EHN | EMPLOYERS HEALTH NETWORK

CREDENTIALING APPLICATON PACKET INSTRUCTIONS

1) **If you are registered with CAQH complete and return the following:**
   - ✓ Provider Data Form, pages 2 and 3
   - ✓ Disclosure and Ownership Form (per practitioner), pages 11 to 12
   - ✓ Attestation, page 9
   - ✓ Release/Acknowledgements, page 10

2) Please make sure you have recently updated your CAQH file. CAQH must be re-attested every 120 days.

3) Ensure all items listed on the Credentialing Application Checklist (page 13 and 14) are uploaded to your CAQH profile.

4) Ensure you authorize Employers Health Network, LLC to review your CAQH file.

5) If you are ***not*** registered with CAQH, please complete a Uniform Credentialing Application and upload to the CAQH website (https://proview.caqh.org/). You will also need to include the items listed on the Credentialing Application Checklist to your CAQH profile. If you need to contact CAQH, you can reach their Provider Help Desk at 888-599-1771.

6) ***If no application is on file with CAQH***, please complete the enclosed application and return along with your signed agreement and items listed on the Credentialing Application Checklist.

NOTE: Credentialing may take 30 to 90 days to complete.

Please return required forms by fax to 318-521-1102, email credentialing@ehnllc.com or by mail to:

Employers Health Network, LLC
Attn: Credentialing
465 West Coleman Blvd, Suite 202
Mount Pleasant, SC 29464

If you have any questions regarding the Credentialing Application call:

Barbara Wren
Provider Credentialing Manager
barbara.wren@ehnllc.com
843-647-7335 ext. 5507

EHN | EMPLOYERS HEALTH NETWORK

PRACTICIONER AND ORGANIZATIONAL PROVIDER CREDENTIALING RIGHTS

After submission of the credentialing application, health care providers have the following rights:

- To review information submitted to support their credentialing applications, with the exception of references, recommendations, and peer-protected information obtained by Employers Health Network.

- To correct erroneous information. When information obtained by the credentialing department varies substantially from information provided by the provider, the credentialing department will notify the provider to correct the discrepancy.

- To be informed, upon request, of the status of their credentialing or recredentialing applications.

- To be notified within 60 calendar days of the credentialing committee or medical director review decision.

- To appeal any recredentialing denial within 30 calendar days of receiving written notification of the decision.

- To know that all documentation and other information received for the purpose of credentialing and recredentialing is considered confidential and is stored in a secure location that is only accessed by authorized EHN associates.

- To receive notification of these rights.

To request any of the above, providers should contact:

Employers Health Network
Attn: Credentialing Department
465 West Coleman Boulevard, Suite 202
Mount Pleasant, South Carolina 29464

EHN | EMPLOYERS HEALTH NETWORK

Provider Data Form

Date:	Product: Employers Health Network, LLC	Are you registered with CAQH? Yes ☐ No ☐

If Yes, CAQH Provider ID:	Individual NPI:

Last Name:	First Name:	Middle Initial:

Date of Birth:	Social Security #:	Medicaid ID #:

Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc.):	Are you a hospital based only provider not practicing in an office setting? ☐ Yes ☐ No
Primary Office Tax ID:	Primary Office Group Billing NPI:

Practice Name:	E-Mail Address:

Primary Office Street Address:	Suite #:

Primary Office City:	State:	County:	Zip:

Primary Telephone:	Primary Fax:

Credentialing Contact Name:	Credentialing Contact Email:	Credentialing Contact Phone:

Primary Specialty:	Applying As: ☐ Specialist ☐ Primary Care Provider (e.g., Primary Care Physician, Mid- level provider)
If PCP, are you accepting new patients? ☐ Yes ☐ No ☐ Yes, existing patients only	What gender or age restrictions do you have? Gender: ☐ No Restrictions ☐ Female Only ☐ Male Only Age: ☐ No Restrictions ☐ Age Limits: Lowest Age________Highest Age ________

If PCP, please list maximum panel size (default is 1,500):

Are you board certified? ☐ Yes ☐ No	If Yes, board name: Please add in notes section if multiple board certified.	Exp. Date:

Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.

