**Fax to: Health Net Federal Services, LLC** **Fax number: 1-844-836-5818**

**Professional providers*** interested in joining the T2017 West Region network:

1. Complete and sign the T2017 Provider Participation Agreement.
2. Complete and sign the Provider Information Form (PIF) for each individual provider in the practice. *(Note: If you are a group of more than 20 providers, please email a roster to* ***hnfsT2017ProvRel@Healthnet.com*** *rather than completing a PIF form for each provider.)*
3. Complete the W-9 Request for Taxpayer Identification Number and Certification.
4. Fax all completed materials to HNFS at **1-844 836 5818**.

**Facilities/ancillary providers**: Do not complete this packet.**
Send an email to HNFS at **hnfsT2017ProvRel@Healthnet.com** to request a 2017 Facility or Ancillary Provider Agreement. The email must include:

- organization name, street, city, state, ZIP code
- type of provider (for example, critical access hospital, home health agency)
- Tax Identification Number (TIN)
- point of contact name/title, telephone number, email address, and fax number

**Mental health care providers: Do not complete this packet.**
Visit **www.mhn.com** > *Provider Site* > *Click here to visit MHN's Provider Portal* > *TRICARE West*

*Examples of professional providers include medical doctors and doctors of osteopathy (MDs/DOs), physician assistants (PAs), nurse practitioners (NPs), and physical, speech and occupational therapists (PTs, STs, OTs).

**Examples of facility/ancillary providers include hospitals (all types), home health agencies, ambulatory surgical centers, hospices, skilled nursing facilities, and durable medical equipment and medical supply companies.


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# PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement and all appendices hereto (“Agreement”) is made by and between the provider named on the signature page of this agreement (“Provider”) and Health Net Federal Services LLC, on behalf of itself and its affiliates (“HNFS”), a wholly-owned subsidiary of Centene Corporation (“Company”).

## R E C I T A L S

A. Provider has the legal authority to enter into this Agreement, and to deliver or arrange for the delivery of Contracted Services.

B. HNFS has the legal authority to enter into this Agreement, and to perform the obligations of HNFS hereunder with respect to the Benefit Programs.

## AGREEMENT

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree as follows:

## I. DEFINITIONS

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Article I.

**1.1 Beneficiary.** A person who is properly enrolled in and/or eligible to receive Covered Services under a Benefit Program at the time services are rendered. The parties acknowledge that the term “Member” may be used interchangeably with “Beneficiary” by HNFS in related materials, such as, for example, Benefit Program documents covering various products, marketing materials, HNFS Policies including without limitation the Provider Manual, correspondence, forms, and similar documents. For purposes of reference in this Agreement, the term Beneficiary includes the term Member wherever used.

**1.2 Benefit Program.** The group agreement, evidence of coverage, summary plan description or similar agreements in effect at the time Covered Services are rendered, including but not limited in type to individual, group, family, Medicare or Medicaid, whereby HNFS or any Payor is obligated to provide or arrange for Covered Services or compensation therefore, to Beneficiaries in accordance with the provisions contained in such agreements, plans and contracts.

**1.3 Benefit Program Requirements.** The rules, procedures, policies, protocols and other conditions to be followed by Participating Providers and Beneficiaries at the time Covered Services are rendered with respect to providing and receiving Covered Services under a particular Benefit Program as set forth in the Benefit Program documents.

**1.4 Clean Claim.** A Clean Claim means a request submitted to HNFS or a Payor by Provider for payment of Contracted Services that may be processed by HNFS or a Payor without obtaining additional information from Provider or from a third party. The specific data elements required for a claim to be deemed a Clean Claim are included in HNFS Policies and may be modified from time to time by HNFS in its sole discretion. The definition of Clean Claim is applicable to this Agreement unless otherwise defined in an addendum or product policy.


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**1.5** **<u>Coinsurance</u>.** That portion, if any, of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program which is calculated as a percentage of the contracted reimbursement rate for such services. Coinsurance does not include Copayments or Deductibles.

**1.6** **<u>Contracted Services</u>.** All Covered Services that are (a) within the appropriate scope of practice of Provider, (b) to be provided to a Beneficiary under the terms of the applicable Benefit Program in effect at the time services are rendered, and (c) compensated in accordance with this Agreement. Contracted Services shall not include Excluded Services.

**1.7** **<u>Coordination of Benefits</u>.** The allocation of financial responsibility between two (2) or more Payors of health care services, each with a legal duty to pay for or provide Covered Services to a Beneficiary at the same time.

**1.8** **<u>Copayment</u>.** That portion, if any, of the cost of Covered Services that a Beneficiary is obligated to pay under a particular Benefit Program, which is a fixed dollar amount that generally is indicated on the Beneficiary's identification card and is paid at the time services are rendered. Copayments do not include Coinsurance or Deductibles.

**1.9** **<u>Covered Services</u>.** The health care services, equipment and supplies that are covered benefits under a Benefit Program.

**1.10** **<u>Deductible</u>.** The amount of money, if any, that a Beneficiary must pay before the Benefit Program pays certain benefits for Covered Services. Deductibles do not include Coinsurance or Copayments.

**1.11** **<u>Emergency</u>**. Unless otherwise defined by the Benefit Program, the term "Emergency" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (and in the case of a pregnant woman, her health or that of her unborn child) in serious jeopardy, or (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

**1.12** **<u>Emergency Services</u>.** Covered Services that are needed immediately because of an Emergency.

**1.13** **<u>Excluded Services</u>.** Those health care services, equipment and supplies that are determined by HNFS or a Payor not to be Covered Services under the applicable Benefit Program in effect at the time services are rendered and for which Provider may bill the Beneficiary.

