

DATE: **Request for Recredentialing Application**

RE:

Dear Dr.:

You are now due for your three-year recredentialing and we are requesting information to begin the process.

Please be sure to answer ALL questions and sign/date both the Attestation and Release form. With your completed application, please return the following items within **45 Days**:

1. **Copy of your current medical or professional license**
2. **Copy of your current DEA Certificate if applicable**
3. **Copy of your current Malpractice Insurance Certificate**
4. **Addendum A & C**
5. **Addendum B** (if any claims occurred within the past 3 years)
6. **W-9 Form**, completed
7. **Special Programs Certificates ( CCS, CHDP, CPSP))**

You may fax your completed application with the above attachments to **951.280.8209**

Or you may mail to: **Primary Provider Management Company**  
**Credentialing Dept**  
**2115 Compton Ave.**  
**Corona, CA 92881**

You may also e-mail your completed application to: **credentialing@ppmcinc.com**.

**If this provider is no longer working at your facility, please FAX us a term letter with the date the provider left your office.**

Please be aware that you will be notified of any information obtained during the recredentialing process that varies substantially from the information provided in your application, and you have the right to correct erroneous information submitted by another party.

If you have any questions regarding the recredentialing process, please feel free to call us directly at **951.280.7830**. If you have any questions regarding your contract with the above listed entity, please contact them directly.

Respectfully,

*Credentialing Department*

# ***PRIMARY PROVIDER MANAGEMENT COMPANY***

## **ADDENDUM TO CALIFORNIA PARTICIPATING PHYSICIAN APPLICATION NOTICE TO PRACTITIONERS OF CREDENTIALING RIGHTS/RESPONSIBILITIES**

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### **I. Application Status**

The Practitioner has the right, upon request, to be informed of the status of his/her credentialing application. The Practitioner has the right to review the information submitted in support of his/her credentialing application. The Practitioner is notified via an acknowledgement page, which is included in the application.

### **II. Right of Review**

As an applicant for credentialing/recredentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure.

You may request to review such information at any time by sending a written request via fax or letter to the Credentialing Committee Chairperson at 2115 Compton Ave, Corona , Ca. 92881 (fax 951-280-8209). Following receipt of your request, you will be contacted by the Credentialing Committee Chairperson, or his/her designee, within three working days in order to arrange a date and time for review of the information in the Credentialing Department of PPMC, INC.

### **III. Notification of Discrepancy**

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

### **IV. Correction of Erroneous Information**

If you believe that erroneous information has been supplied to PPMC, INC. by primary sources, you may correct such information by submitting written notification to the Credentialing Committee Chairperson at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to PPMC, INC. within fourteen working days of your credentials file review date and/or the date that PPMC, INC. notified you of the discrepancy.

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

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PROVIDER WORK HISTORY

- ❖ LIST MONTH/ YEAR
- ❖ EXPLAIN GAPS GREATER THAN SIX MONTHS
- ❖ LIST THE CLINIC/OFFICE THAT THE PROVIDER IS BEING CREDENTIALLED FOR 1<sup>ST</sup>, FOLLOWED BY THE PREVIOUS EMPLOYMENT

From: \_\_\_\_\_ To: PRESENT

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: CA

From: \_\_\_\_\_ To: \_\_\_\_\_

Employer Name /Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Employer Name /Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Employer Name /Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Employer Name /Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# California Participating Physician Reapplication

This application is submitted to: PRIMARY PROVIDER MANAGEMENT COMPANY, herein, this Healthcare Organization<sup>1</sup>

**I. INSTRUCTIONS**

**This form should be typed or legibly printed in black or blue ink.** If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the reapplication. **Current copies of the following documents must be submitted with this reapplication:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable) within last three years
- Face Sheet of Professional Liability Certification

**II. IDENTIFYING INFORMATION**

|   |                                  |         |
|---|----------------------------------|---------|
| Last Name:  | First Name:                      | Middle: |
| Is there any other name under which you have been known? Name (s):                            |                                  |         |
| Home Mailing Address:   | City:                            |         |
|   | State: CA                        | ZIP:    |
| Home Telephone Number:<br>Home Fax Number: (     )  | E-Mail Address:<br>Pager Number: |         |
| Citizenship (If not a United States citizen, please include copy of Alien Registration Card): |                                  |         |
| Specialty:  | D.O.B:                           | SS#:    |
| Subspecialties:   |                                  |         |