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

Do you have a CLIA Certificate? ☐ Yes ☐ No	Do you have a CLIA waiver? ☐ Yes ☐ No	Type of Service Provided:

Certificate Number: Certificate Expiration Date:	CLIA Name: Tax ID #:

If provider practices at more than one location, please include those additional locations on the following page (page 3).

Additional Practice Locations

Location Name:	Tax ID Number:	Group NPI Number:
Street Address:	City, State, Zip Code:	
Location Phone Number:	Location Fax Number:	
Billing Address (if different from page 2):	City, State, Zip Code:	
Point of Contact Name and Phone Number	E-Mail Address:	
Location Name:	Tax ID Number:	Group NPI Number:
Street Address:	City, State, Zip Code:	
Location Phone Number:	Location Fax Number:	
Billing Address (if different from page 2):	City, State, Zip Code:	
Point of Contact Name and Phone Number	E-Mail Address:	
Location Name:	Tax ID Number:	Group NPI Number:
Street Address:	City, State, Zip Code:	
Location Phone Number:	Location Fax Number:	
Billing Address (if different from page 2):	City, State, Zip Code:	
Point of Contact Name and Phone Number	E-Mail Address:	
Location Name:	Tax ID Number:	Group NPI Number:
Street Address:	City, State, Zip Code:	
Location Phone Number:	Location Fax Number:	
Billing Address (if different from page 2):	City, State, Zip Code:	
Point of Contact Name and Phone Number	E-Mail Address:	

CREDENTIALING & RECREDENTIALING APPLICATION

Please type or use black ink

What is your CAQH number? ____________

Under what specialty do you choose to be listed in the directory? ________________________________

Please specify any sub-specialty. ____

General Information

Last Name	First Name		Middle Initial	Professional Designation or Title
Social Security Number **(REQUIRED)**	Date of Birth **(REQUIRED)**	Sex	Maiden/Other Name	
Email Address			Start/Stop date for Maiden/Other Name	

Primary Office Information

Practice Name				Start Date (month/year)
Practice Address Line 1		Practice Address Line 2		
City	State	Zip	Appointment Telephone	
Office Manager (if applicable)			Fax Telephone	

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)				Type of Corporation
Billing Address Line 1		Billing Address Line 2		
City	State	Zip	Telephone	
Employer Identification Number (EIN)	Your NPI Number	Your Medicare Number	Your Medicaid Number	

Hours of Operation (actual practice hours each day at this location):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From - To							

Is this office handicapped accessible? Yes ☐ No ☐ Is this office accessible to public transportation? Yes ☐ No ☐

Identify any foreign language(s) or sign language that is spoken fluently in treating patients in this office. (select no more than 5):

☐ Arabic (AR) ☐ Chinese (CH) ☐ Farsi (FA) ☐ French (FR) ☐ German (GE)

☐ Hebrew (HE) ☐ Hindi (HI) ☐ Italian (IT) ☐ Japanese (JA) ☐ Korean (KO)

☐ Laotian (LA) ☐ Portuguese (PO) ☐ Russian (RU) ☐ Sign Language (SL) ☐ Spanish (SP)

☐ Vietnamese (VI) ☐ Tagalog (TA) ☐ Other (specify): ________________________________

Additional Office Information

Practice Name			
Practice Address Line 1		Practice Address Line 2	
City	State	Zip	Appointment Telephone
Office Manager (if applicable)			Fax Telephone

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)			
Billing Address Line 1		Billing Address Line 2	
City	State	Zip	Telephone
Employer Identification Number (EIN)	Your NPI Number	Your Medicare Number	Your Medicaid Number

Hours of Operation (actual practice hours each day at this location):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From - To							

Is this office handicapped accessible? Yes ☐ No ☐ Is this office accessible to public transportation? Yes ☐ No ☐

Does this office meet ADA accessibility requirements? Yes ☐ No ☐

License/Certification Information

DRUG CERTIFICATE: Please list your DEA certificate.