**1.14** **<u>Facility(ies)</u>.** All service locations operated or subcontracted by Provider at the time that Contracted Services are provided under this Agreement. Provider's service locations as of the date this Agreement is executed by the parties are listed after the signature page of this Agreement. Provider shall update the listing of service locations after the signature page of this Agreement as changes, additions or deletions occur, but failure to update shall not be deemed or construed to exclude any service location from the definition of Facilities under this Section 1.14.

**1.15** **<u>HNFS Policies</u>.** The policies, procedures and programs established by HNFS or Payor and applicable to Participating Providers in effect at the time Contracted Services are rendered, including without limitation the Provider Manual, grievance and appeal procedures, provider dispute and/or appeal process, drug


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formulary or preferred drug list, fraud detection, recovery procedures, eligibility verification, payment and review policies, coding guidelines, anti-discrimination requirements, medical management programs, and Benefit Program Requirements. The medical management program includes HNFS's credentialing and re-credentialing, utilization management, quality improvement, peer review, medical and other record reviews, outcome rate reviews, prior authorization, Referral and other policies related to the rendition by Participating Providers of Covered Services to Beneficiaries.

**1.16 Medically Necessary.** The term "Medically Necessary" shall have the same meaning as that term has in the applicable Benefit Program, unless otherwise required by applicable State or federal law, in which case such term shall have the meaning required by applicable State or federal law.

**1.17 Participating Provider.** A hospital, physician, physician organization, other health care provider, supplier, or other organization that has met HNFS credentialing and/or re-credentialing requirements, if any, and has, or is governed by, an effective written agreement directly with HNFS, or indirectly through another entity, such as another Participating Provider, to provide Covered Services.

**1.18 Payor.** Any public or private entity contracted directly or indirectly with HNFS which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Services rendered to Beneficiaries under a Benefit Program, including without limitation Self-Funded Health Plans, and authorized by HNFS to access Provider's services under this Agreement.

**1.19 Professional Provider.** The physicians, allied health professionals and other health care providers, if any, who contract with Provider or are employed by Provider, and who have been accepted by HNFS to provide Contracted Services to Beneficiaries pursuant to this Agreement.

**1.20 Provider Manual**. The written compilation of policies, procedures, protocols and other information applicable to Participating Providers. The Provider Manual is available on HNFS's website at www.hnfs.com.

**1.21 Referral.** Referral of a Beneficiary by a Participating Provider, that may be required under a Benefit Program or a HNFS Policy, to another health care provider, prior to the rendition of Covered Services, usually for a specified number of visits or type or duration of treatment.

**1.22 Self-Funded Health Plan.** A Self-Funded Health Plan is a Benefit Program that HNFS administers, but does not insure or underwrite the liability of, and that retains the financial responsibility for payment of (a) claims for coverage under such Benefit Programs, and (b) any expenses incident to the Benefit Program except those specifically assumed by HNFS in any administrative services agreement between the Self-Funded Health Plan or its sponsor and HNFS. HNFS is not the Payor for any Self-Funded Health Plan.

**1.23 State.** The State where services supplies, or equipment are provided.

## II. REPRESENTATIONS AND DUTIES OF PROVIDER

**2.1 Representations, Warranties and General Obligations.** Provider represents, warrants and agrees on behalf of itself, and to the extent that Provider is not an individual Provider for each of its Facilities and Professional Providers, as applicable, that:


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2.1.1 Provider is licensed or certified, as applicable to the Contracted Services, without restriction or limitation by the State to provide Contracted Services;

2.1.2 Provider operates and provides Contracted Services in compliance with all applicable local, State, and federal laws, rules, regulations and institutional and professional standards of care;

2.1.3 Provider is certified to participate in Medicare under Title XVIII of the Social Security Act, and in Medicaid under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act;

2.1.4 Provider is not debarred or suspended from a state or federal health care program;

2.1.5 Provider is accredited or certified by the accrediting or certifying organization(s) listed on the signature page of this Agreement, if any;

2.1.6 Provider shall notify HNFS in writing, thirty (30) days in advance, of any changes to federal tax identification numbers. Provider agrees to compensate HNFS for any IRS fine associated with incorrect federal tax identification numbers, should Provider fail to notify HNFS in writing, prior to the change;

2.1.7 Provider shall maintain applicable licensure, compliance, eligibility, certification and accreditation throughout the term of this Agreement, and shall immediately notify HNFS of any changes or if Provider becomes suspended or debarred from a state or federal health care program;

2.1.8 Provider has the unqualified authority to and hereby binds itself, and any Facilities and Professional Providers covered by this Agreement, to the terms and conditions of this Agreement, including any HNFS Policies, the Provider Manual, addenda appendices, attachments and exhibits, extensions and renewals, as applicable in effect at the time Covered Services are rendered. In the event Provider does not possess the right to legally bind any of its Facilities or Professional Providers to this Agreement, Provider shall ensure that, as a condition of their participation under this Agreement, each such Facility or Professional Provider executes an Election to Participate described in Section 2.4. If Provider has written agreements with its Professional Providers and/or Facilities, Provider represents and agrees that (a) the terms of such agreements do not conflict with the terms of this Agreement, (b) the terms of this Agreement shall apply in any situation where there is any inconsistency or conflict between the terms of this Agreement and the terms of any such agreement or with respect to any matter which is not addressed in any such agreement between Provider and the Professional Provider/Facility, and (c) that this provision shall supersede any similar provision in any agreement between Provider and Professional Provider/Facility;