**III. PRACTICE INFORMATION - WITHIN LAST THREE YEARS. If nothing has changed, please check here**

|                                     |                                      |      |
|-------------------------------------|--------------------------------------|------|
| Practice Name (if applicable):      | Department Name (If hospital based): |      |
| Primary Office Street Address:      | City/State/Zip:                      |      |
| Telephone Number:                   | Fax Number:                          |      |
| Office Manager/Administrator:       | Telephone Number:                    |      |
|                                     | Fax Number:                          |      |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number:               |      |
| Secondary Office Street Address:    | City:                                |      |
|                                     | State:                               | ZIP: |

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

Physician Name: \_\_\_\_\_

|                                     |                          |      |  |
|-------------------------------------|--------------------------|------|--|
| Office Manager/Administrator:       | Telephone Number: (    ) |      |  |
|                                     | Fax Number: (    )       |      |  |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number:   |      |  |
| Tertiary Office Street Address:     | City:                    |      |  |
|                                     | State:                   | ZIP: |  |
| Office Manager/Administrator:       | Telephone Number: (    ) |      |  |
|                                     | Fax Number: (    )       |      |  |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number:   |      |  |

Other Medical Interests in Practice, Research, etc.:

**IV. RESIDENCIES/FELLOWSHIPS - WITHIN LAST THREE YEARS. If nothing has changed, please check here**   
**(Attach additional sheets if necessary. Reference this section number and title)**

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

|  |                   |               |             |
|--|-------------------|---------------|-------------|
| Institution:   | Program Director: |               |             |
| Mailing Address:   | City:             |               |             |
|  | State:            | ZIP:          |             |
| Type of Training (eg. residency, etc.):  | Specialty:        | From: (mm/yy) | To: (mm/yy) |
| Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.) |                   |               |             |

**V. BOARD CERTIFICATION - WITHIN LAST THREE YEARS. If nothing has changed, please check here**

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

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

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

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

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

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

**VI. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.) - WITHIN LAST THREE YEARS.**

If nothing has changed, please check here

|       |         |                  |
|-------|---------|------------------|
| Type: | Number: | Expiration Date: |
| Type: | Number: | Expiration Date: |

**VII. MEDICAL LICENSURE/REGISTRATION (Remember to attach copies of documents)**

|  |                          |
|--|--------------------------|
| California State Medical License Number:                           | Expiration Date:         |
| Drug Enforcement Administration (DEA) Registration Number:         | Expiration Date:         |
| Controlled Dangerous Substances Certificate (CDS) (if applicable): | Expiration Date:         |
| Medicare UPIN/National Physician Identifier (NPI):                 | MediCal/Medicare Number: |

**VIII. ALL OTHER STATE MEDICAL LICENSES**

|        |                 |                  |
|--------|-----------------|------------------|
| State: | License Number: | Expiration Date: |
| State: | License Number: | Expiration Date: |

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

|  |                   |                          |             |
|--|-------------------|--------------------------|-------------|
| Current Insurance Carrier :  | Policy #:         | Original Effective Date: |             |
| Mailing Address:   |                   | City:                    |             |
|  |                   | State:                   | ZIP:        |
| Per claim amount:  | Aggregate amount: | Expiration Date:         |             |
| Please list all of your professional liability carriers within the past two years other than the one listed above: |                   |                          |             |
| Name of Carrier:   | Policy #:         | From: mm/yy              | To: (mm/yy) |
| Mailing Address:   |                   | City:                    |             |
|  |                   | State:                   | ZIP:        |
| Name of Carrier:   | Policy #:         | From: (mm/yy)            | To: (mm/yy) |
| Mailing Address:   |                   | City:                    |             |
|  |                   | State:                   | ZIP:        |

**X. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS**

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past two years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If you do not have hospital privileges, please explain on a separate sheet.

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

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

**B. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS - WITHIN LAST THREE YEARS**

|  |             |                     |
|--|-------------|---------------------|
| Name and Mailing Address of <b>Other Hospital/Institution:</b> | City:       |                     |
|  | State:      | ZIP:                |
| From: (mm/yy)  | To: (mm/yy) | Reason for leaving: |
| Name and Mailing Address of <b>Other Hospital/Institution:</b> | City:       |                     |
|  | State:      | ZIP:                |
| From: (mm/yy)  | To: (mm/yy) | Reason for leaving: |

**XI. WORK HISTORY - WITHIN LAST THREE YEARS. If nothing has changed, please check here**

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

|                             |               |                           |
|-----------------------------|---------------|---------------------------|
| Current Practice:           | Contact Name: | Telephone Number: (     ) |
|                             |               | Fax Number: (     )       |
| Mailing Address:            | City:         |                           |
|                             | State:        | ZIP:                      |
| Name of Practice /Employer: | Contact Name: | Telephone Number: (     ) |
|                             |               | Fax Number: (     )       |
| Mailing Address:            | City:         |                           |
|                             | State:        | ZIP:                      |

## XII. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer to L is "no," please provide full details on separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?