DEA Certificate #	State	Exp. Date (mm/dd/yy)

(NOTE: to expedite credentialing, please enclose a copy of your DEA certificate even if it has not expired.)

CDS Certificate #	State	Exp. Date (mm/dd/yy)

(NOTE: to expedite credentialing, please enclose a copy of your CDS certificate even if it has not expired.)

PROFESSIONAL LICENSE(S): Please list your current professional license(s). To expedite credentialing, submit a copy of your current state license even if it has expired. **Please list licenses you have held for the most recent five (5) year period.**

Board Name	Certificate #	Cert. Date (mm/dd/yy)	Exp. Date (mm/dd/yy)

Malpractice Insurance

Please list current malpractice insurance informaiton. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage, even if the policy below has not expired.

Current Carrier (Name and Address)	Policy Number	Dates of Coverage	Coverage Limits

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.

Current Carrier (Name and Address)	Policy Number	Dates of Coverage	Reason for Changing Carriers

Please list and claims history including closed, pending and dismissed claims. ____________________

____
____
____
____
____
____

Education Information

Educational Institution (include name and complete address)	Degree	Specialty	From (mm/yy)	To (mm/yy)
Undergraduate				
Graduate/Medical School				
Internship				
Residency				
Fellowship				

If you are a foreign medical school graduate, ECFMG#__________________________________
(Please attach copy of certificate(s))

CONTINUING EDUCATION: List any continuing education seminars/workshops you have attended in the past 24 months. Please attach copy of CEU certificate(s) of completion or you may attach a copy of your Accredited Continuing Education Agency's Report, if applicable.

Course Subject	Sponsoring Organization (Name and Address)	Date Started (mm/dd/yy)	Date Completed (mm/dd/yy)	# of CEUs Awarded

BOARD CERTIFICATION/SPECIALTY: If not board certified please provide a written explanation of board status (i.e.. pending results scheduled, or not certified)

Board Name	Certificate #	Cert. Date (mm/dd/yy)	Exp. Date (mm/dd/yy)

Work History/Military Experience

Please complete this section for work history and military experience. **Please fully explain fully any gaps of six months or more on a separate sheet of paper.** Submit a current curriculum vitae (must specify month and year).

From (mm/yy)	To (mm/yy)	Name & Address of Employer	Description of Activities

HOSPITAL PRIVILEGES

Please list all and if necessary, use separate sheet of paper. If no hospital privileges please provide written admitting arrangements.

Primary Admitting Facility	Address	Date	Type of Privilege	Percentage

Other Hospital Privileges	Address	Type of Privilege

Covering Physicians

Please list below any covering physicians:

Name	Address 1			Address 2
City	State	Zip	Telephone	Fax

Name	Address 1			Address 2
City	State	Zip	Telephone	Fax

Name	Address 1			Address 2
City	State	Zip	Telephone	Fax

Disclosure Questions

NOTE: If "**YES**" is checked (except if marked *), **please explain fully** on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudications, original complaint, and final disposition). An attached signed statement by you regarding the alleged incident will suffice for pending cases.

Yes or No must be checked for each question.