2.1.9 Provider shall comply with HNFS Policies during the term of this Agreement and any extensions or renewals thereof. Provider agrees that it will be bound by any changes to the HNFS Policies within thirty (30) days of notice of said changes;

2.1.10 Provider shall render Contracted Services using the same standard of care, skill and diligence as is customarily used by similar providers in the United States of America, and in the same manner, and with the same availability, as Provider renders services to its other patients;


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2.1.11 Provider shall maintain such physical plant, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services; and

2.1.12 Provider acknowledges that HNFS is relying upon the representations, warranties, and general agreements set forth in this section in making its decision to enter into this Agreement and in performing its obligations under this Agreement. The representations, warranties and general agreements set forth in Section II are continuing and shall survive termination of this Agreement with respect to Contracted Services delivered during the term of this Agreement and any extensions or renewals thereof.

**2.2 Provision of Services.** Provider agrees to render Contracted Services to Beneficiaries of Benefit Programs under the terms and conditions of this Agreement and any addenda attached hereto. HNFS may add new Benefit Programs and/or Payors by addendum(a) to this Agreement in accordance with Section 7.1.

**2.3 Non-Discrimination.** Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's coverage under a Benefit Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider, HNFS or Payor. Provider agrees to make reasonable accommodations for Beneficiaries with disabilities or handicaps, including but not limited to, providing such auxiliary aides and services to Beneficiaries as are reasonable, necessary and appropriate for the proper rendering of Contracted Services at the Provider's expense.

**2.4 Subcontracting.** The following requirements shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement and apply if any of the Contracted Services are to be provided by a subcontractor, including without limitation any Facilities or Professional Providers, but excluding employees and routine vendors required in the normal course of Provider's business such as laundry suppliers and the like.

2.4.1 Provider and the subcontractor shall enter into a written agreement that expressly provides (a) that the rendering of Contracted Services by the subcontractor is subject to and agrees to comply with the terms of this Agreement, (b) that the subcontractor agrees to seek payment solely and exclusively from Provider, and (c) that the subcontractor shall hold HNFS, Payor, and Beneficiaries harmless from and against any and all claims for payment for such services. Provider shall furnish HNFS with copies of the form of any such existing subcontracts within ten (10) days of execution of this Agreement.

2.4.2 Every such subcontract shall comply with all applicable local, State and federal laws, be consistent with the terms and conditions of this Agreement, and be terminable with respect to Beneficiaries, Benefit Programs and/or Contracted Services upon request of HNFS.

2.4.3 Provider shall not subcontract either directly or indirectly, with any provider or supplier that has been excluded from participation in the Medicare Program or in the State Medicaid program under Section 1128 of the Social Security Act.

2.4.4 Each such subcontractor shall meet applicable HNFS credentialing and re-credentialing requirements, prior to the subcontract becoming effective with respect to Contracted Services.


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2.4.5 Provider agrees to be solely responsible to pay the subcontractor and Provider shall hold, and ensure that subcontractors hold, HNFS, Payor, and Beneficiaries harmless from and against any and all claims which may be made by such subcontractors in connection with Contracted Services rendered to Beneficiaries under any such subcontract, except for any amounts permitted in accordance with Section 4.3.

2.4.6 In the event that any of Provider's subcontracts fail to comply with the requirements set forth herein, HNFS and/or Payor shall not be required to recognize the existence or validity of the subcontract with respect to Beneficiaries, Benefit Programs and/or Covered Services. HNFS and/or Payor shall further have the right, but not the obligation, to directly pay subcontractors submitting claims for Contracted Services, and Provider shall indemnify and hold harmless HNFS and/or Payor for all such payments and related costs.

**2.5** **HNFS Policies.** Provider agrees to participate in, cooperate with and comply with all HNFS Policies, as amended from time to time, which are hereby incorporated by reference to this Agreement. Provider acknowledges that HNFS may implement changes in a HNFS Policy without Provider's consent and that such changes are not subject to the terms of Section 7.1 of the Agreement. Section 3.2 of this Agreement outlines the dissemination and notice of the HNFS Policies to Provider.

**2.6** **Credentialing Program.** Provider shall submit to HNFS or its designee any applicable credentials application or re-credentialing application that meets minimum requirements of HNFS. In no event will this Agreement be executed by HNFS, nor will Provider or any Professional Provider or subcontractor begin performing or continue to perform, as applicable, Provider's obligations under this Agreement, until Provider and/or such Professional Provider and/or such Facility has satisfied applicable credentialing or re-credentialing requirements, if any. Failure to submit re-credentialing materials may, at HNFS's option, subject the Professional Provider to suspension or termination under this Agreement, or termination of this Agreement in its entirety.