Yes  No

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?

Yes  No

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes  No

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes  No

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes  No

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes  No

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?

Yes  No

H. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes  No

I. Do you presently use any drugs illegally?

Yes  No

J. Have any judgments been entered against you, or settlements been agreed to by you within the last three (3) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?

Yes  No

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes  No

L. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

Yes  No

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

Print Name Here: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_

(Stamped Signature Is Not Acceptable)



**INFORMATION RELEASE/ACKNOWLEDGMENTS**

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

I am informed and acknowledge that federal and state<sup>2</sup> laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

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

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

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

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

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

I hereby affirm that the information submitted in this reapplication and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my reapplication or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original; however, current dates are required on pages 5 and 6.

Print Name Here: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(Stamped Signature Is Not Acceptable)

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

Physician Name: \_\_\_\_\_





**VI. FOREIGN LANGUAGES SPOKEN**

|                        |                    |
|------------------------|--------------------|
| Fluently by Physician: | Fluently by Staff: |
|------------------------|--------------------|

**VII. LABORATORY SERVICES**

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

|  |               |                              |
|--|---------------|------------------------------|
| Tax ID #:  | Billing Name: | Type of Service Provided:    |
| Do you have a CLIA certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No |               |                              |
| Do you have a CLIA waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No      |               |                              |
| Certificate Number:  |               | Certificate Expiration Date: |

**VIII. PROFESSIONAL ORGANIZATIONS**

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

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

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

Print Name Here: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Stamped Signature Is Not Acceptable)

# California Participating Physician Application

## Addendum B

### Professional Liability Action Explanation

This Addendum is submitted to \_\_\_\_\_ herein, this Healthcare Organization <sup>1</sup>.

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

#### I. IDENTIFYING INFORMATION

|                 |        |         |
|-----------------|--------|---------|
| Last Name:      | First: | Middle: |
| Street Address: | City:  |         |
|                 | State: | ZIP:    |

#### II. CASE INFORMATION

|  |                              |
|--|------------------------------|
| City, County and State where lawsuit filed:<br>_____ | Court case number, if known: |
|--|------------------------------|

|  |                  |                 |                          |
|--|------------------|-----------------|--------------------------|
| Date of alleged incident serving as basis for the lawsuit/arbitration: | Date Suit Filed: | Sex of patient: | Age of patient:<br>_____ |
|--|------------------|-----------------|--------------------------|

Location of Incident:

Hospital       My office       Other doctor's office       Surgery Center

Other, (please specify)

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action?       Yes       No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name \_\_\_\_\_ Phone Number (      )

Name \_\_\_\_\_ Phone Number (      )



<sup>1</sup> As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

**III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)**

- Lawsuit/arbitration still ongoing, unresolved.
- Judgment rendered and payment was made on my behalf. Amount paid on my behalf: \$
- Judgment rendered and I was found not liable.
- Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: \$
- Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

**Summarize** the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **Please print.**

**SUMMARY**

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Physician Application. In order for participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization."

Print Name Here: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_

(Stamped Signature Is Not Acceptable)

# California Participating Physician Application

## *Addendum C*

**Section A                                      CONFIDENTIAL QUESTIONS -- HEALTH HISTORY**

|   |   |
|---|---|
| <p>1. In the last five (5) years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?</p> <p><b>If yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your abstinence prospectively and your adherence to prevailing standards of professional performance.</b></p>                         | <p><input type="checkbox"/> YES     <input type="checkbox"/> NO</p> |
| <p>2. Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?</p> <p><b>If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.</b></p> | <p><input type="checkbox"/> YES     <input type="checkbox"/> NO</p> |
| <p>3. Are you a certified Worker's Compensation provider?</p> <p><b>If yes, please attach a copy of your certificate.</b></p>   | <p><input type="checkbox"/> YES     <input type="checkbox"/> NO</p> |
| <p>4. Are you a reservist? If yes, what branch of the military? _____</p> <p>Anticipated date of separation from reserve duty? ____/____/____</p>   | <p><input type="checkbox"/> YES     <input type="checkbox"/> NO</p> |
| <p>5. Medicaid/Medi-Cal #:</p>  |   |