1. **Health Status:** Do you currently have any physical, mental, or emotional condition which may impair your ability to render the professional services which are the subject of this application? Yes ☐ No ☐
   a. Do you currently use illegal drugs or abuse drugs or alcohol? Yes ☐ No ☐
2. **Insurance Coverage:** Do you currently have malpractice insurance coverage? Yes ☐ No ☐
   a. Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application? Yes ☐ No ☐
3. **License:** Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited? Yes ☐ No ☐
   a. Have you ever voluntarily surrendered your license? Yes ☐ No ☐
   b. Are there formal charges pending against you at this time? Yes ☐ No ☐
4. **DEA:** Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited? Yes ☐ No ☐
5. **Hospital Privileges:** Do you currently have admitting privileges at any hospital or healthcare facility?
   a. Are all of your admitting privileges in good standing? Yes ☐ No ☐
6. **Hospital Actions/Sanctions:** Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges? Yes ☐ No ☐
   a. Has any hospital ever dismissed you from its staff? Yes ☐ No ☐
   b. Has any hospital ever revoked, suspended, or limited your privileges? Yes ☐ No ☐
   c. Has any hospital initiated either type of aforementioned action by formal notice to you? Yes ☐ No ☐
   d. Has any hospital refused or denied you privileges? Yes ☐ No ☐
   e. Have you ever voluntarily surrendered your hospital privileges? Please explain actions on separate page. Yes ☐ No ☐
7. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured? Yes ☐ No ☐
8. **Medicare/Medicaid:** Have you ever been fined, had an arrangement suspended, been expelled from participation, or had criminal charges brought against you by Medicare or Medicaid? Yes ☐ No ☐
9. **Criminal Offenses:** Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? Yes ☐ No ☐
   a. Have you ever been named as a defendant in any criminal proceeding? Yes ☐ No ☐
10. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county; state or national professional society hospital medical or clinical staff)? Yes ☐ No ☐
11. **Malpractice Action:** Has any malpractice action against you been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against you in a malpractice action? Yes ☐ No ☐
    a. To your knowledge, is any malpractice action against you currently pending? Yes ☐ No ☐

I hereby attest that all the information in this application is warranted to be true, correct, and complete.

____

Name (Please Print)

____ ____________________

Signature Date (mm/dd/yy)

AUTHORIZATION, ATTESTATION, AND RELEASE

I hereby specifically authorize and consent for the following organizations to release to Employers Health Network, LLC any and all records and information in your possession, which relates to my credentials as a physician and/or healthcare provider. The purpose of this authorization and consent to release is to permit EHN to properly gather and verify my credentials to engage in the delivery of healthcare or practice medicine.

The purpose of this authorization and consent to release is to permit Employers Health Network, LLC to properly gather and verify my credentials in accordance with the guidelines established by the National Committee on Quality Assurance (NCQA). I agree to notify EHN of any change in information.

I agree this authorization and consent shall remain valid and in full force and effect until specifically withdrawn by me in writing. I agree that a photocopy of this document will serve as a duplicate original.

PRACTITIONER AND ORGANIZATIONAL PROVIDER CREDENTIALING RIGHTS

After the submission of the application, health care providers have the following rights:

- To Review information submitted to support their credentialing applications, with the exception of references, recommendations, and peer-protected information obtained by the plan.
- To correct erroneous information. When information obtained by the Credentialing department varies substantially from information provided by the provider, the Credentialing department will notify the provider to correct the discrepancy.
- To be informed, upon request, of the status of their credentialing or recredentialing applications.
- To be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- To appeal any recredentialing denial within 30 days of receiving written notification of the decision.
- To know that all documentation and other information received for the purpose of credentialing and recredentialing is considered confidential and is stored in a secure location that is only accessed by authorized plan associates.
- To receive notification of these rights.

To request any of the above, providers should contact Employers Health Network Credentialing Department, 465 West Coleman Blvd., Suite 202, Mount Pleasant, South Carolina 29464.

_______________________________	_______________________________
Please print name clearly	Signature
_______________________________	_______________________________
Date signed (mm/dd/yy)	State License number

Employers Health Network, LLC
Disclosure of Ownership and Control Interest Statement

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

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity

Name of Individual, Group Practice, or Disclosing Entity:

DBA Name:

Address:

Federal Tax Identification Number: Provider CAQH #:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through IUIS-OIG Website) If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

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

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

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

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

Name/Title	DOB	Address	SSN	% Interest

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

Signature ______________________ **Title (or indicate if authorized Agent)** ______________________

Name (please print) ______________________ **Date** ______________________

Please return the form by fax to 318-521-1102,
email credentialing@ehnllc.com or by mail to:

Employers Health Network, LLC
Attn: Credentialing
465 West Coleman Blvd, Suite 202
Mount Pleasant, SC 29464

Contract & Credentialing Check List

EMPLOYERS HEALTH NETWORK

In order to proceed with the credentialing process the contract coordinator must have the following documents fully completed by the provider.