**2.7** **Notice of Adverse Action.** Provider shall notify HNFS within five (5) days of the occurrence of any of the following:

2.7.1 Any action taken to restrict, suspend or revoke Provider's, a Facility's and/or Professional Provider's license or certification to provide Covered Services;

2.7.2 Any suit or arbitration action brought by a Beneficiary against Provider, a Facility and/or Professional Provider for malpractice, and Provider shall send HNFS a summary of the final disposition of such action;

2.7.3 Any misdemeanor conviction or felony information or indictment naming Provider, a Facility and/or a Professional Provider, and Provider shall send Health Net a summary of the final disposition thereof;

2.7.4 Any disciplinary proceeding or action naming Provider, a Facility and/or a Professional Provider before an administrative agency in any state;

2.7.5 Any cancellation or material modification of the professional liability insurance required to be carried by Provider, a Facility and/or a Professional Provider under the terms of this Agreement


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2.7.6 Any action taken to restrict, suspend or revoke Provider's, a Facility's and/or a Professional Provider's participation in Medicare, Medicaid, CHAMPUS, or TRICARE, or any succeeding program;

2.7.7 Any action which results in the filing of a report on Provider, a Facility and/or a Professional Provider under State laws and/or regulations relating to the provision of, or the billing and payment for, Covered Services;

2.7.8 Any other event or situation that could materially affect Provider's ability to carry out Provider's duties and obligations under this Agreement.

**2.8 Professional Liability Insurance.** Provider shall maintain professional liability insurance in an amount no less than the greater of the following: (i) the amount required by law of the authorizing State; (ii) the amount required by the Federal Acquisition Regulation; (iii) the amount required by the accrediting body having jurisdiction over Provider; (iv) the amount required, if any, by the Provider's participation in a state liability pool / fund; or (v) for Institutional Provider three million dollars ($3,000,000) per claim and ten million dollars ($10,000,000) in the aggregate of all claims per policy year, and for Professional Provider two hundred thousand dollars ($200,000) per claim and six hundred thousand dollars ($600,000) in aggregate of all claims per policy years. Provider agrees to provide HNFS with written evidence, acceptable to HNFS, of such insurance coverage within three (3) days of such request by HNFS. Provider also agrees to notify, or to ensure that its insurance carriers notify, HNFS at least thirty (30) days prior to any proposed termination, cancellation or material modification of any policy for all or any portion of the coverage required herein. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than three (3) years after the end of the contract term must also be provided, or as long as may be required by local law or ordinance. In all cases, each Professional Provider and Facility must have medical malpractice coverage, except for providers that are federal entities, or state entities that are self-insured by the State. Notwithstanding any insurance coverages of Provider, nothing in Section 2.8 shall be deemed to limit or nullify Provider's indemnification obligations under this Agreement.

**2.9 Non-Solicitation.** Neither Provider nor any employee, agent nor subcontractor of Provider shall solicit or attempt to convince or otherwise persuade any Beneficiary to discontinue participation in any Benefit Program or in any other manner interfere with HNFS's contract and/or property rights. Notwithstanding the foregoing, HNFS in no way restricts Provider from discussing medical treatment options with Beneficiaries regardless of Benefit Program coverage options. Further, HNFS and Provider, and its employees and subcontractors shall portray each other in a positive light to Beneficiaries and the public.

## III. REPRESENTATIONS AND DUTIES OF HEALTH NET

**3.1 Benefit Programs.** HNFS may modify, add or delete Benefit Programs and/or Benefit Program Requirements from time to time and at any time as HNFS deems appropriate in HNFS's sole discretion, and shall use reasonable efforts to provide timely notification to Provider of any such Benefit Program and/or Benefit Program Requirement modifications, additions or deletions; provided that the addition of a Benefit Program shall be subject to Section 7.1.

**3.2 HNFS Policies.** HNFS shall develop policies and operate programs to promote the delivery of cost effective health care services by Participating Providers. HNFS shall furnish Provider with copies of, or electronic access to, operation manuals containing the provisions of relevant HNFS Policies and the methods of administration of this Agreement, including without limitation, appeals procedures, and billing and accounting


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of Contracted Services rendered hereunder. HNFS shall have the right to modify, add or delete HNFS Policies from time to time and at any time as HNFS deems appropriate in HNFS's sole discretion. HNFS shall use reasonable efforts to provide timely notification to Provider of any such modifications, additions or deletions. Such changes to HNFS Policies are not subject to the provisions of Section 7.1 of this Agreement.

**3.3** **Insurance.** HNFS shall maintain insurance programs or policies appropriate and necessary to protect itself and its employees against any claim for damages arising by reason of personal injury or death of a Beneficiary.

**3.4** **Reporting to Regulators.** HNFS and/or Payor shall accept sole responsibility for filing reports, obtaining approvals and complying with applicable laws and regulations of State, federal and other regulatory agencies having jurisdiction over HNFS and/or Payor; provided, however, that Provider agrees to cooperate in providing HNFS and/or Payor with any information and assistance reasonably required in connection therewith, including without limitation, permitting the regulatory agencies to conduct periodic site evaluations of Provider, Facilities, Professional Providers and any of their equipment, operations, and billing and medical records of Beneficiaries.

## IV. COMPENSATION

**4.1** **Payment Rates.** HNFS or Payor shall pay, and Provider shall accept as payment in full for Contracted Services the amounts payable by HNFS or Payor as set forth in the applicable Addendum, Schedule and Exhibit to this Agreement, less Copayments, Coinsurance and Deductibles payable by Beneficiaries in accordance with the applicable Benefit Program or as otherwise permitted by Section 4.5 of this Agreement.

