
 Tuesday: _____
 Wednesday: _____
 Thursday: _____
 Friday: _____
 Saturday: _____
 Sunday: _____
 Do you provide 24 hour coverage? Yes No
 If no, please explain how your patients obtain advice and care after hours:

A. Inpatient Coverage Plan (for those without admitting privileges) Does Not Apply

Name of Admitting Physician/Practice/Clinic/Group: Hospital Where privileged:

B. Covering Practitioners/Call Group Does Not Apply

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

Effective Date at Secondary Practice location (MM/YY) _____ CHECK ALL THAT APPLY

Practice Setting
Clinic/Group Solo Practice Home Based Hospital Based Primary Care Site Urgent Care Other

Practitioner Profile
 PCP Specialist Check if you are both PCP & OB OB in your practice Yes No Deliveries Yes No

Name of Secondary Practice / Affiliation or Clinic Name: _____ Department Name (if hospital based): _____

Primary Office Street Address: _____ City: _____
State: _____ Zip Code: _____ Org. NPI# _____

Patient Appointment Telephone Number: _____ Fax Number: _____
() ()

Mailing Address: (if different from above) _____

Billing Address: (if different from above) _____

Practice Website _____

Office Manager / Administrator Name: _____ Administration Telephone Number: _____
()

E-mail Address: _____ Fax Number: _____
()

Credentialing Contact (if different from above): _____ Telephone Number: _____
()

E-mail Address: _____ Fax Number: _____
()

Name Affiliated with Tax ID Number: _____ Federal Tax ID Number: _____

Is the office wheelchair accessible? Yes No

Are you accepting new patients? Yes No
Have you limited your practice in any way (e.g. 18 years or older?)
Yes No If yes, please explain:

Do you currently supervise ARNP's or PA's? Yes No
If yes, please provide the name and specialty below:

Please list languages fluently spoken by office staff:

Office Hours
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday: _____
Do you provide 24 hour coverage? Yes No
If no, please explain how your patients obtain advice and care after hours:

A. Inpatient Coverage Plan (for those without admitting privileges) _____ Does Not Apply

Name of Admitting Physician/Practice/Clinic/Group: _____	Hospital Where privileged: _____

B. Covering Practitioners/Call Group _____ Does Not Apply

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed			

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS
(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:	Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):	Date Issued:	

5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

6. UNDERGRADUATE EDUCATION (Do not abbreviate) **Does Not Apply**

College or University Name:	Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

7. MEDICAL/PROFESSIONAL EDUCATION (Do not abbreviate)

Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

8. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION **Does Not Apply**

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary) **Does Not Apply**

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

10. RESIDENCIES (Attach Additional Sheet if Necessary) Does Not Apply

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

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

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

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

11. FELLOWSHIPS (Attach Additional Sheet if Necessary) Does Not Apply

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):

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

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):

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

12. PRECEPTORSHIP (Attach Additional Sheet if Necessary) Does Not Apply

Institution:	Address:	City:	State:	Zip Code:
Telephone Number ()	Fax Number ()	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Training:	Department Chairman:		

13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary) Does Not Apply

Institution:	Address:	City:	State:	Zip Code:
Telephone Number ()	Fax Number ()	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Position:	Faculty Director:		

14. BOARD CERTIFICATION				Does Not Apply <input type="checkbox"/>
Are you board or otherwise professionally certified?				
<input type="checkbox"/> Yes If "Yes", please complete below:	<input type="checkbox"/> No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If so, list certification and date:				
If you participate in a specialty which does not have board certification, please indicate specialty:				

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.)		
(Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, AND OTHER INSTITUTIONAL AFFILIATIONS		Does Not Apply <input type="checkbox"/>
Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.		
A. CURRENT HOSPITAL AFFILIATIONS (Do not abbreviate)		
Name of Primary Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone number:	Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:	
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply <input type="checkbox"/>		
<input type="checkbox"/> Primary practice admits only <input type="checkbox"/> Secondary Practice admits only <input type="checkbox"/> can admit to for all locations		
Name of Secondary Admitting Hospital:	Department:	

Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply <input type="checkbox"/> <input type="checkbox"/> Primary practice admits only <input type="checkbox"/> Secondary Practice admits only <input type="checkbox"/> Can admit to for all locations	
Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply <input type="checkbox"/> <input type="checkbox"/> Primary practice admits only <input type="checkbox"/> Secondary Practice admits only <input type="checkbox"/> Can admit to for all locations	

B. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves		Division
Name of Primary Base:	City, State , Zip	
Mailing Address	Fax Number:	
Phone number:	Appointment Date:	
Status (active, provisional, courtesy, temporary, etc.):		

C. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)		Division
Name of Primary Base:	City, State , Zip	
Mailing Address	Fax Number:	
Phone number:	Appointment Date:	
Status (active, provisional, courtesy, temporary, etc.):		

D. APPLICATIONS IN PROCESS (Do not abbreviate)			
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

E. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)	
Name of Admitting Hospital:	Department:

Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

17. WORK HISTORY (Do not abbreviate)(Do not list if already listed under Hospital Affiliations)

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.