If registered with CAQH please submit per practitioner:

- ☐ CAQH: Ensure you have authorized Employers Health Network, LLC to access your data.
- ☐ CAQH: Ensure that your data has been recently.
- ☐ Completed and signed 'Disclosure of Ownership & Control Interest Statement' Form
- ☐ Provider Data Form
- ☐ W-9: Completed & signed, if practitioners share same tax ID only one W-9 needs to be submitted
- ☐ For PA, NP, and CNM providers: Complete Collaboration Agreement (where required by licensing agency)
- ☐ Verify that your malpractice insurance information is current

If *not* registered with CAQH please submit per practitioner:

- ☐ CAQH: If you would like to become registered with CAQH, please follow the instructions provided in this link - http://www.caqh.org/solutions/caqh-proview-providers-and-practice-managers
- ☐ Employers Health Network, LLC Credentialing Application Form
- CLIA Certificate (if applicable)
- ☐ Declaration Page for Professional Liability Policy
  - ☐ Any supporting documentation for any disciplinary actions
- Completed and signed 'Disclosure of Ownership & Control Interest Statement' Form
- ☐ ECFMG Certificate (if applicable)
- ☐ Federal DEA Registration
- ☐ State License (All states that provider holds a license)
- ☐ State CDS License
- ☐ Copy of Board Certification certificate (if applicable)
- ☐ Copy of CV
- ☐ W-9: Completed & signed, if practitioners share same tax ID only one W-9 needs to be submitted

If Hospital, Ancillary or Clinic (Hospitals, Ancillaries and Clinics are not in CAQH):

If practitioners are included in the contract submit the documentation listed above for each practitioner in addition to the documentation required for hospital/ancillary/clinic applications.

- ☐ **Accreditation/certification by a nationally-recognized body**
  - ☐ **If not accredited by a nationally-recognized accrediting body, a copy of the most recent Site Evaluation Results by a governmental agency is required. If the most current survey is not within the last three years, please provide a written explanation.**
- ☐ **CLIA certificate (if applicable)**
- ☐ **Declaration page for current general liability coverage**
- **Any supporting documentation for any disciplinary actions**
- ☐ **Department of Health and hospitals License (if applicable)**
- ☐ **Completed and signed 'Disclosure of Ownership & Control Interest Statement' form**
- ☐ **Federal DEA registration**
- ☐ **Hospital/ancillary/clinic provider credentialing application completed (one per hospital/ancillary/clinic provider)**
- ☐ **State operational license**
- ☐ **Medicaid/Medicare certification - if not certified, provide proof of participation**
- ☐ **Pharmacy license**
- ☐ **W-9: Completed and signed**

If provider is hospital based & employed by the hospital:

- ☐ **Completed (Excel spreadsheet) template for "Cred Not Required" Roster**
- ☐ **Completed and signed 'Disclosure of Ownership & Control Interest Statement' form**
- ☐ **W-9: completed and signed**
- ☐ **Hospital/ancillary/clinic provider credentialing application completed (group)**

If provider is approved by *Employers Health Network, LLC* for delegated credentialing:

- ☐ **Credentialing policy and procedure**
- ☐ **Delegation agreement (comes from negotiator)**
  - ☐ **Sub-delegation agreement(s) (if applicable)**
- ☐ **Individual credentialing files will need to be provided as part of the pre-delegation evaluation**
- ☐ **Roster (Excel spreadsheet) of delegated group using the "Delegate Roster Format" file**
- ☐ **EHN annually audits credentialing files, Policies and Procedures, as well as performance against NCQA standards.**

If you have questions regarding any of the credentialing documents please contact your assigned Contract Coordinator or send an email to credentialing@ehnllc.com for the most efficient response.

Once you have completed all of the appropriate credentialing documents, please choose one of the following steps below:

Fax: 318-521-1102
E-mail: credentialing@ehnllc.com *(Please use a secured email)*
Mail address: Employers Health Network, LLC, ATTN: Credentialing 465 West Coleman Boulevard, Suite 202 Mount Pleasant, SC 29464

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

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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