**4.2** **Billing and Payment.** The terms of Section 4.2 shall survive termination of this Agreement with respect to Contracted Services rendered during the term of the Agreement:

4.2.1 **Billing.** If Provider is compensated on a fee-for-service basis, Provider shall submit to HNFS or the applicable Payor, via the electronic claims submission program or hardcopy as determined by HNFS or the applicable Payor, Clean Claims. HNFS and/or Payor is the secondary payor under Coordination of Benefits. Provider shall submit Clean Claims accompanied by the explanation of benefits (EOB) or explanation of payment (EOP) from the primary Payor to HNFS or the applicable Payor within ninety (90) days of the date of the EOB/EOP. If Provider fails to comply with the timely claims submission/filing requirements set forth herein, neither HNFS nor Payor shall have any obligation to pay such claims and Provider shall be prohibited from billing the Beneficiary as set forth in Section 4.3 hereof.

Provider agrees to comply with HNFS Policies when billing and collecting and/or appealing payment for Contracted Services rendered pursuant to this Agreement. Provider agrees that HNFS and/or Payor shall have the right to determine the accuracy, appropriateness and reasonableness of all Clean Claims submitted to it, including but not limited to verification of diagnostic codes, DRG assignment, procedure codes and any and all other elements of the submitted claim that affect the liability of HNFS and/or Payor. Based on its review of the accuracy, appropriateness and reasonableness of claims information submitted by Provider, HNFS and/or Payor may modify such information and use the modified information as the basis for payment of Contracted Services. HNFS and/or Payor shall include with its payment an explanation of the reasons for any modification of submitted information.


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4.2.2 **Payment**. HNFS or Payor shall make payment on each of Provider's timely-submitted Clean Claims in accordance with this Agreement or pursuant to the timeframes and procedures required by State and federal law as applicable. In no event shall HNFS be under any obligation to pay Provider for any claim, payment of which is the responsibility of another Payor under a particular Benefit Plan, including without limitation Self-Funded Health Plans.

**4.3 Beneficiary Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by HNFS or a Payor, insolvency of HNFS or a Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries or persons acting on their behalf other than HNFS or a Payor for Contracted Services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles made in accordance with applicable Benefit Program Requirements.

Provider further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries, and (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf.

At HNFS's option, the terms of the binding arbitration provisions of this Agreement shall not apply to HNFS's actions to enforce the terms of this provision against Provider, Professional Providers, Facilities, or any of their subcontractors; specifically, in the event Provider fails to cure to HNFS's reasonable satisfaction breach of this provision immediately upon written notice, HNFS may pursue legal or regulatory action to enforce the terms of this section in addition to any other remedy granted to HNFS under law or in equity. Provider shall pay HNFS for its reasonable attorney's fees and costs of enforcement.

**4.4 Conditions for Compensation for Excluded Services.** Provider may bill a Beneficiary for Excluded Services rendered by Provider to such Beneficiary only if the Beneficiary is notified in advance that the services to be provided are not Covered Services under the Beneficiary's Benefit Program, and the Beneficiary requests in writing that Provider render the Excluded Services, prior to Provider's rendition of such services.

**4.5 Coordination of Benefits and Third Party Recovery Programs.** Provider shall cooperate and comply with HNFS's coordination of benefits and third party recovery programs as described in HNFS's Provider Manual.

## V. TERM AND TERMINATION

**5.1 Term.** The term of this Agreement shall commence on the Effective Date and shall continue for a period of two (2) years thereafter. This Agreement shall automatically renew for successive one (1) year periods, unless terminated pursuant to Section 5.2, 5.3, 5.4, or 5.5. Regardless of the Effective Date or any renewal date of this Agreement, Provider shall not begin providing Contracted Services to Beneficiaries and HNFS shall have no obligation to pay for such services until the completion of HNFS's or a Payor's credentialing, re-credentialing and certification processes, if any.

**5.2 Immediate Suspension or Termination.** HNFS may terminate this Agreement or, at HNFS's discretion, suspend or terminate a Facility's or Professional Provider's participation hereunder immediately upon notice to Provider (Provider, Facilities and Professional Providers are collectively and individually referred to in this section as "Provider"), in the event of (a) Provider's violation of any applicable material law, rule or regulation, (b) Provider's failure to maintain the professional liability insurance coverage specified hereunder, (c)


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Provider or Professional Provider's failure to submit a Re-Credentialing Application; (d) any situation involving an investigation conducted or complaint filed by a state or federal agency or licensing board that restricts Provider's ability to operate a Facility or practice in a hospital, results in substantial limitation on, or reportable discipline against Provider's license, accreditation, or certification, (e) HNFS's determination that the health, safety or welfare of any Beneficiary may be in jeopardy, (f) any lawsuit or claim filed or asserted against Provider or alleging professional malpractice after HNFS's reasonable inquiry regarding the allegations supporting such lawsuit or claim, or (g) any indictment, charge, arrest or conviction of a felony, or any criminal charge related to the medical, financial and other practices of Provider.

**5.3 Termination Due to Material Breach.** Both parties agree to use best efforts to cure a material breach of this Agreement within thirty (30) days of receipt of written notice to cure from the other (the "Cure Period"). If the breach is cured within the Cure Period, or if the breach is one that cannot reasonably be corrected within the Cure Period, and the defaulting party is making substantial and diligent progress toward correction during the Cure Period to the reasonable satisfaction of the non-defaulting party, this Agreement shall remain in full force and effect. Notwithstanding the foregoing, if the defaulting party fails to cure a material breach within the Cure Period, the non-defaulting party may terminate this Agreement by providing the defaulting party thirty (30) days prior written notice of termination. The non-defaulting party may exercise this termination option, if at all, within thirty (30) days of the date the Cure Period expires. The provisions of this Section 5.3 shall not apply to claims payment timeliness issues which are governed by Article IV of this Agreement.