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

\_\_\_\_\_  
**Provider Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

**Section B****ANCILLARY PERSONNEL**

List any licensed ancillary / physician extender personnel with whom you employ, who provide direct patient care including Nurse Practitioners, Physician Assistants and Certified Nurse Midwives.

| Name | Ancillary Type | California Professional License # |
|------|----------------|-----------------------------------|
|      |                |                                   |
|      |                |                                   |
|      |                |                                   |

**Section C****PRACTICE INFORMATION**

Do you intend to serve as a Primary Care Physician?  YES  NO

Do you intend to serve as a Specialty Care Physician?  YES  NO

If you wish to serve as a specialist, please list your:  YES  NO

Primary specialty: \_\_\_\_\_

Secondary specialty: \_\_\_\_\_

Tertiary specialty: \_\_\_\_\_

Please list your affiliations with IPAs/Medical Groups:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Language(s) spoken fluently by the provider and office staff:

- | Person   | Language(s) |
|----------|-------------|
| 1. _____ |             |
| 2. _____ |             |
| 3. _____ |             |



**Primary Care Experience  
Attestation  
Addendum E**

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

- Adults (16 years of age and older)
- Pediatrics (0 to 16 years of age) – *Documentation of CHDP certification is required.*
- If you desire age limitations different from above, please specify: \_\_\_\_\_

\_\_\_\_\_

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial of participation or dismissal from participation with Care1st Health Plan.

Physician's Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Stamped signature is not acceptable)

\*\*If you have not completed at least one year of Family Medicine, Internal Medicine, or Pediatrics post-graduate training or a Rotating/Transitional Internship in the U.S., please provide, in writing, the names and addresses of at least two (2) Primary Care Physicians (PCP) who we may contact for a professional reference of your PCP experience.

# Practitioner 2168 Fax Back Form

PRIMARY PROVIDER MANAGEMENT COMPANY, INC

Name: \_\_\_\_\_

- No, I do not wish to be designated as an HIV/AIDS specialist.
- Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:
- I am a member of the American Academy of HIV Medicine.

OR

- I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five hours of which was related to antiretroviral therapy;

OR

- In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease;

OR

- In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine;

OR

- In the past 24 months I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

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

Physician's Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ License # \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax #: \_\_\_\_\_

Name and Title of Person Submitting Form \_\_\_\_\_

## 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, if different from above   |   |
| Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership<br><input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee<br><input type="checkbox"/> Other (see instructions) ▶ |   |
| 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 Line 1 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         |
| or                             |
| Employer identification number |

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

### 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 ▶

## 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 28% of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, 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.

## 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” line.

**Limited liability company (LLC).** Check the “Limited liability company” box only and enter the appropriate code for the tax classification (“D” for disregarded entity, “C” for corporation, “P” for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line.

For an LLC classified as a partnership or a corporation, enter the LLC’s name on the “Name” line and any business, trade, or DBA name on the “Business 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” line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### 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, 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 chart below 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 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker |
| Barter exchange transactions and patronage dividends                                   | Exempt payees 1 through 5  |
| Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup> | Generally, exempt payees 1 through 7   |

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, 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](http://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](http://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 [www.irs.gov](http://www.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 items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments 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.

## 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.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

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](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal 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](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

## 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 <sup>1</sup> |
| 3. Custodian account of a minor (Uniform Gift to Minors Act)  | The minor <sup>2</sup>  |
| 4. a. The usual revocable savings trust (grantor is also trustee)   | The grantor-trustee <sup>1</sup>  |
| b. So-called trust account that is not a legal or valid trust under state law   | The actual owner <sup>1</sup>   |
| 5. Sole proprietorship or disregarded entity owned by an individual   | The owner <sup>3</sup>  |
| For this type of account:   | Give name and EIN of:   |
| 6. Disregarded entity not owned by an individual  | The owner   |
| 7. A valid trust, estate, or pension trust  | Legal entity <sup>4</sup>   |
| 8. Corporate or LLC electing corporate status on Form 8832  | The corporation   |
| 9. Association, club, religious, charitable, educational, or other tax-exempt organization  | The organization  |
| 10. Partnership or multi-member LLC   | The partnership   |
| 11. A broker or registered nominee  | The broker or nominee   |
| 12. 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   |

<sup>1</sup> 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.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

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

<sup>4</sup> 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.** 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.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax 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. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.