Name of Practice / Employer:	Contact Name:	Telephone Number: ()	
Reason for Leaving:	Email Address	Fax Number: ()	
Mailing Address	City:	State:	Zip: From (mm/yyyy) To (mm/yyyy)

Name of Practice / Employer:	Contact Name:	Telephone Number: ()	
Reason for Leaving:	Email Address	Fax Number: ()	
Mailing Address:	City:	State:	Zip Code: From (mm/yyyy): To (mm/yyyy):

Name of Practice / Employer:	Contact Name:	Telephone Number: ()	
Reason for Leaving:	Email Address	Fax Number: ()	
Mailing Address:	City:	State:	Zip Code: From (mm/yyyy): To (mm/yyyy):

18. GAPS IN HISTORY Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

19. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency or fellowship for a period of less than three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()	

20. PROFESSIONAL AFFILIATIONS (Do not abbreviate)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO

21. PROFESSIONAL LIABILITY (Do not abbreviate)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began:	Expiration Date:

**B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)
(Attach Additional Sheet if Necessary)**

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - To be completed by the practitioner

Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A. PROFESSIONAL SANCTIONS			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a.	License to practice any profession in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Other professional registration or certification in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	c.	Specialty or subspecialty board certification	YES <input type="checkbox"/> NO <input type="checkbox"/>
	d.	Membership on any hospital medical staff	YES <input type="checkbox"/> NO <input type="checkbox"/>
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES <input type="checkbox"/> NO <input type="checkbox"/>
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES <input type="checkbox"/> NO <input type="checkbox"/>
	g.	Professional society membership or fellowship	YES <input type="checkbox"/> NO <input type="checkbox"/>
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES <input type="checkbox"/> NO <input type="checkbox"/>
	i.	Academic Appointment	YES <input type="checkbox"/> NO <input type="checkbox"/>
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES <input type="checkbox"/> NO <input type="checkbox"/>
B. CRIMINAL HISTORY			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES <input type="checkbox"/> NO <input type="checkbox"/>
	a.	Do you have notice of any such anticipated charges?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Are you currently under governmental investigation?	YES <input type="checkbox"/> NO <input type="checkbox"/>
C. AFFIRMATION OF ABILITIES			
1.	Do you presently use any drugs illegally?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. <u>If the answer to this question is yes</u> , please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES <input type="checkbox"/> NO <input type="checkbox"/>
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are there any such claims being asserted against you now?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES <input type="checkbox"/> NO <input type="checkbox"/>
5.	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		YES <input type="checkbox"/> NO <input type="checkbox"/>

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____ Date _____

Type or Print name here _____

22. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Does Not Apply

Practitioner Name:(print or type)

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events:

Date: Details:

Your role and specific responsibility in the incident:

Subsequent events, including patient's clinical outcome:

Date suit or claim was filed:

Name and Address of Insurance Carrier that handled the claim:

--

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit or other action:

Date of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? \$

23. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name
Here: _____

Signature: _____
(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

Healthcare Organization: -
And/or Designated Agent:

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation or Credentials Update (CU) form, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.
6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.
7. I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.
8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.
11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.
12. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name
Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

****Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).***

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	
	<input type="checkbox"/> Exempt payee	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

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

Social security number									

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

Employer identification number									

Part II Certification

Under penalties of perjury, I certify that:

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

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 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If 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 on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the 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 withholding on your share of partnership income.

The person who gives 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 is in the following cases:

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

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (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 not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, 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 the instructions below and the separate Instructions for the Requester of Form W-9.

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

Updating Your Information

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

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

Disregarded entity. Enter the owner's name on the “Name” line. The name of the entity entered on the “Name” line should never be a disregarded entity. The name on the “Name” line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the “Name” line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the “Business name/disregarded entity name” line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

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

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

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

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

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

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. 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 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7 ²

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

If you are asked to complete Form W-9 but do not have a TIN, 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 domestic 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 item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

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 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 Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

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

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

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

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

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

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

Protect yourself from suspicious emails or phishing schemes.

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

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

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

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

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. 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.

TRICARE Supplemental Questions

Date: _____ Provider Name: _____

Physical Address: _____

City, State, Zip code: _____

I. Provider Capability/Services

Please identify what age and gender groups you provide services for (check all that apply)

- Preschool 0-5
- Children 6-12
- Adolescent 13-17
- Adults 18-65
- Geriatrics 65+
- Male patients
- Female patients

Please check those capabilities in which you are certified or have received specific or on-going training. These may or may not be a covered benefit.

Dental:

- TMJ

Dermatology:

- MOHS Surgery only

Infectious Disease:

- HIV

Neurology:

- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- Epilepsy
- Huntington's Disease
- Memory Loss
- Parkinson's Disease

Obstetrics/Gynecology

- High Risk OB/Pregnancy

Ophthalmology:

- Cataract Laser Surgery
- Cornea Specialist
- Glaucoma Specialist
- Oculoplastics
- Orbit Specialist
- Retinal Specialist
- Strabismus Specialist

Pain Management:

- Short Term Pain Management

Radiology:

- Professional Services
- Ultrasound Only

Speech Pathology:

- Autism (speech)
- Developmental Disabilities

Surgery (Orthopedic):

- Arthroscopic Surgery
- Elbow Surgery
- Foot and Ankle Surgery
- Hip Surgery
- Joint Replacement
- Knee Surgery
- Shoulder Surgery
- Wrist Surgery

Surgery (Other):

- Bariatric Surgery
- Breast Surgery
- Gastric Banding

Other:

- EMG
- Sleep Studies
- Sleep Study Prosthetics
- Telemedicine Services
- Urodynamics
- Venous Closures

II. Military Status

- 1) Are you an Active Duty Service Member (ADSM)? Yes No
- 2) Are you currently employed at Military Treatment Facility (MTF)? Yes No
- 3) In the past twelve (12) months have you been employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly for decisions regarding Department of Defense payments? Yes No

Signature _____

Date Signed _____