**5.4 Termination Upon Notice.** Either party may terminate this Agreement for any reason or no reason upon one hundred and twenty (120) days prior written notice to the other party. In the event either party provides the other party with such notice, HNFS may, at its option, begin to transition Beneficiaries immediately under this Agreement to another Participating Provider.

**5.5 Change of Control.** This Agreement may be terminated by HNFS or its successor upon a change in control of HNFS or of Provider upon written notice to Provider at any time following such change of control which termination shall be effective as of the date set forth in said written notice.

**5.6 Effect of Termination.** Upon the effective date of termination of this Agreement, the provisions of this Agreement shall be of no further force or effect, except as otherwise provided in this Agreement. Notwithstanding the foregoing, each party to this Agreement shall remain liable for any obligations and liabilities arising from the activities carried out by such party prior to the effective date of termination.

## VI. RECORDS, AUDITS AND REGULATORY REQUIREMENTS

**6.1 Access to Records, Audits.** The records referred to in Section 6.1 shall be and remain the property of Provider. Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit HNFS and Payors, or their designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over HNFS or any Payor ("Regulatory Agencies"), access to Provider's records, at Provider's place of business during normal business hours, in order to inspect and review and make copies of such records. Such Regulatory Agencies shall include, but not be limited to, the State Department of Health, the State Department of Insurance, and the United States Department of Health and Human Services and any of their representatives. When requested by HNFS, Payors, and/or Regulatory Agencies, Provider shall produce copies of any such records at no charge. Additionally, Provider agrees to permit HNFS, Payors, Regulatory Agencies or their representatives, to conduct audits, site evaluations and inspections of Provider's records, offices and service locations. Provider shall make available the access, audits,


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evaluations, inspections, records, and/or copies of records required by this Section at no cost to HNFS, Payor and/or the Regulatory Agency within a reasonable time period, but not more than five (5) days after the request is submitted to Provider.

**6.2 Continuing Obligation.** The obligations of Provider under this Article VI shall not be terminated upon termination of this Agreement, whether by rescission, non-renewal or otherwise. After such termination of this Agreement, HNFS, Payors and Regulatory Agencies shall continue to have access to Provider's records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules and regulations.

**6.3 Regulatory Compliance.** Provider agrees to comply with all applicable local, State, and federal laws, rules and regulations, now or hereafter in effect, regarding the performance of Provider's obligations hereunder, including without limitation, laws or regulations governing Beneficiary confidentiality, privacy, appeal and dispute resolution procedures to the extent that they directly or indirectly affect Provider, Provider's Facility(ies), Provider's Professional Providers, a Beneficiary, HNFS, or Payor, and bear upon the subject matter of this Agreement. If HNFS is sanctioned under any regulatory body for non-compliance that is caused by Provider, Provider shall compensate HNFS for amounts tied to this sanction incurred by HNFS including HNFS's costs of defense and fees.

## VII. GENERAL PROVISIONS

**7.1 Amendments.** All amendments to this Agreement proposed by Provider must be agreed to in writing by HNFS in advance of the effective date thereof. Any amendment to this Agreement proposed by HNFS shall be effective thirty (30) days after HNFS has given written notice to Provider of the amendment, and Provider has failed within that time period to notify HNFS in writing of Provider's rejection of the requested amendment. Amendments required because of legislative, regulatory or legal requirements do not require the consent of Provider or HNFS and will be effective immediately on the effective date of the requirement. Any amendment to this Agreement requiring prior approval of or notice to any federal or state regulatory agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired.

**7.2 Separate Obligations.** For purposes of this Section 7.2, the term "Affiliate" shall mean Company, or an entity that controls, is controlled by, under common control with Company. The rights and obligations of HNFS under this Agreement shall apply to each Affiliate and Payor covered by this Agreement only with respect to the Benefit Programs of such Affiliate or Payor. No such Affiliate or Payor shall be responsible for the obligations of any other Affiliate or Payor under this Agreement with respect to the other Affiliate's or Payor's Benefit Programs. The terms of this Section 7.2 shall survive termination of this Agreement.

**7.3 Assignment.** Neither this Agreement, nor any of Provider's rights or obligations hereunder, is assignable by Provider without the prior written consent of HNFS. HNFS expressly reserves the right to assign, delegate or transfer any or all of its rights, obligations or privileges under this Agreement without consent of Provider. The terms of this Section 7.3 shall survive termination of this Agreement.

**7.4 Confidentiality.** Except as required by a state or federal government agency, HNFS, Payors and Provider agree to hold Beneficiary health information and records, the terms of this Agreement, and all confidential or proprietary information or trade secrets of each other, in trust and confidence. HNFS, Payors and Provider each agree to keep strictly confidential all compensation rates set forth in this Agreement and its Addenda, except that this provision does not preclude disclosure by HNFS to potential customers, Beneficiaries


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and Regulatory Agencies of the method of compensation used by HNFS with respect to its Participating Providers, e.g., fee-for-service, capitation, shared risk pool, DRG or per diem. HNFS, Payors and Provider agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. HNFS, Payors and Provider agree that nothing in this Agreement shall be construed as a limitation of (a) Provider's rights or obligations to discuss with the Beneficiaries matters pertaining to the Beneficiaries' health regardless of Benefit Program coverage options, or (b) HNFS's rights or obligations with respect to subcontractors, including without limitation delegated providers. The terms of this Section 7.4 shall survive termination of this Agreement.

**7.5 Dispute Resolution Process.** The parties agree to use the dispute resolution process set forth in this Section 7.5, and binding arbitration as described in Section 7.6, as the final steps in resolving any controversy or dispute that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract, or otherwise (a "Dispute"). The parties each understand and agree that any and all HNFS internal appeals processes (including without limitation as set forth in the Provider Manual's grievance and appeal procedures, found online) must be properly pursued and exhausted before engaging in the dispute resolution process set forth in this Section 7.5.

(a) Meet and Confer Process:

Initiation: If the parties are unable to resolve any Dispute through applicable HNFS internal appeal processes, if any, the parties agree to meet and confer within thirty (30) days of a written request by either party in a good faith effort to informally settle any Dispute.

Confidentiality: All documents created for the purpose of, and exchanged during, the meet and confer process and all meet and confer discussions, negotiations and proceedings shall be treated as compromise and settlement negotiations subject to applicable State law. To the extent the parties produce or exchange any documents, including documents that are otherwise subject to the attorney work product or attorney-client privilege doctrine, the parties agree that such production or exchange shall not waive the protected nature of those documents and shall not otherwise affect their inadmissibility as evidence in any subsequent proceedings.

**7.6 Binding Arbitration**. If the parties are unable to resolve a Dispute through the dispute resolution process set forth in Section 7.5, the parties agree that such Dispute shall be settled by final and binding arbitration, upon the motion of either party, under the appropriate rules of the AAA or JAMS, as agreed by the parties. The parties each understand and agree that the exhaustion of any HNFS internal appeals processes and the dispute resolution process set forth in Section 7.5 hereof are conditions precedent to binding arbitration under this Section 7.6. Notwithstanding the foregoing, nothing contained herein is intended to require binding arbitration of disputes alleging medical malpractice between a Beneficiary and Provider or to Disputes between the parties alleging breaches of confidentiality of Beneficiary information, trade secret or intellectual property obligations. The arbitration shall be conducted in Sacramento County, California by a single, neutral arbitrator who is licensed to practice law. The written demand shall contain a detailed statement of the matter and facts and include copies of all available related documents supporting the demand. Arbitration must be initiated within one (1) year after the date the Dispute arose by submitting a written demand to the other party.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable State and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be


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final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award that could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties waive their right to a jury or court trial.

The parties recognize and agree that theirs is an ongoing business relationship that may lead to sensitive issues with respect to the exchange of information related to any Dispute. The parties agree, therefore, to enter into such protective orders (including without limitation creating a category of discovery documents "for attorneys' eyes only" to the extent feasible given the nature of the evidence and the Dispute). All discovery information shall be used solely and exclusively for arbitration of the Dispute between the parties and may not be used for any other purpose. After the arbitration award becomes final, each party shall return or destroy all attorneys' eyes only and highly confidential documents obtained from the other party during the course of the arbitration, and within thirty (30) days of such date shall provide to the other party an officer's certificate signed under penalty of perjury indicating that all such information has been returned or destroyed.

In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The parties agree that the content and decision of any arbitration proceeding shall be confidential unless disclosure is required by applicable State or federal statutes or regulations. The terms of Section 7.5 and Section 7.6 shall survive termination of this Agreement.

**7.7 Entire Agreement.** This Agreement represents the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

**7.8 Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern.

**7.9 Indemnification.**

7.9.1 Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

7.9.2 Provider agrees to indemnify, defend, and hold harmless HNFS, its agents, officers, and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Provider's performance or failure to perform its obligations hereunder.


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7.9.3 HNFS agrees to indemnify, defend, and hold harmless Provider, its agents, officers, and employees from and against any and all liability expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from HNFS's performance or failure to perform its obligations hereunder.

**7.10 Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit Provider or HNFS or Payor from entering into agreements with other health care providers or purchasers of health care services.

**7.11 No Third Party Beneficiary.** Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or remedies in any third party, including a Beneficiary. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of Provider or HNFS or Payor with respect to such Beneficiaries.

**7.12 Notice.** Any notice required or desired to be given under this Agreement shall be in writing. Notices shall be deemed given five (5) days post deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, e-mail, or facsimile, notices shall be deemed given upon documentation of receipt. All notices shall be addressed as indicated on the signature page(s) to this Agreement.

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section. In the event Provider fails to complete the notice information below or fails to notify HNFS of any changes to such information, HNFS reserves the right to send notice to the practice address included on the claim form.

**7.13 Regulation.** HNFS and/or applicable Payor is subject to the requirements of various local, State, and federal laws, rules and regulations. Any provision required to be in this Agreement by any of the above shall bind Provider and HNFS and/or applicable Payor whether or not expressly set forth herein.

**7.14 Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

**7.15 Status as Independent Entities.** None of the provisions of this Agreement is intended to create or shall be deemed or construed to create any relationship between Provider and Health Net and/or Payor other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor HNFS and/or Payor, nor any of their respective agents, employees or representatives shall be construed to be the agent, employee or representative of the other.

**7.16 Addenda.** Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement.

**7.17 Regulatory Approval.** If HNFS has not been licensed to provide, or arrange for services in connection with, a particular Benefit Program in a particular State, or has not received all required regulatory approvals for use of this Agreement with respect to a particular Benefit Program in such State prior to the execution of this Agreement, this Agreement shall be deemed to be a binding letter of intent with respect to such Benefit Program in that State. In such event, this Agreement shall become effective with respect to any


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such Benefit Program in that State on the date that the required licensure and regulatory approvals are obtained. If such licensure or regulatory approval is conditioned upon amendment of this Agreement, then this Agreement shall be amended automatically pursuant to Section 7.1 hereof.

**7.18 Calculation of Time.** The parties agree that for purposes of calculating time under this Agreement, any time period of less than ten (10) days shall be deemed to refer to business days and any time period of ten (10) days or more shall be deemed to refer to calendar days unless otherwise explicitly provided.

**SIGNATURES ON NEXT PAGE**


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**THIS CONTRACT CONTAINS A BINDING ARBITRATION CLAUSE**
**WHICH MAY BE ENFORCED BY THE PARTIES.**

**IN WITNESS WHEREOF**, the parties have executed this Agreement to be effective on the day HNFS has executed this Agreement.

The Parties hereby expressly agree that electronic signatures are permissible to evidence a binding transaction.

| **Provider** | **HNFS** |
|---|---|
| ______________________ | **Health Net Federal Services, LLC** |
| Provider Name | |
| ______________________ | ______________________ |
| Signature | Signature |
| ______________________ | ______________________ |
| Print Name | Print Name |
| ______________________ | ______________________ |
| Title | Title |
| ______________________ | ______________________ |
| Date | Date |

Tax ID
______________________
Federal Tax Identification Number (Required)

Contract Name
______________________
Name of Tax Identification Number Owner **(Required)**

---

**REQUIRED**

**Check and complete one of the following options:**

☐ I have attached a complete list/roster of Provider information which has _____ (number of) pages.

-or-

☐ I have completed the immediately following list/roster of Provider information.


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**Provider's Location and Facilities Covered by this Agreement**[1]**:**

| Provider Name and Address - or - Location/Facility Name and Address - and - Prior Authorization and Referral Fax Number | Specialty - or - Type of Facility | State License Number (Example: NY 1235678) | Federal Tax Identification Number | Medicare Provider Number | The Joint Commission (TJC) or Other Accreditation/ Certification as it applies to listed Provider | NPI (National Provider Identifier) | NPI Type 1 or 2 (check one)[2] |
|---|---|---|---|---|---|---|---|
| | | | | | | | ☐1 -or- ☐2 |
| | | | | | | | ☐1 -or- ☐2 |
| | | | | | | | ☐1 -or- ☐2 |
| | | | | | | | ☐1 -or- ☐2 |

[1] The locations and facilities reflected above are not exclusive.
[2] NPI Type 1 is for the individual. NPI Type 2 is for the group.

Notices: **Provider must complete all demographic information below, including the legal point of contact, fax number and email address for legal notices and general information.**

All notices shall be addressed as follows:

**HNFS:**

Health Net Federal Services, LLC
2107 Wilson Boulevard, Suite 900
Arlington, VA 22201
Attn: Provider Network Management
Fax: (571) 227-6708

**Provider:**

***Legal Notice and General Information***
***- Required Information -***
***PLEASE COMPLETE ALL***

Name ______________________________

Address Street (1) ______________________________

Address Street (2) ______________________________

City, State, ZIP ______________________________

**Attn: (name/title or department)** ______________________________

**Fax (legal notice and general information):** ______________________________

**Email (legal notice and general information):** ______________________________

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**PROGRAM ATTACHMENT**
**HEALTH NET FEDERAL SERVICES**
**PROVIDER PARTICIPATION AGREEMENT**

**TRICARE® PROGRAMS**

This Program Attachment sets forth the terms and conditions pursuant to which Provider agrees to render health care services to eligible individuals who are entitled to health care benefits under one or more programs of the Department of Defense ("TRICARE"), which has contracted with HNFS to arrange for the availability of health care services for such individuals through a network of providers. In the event that any definition, term, condition or provision contained in this Program Attachment is inconsistent with or in conflict with any definition, term, condition or provision set forth in the Agreement, the definitions, terms, conditions and provisions of this Program Attachment shall control.

## I. DEFINITIONS

Except as provided below, the definitions set forth in the Agreement shall apply to this Program Attachment.

**1.1** **Beneficiary.** A person who is properly enrolled in and/or eligible to receive Covered Services under the TRICARE Program at the time services are rendered.

**1.24** **TRICARE Regulations.** All applicable TRICARE regulations, operations manuals, system manuals, policy manuals and reimbursement manuals, including, but not limited to: Title 10, United States Code, Chapter 55; 32 C.F.R., Part 199; TRICARE Operations Manual (TOM); TRICARE Policy Manual (TPM); TRICARE Reimbursement Manual (TRM); and TRICARE Systems Manual (TSM)

## II. REPRESENTATIONS AND DUTIES OF PROVIDER

**2.1** **Compliance with TRICARE regulations and HNFS Policies and Procedures.** Provider shall comply with TRICARE Regulations and HNFS policies and procedures during the term of this Program Attachment.

**2.2** **Verification of Eligibility.** Except in an Emergency, HNFS may require Provider to: (a) verify that the individual is eligible to receive Covered Services; (b) determine that the requested treatment is Medically Necessary; and (c) obtain a Referral or Prior Authorization to provide Covered Services prior to rendering such services. Provider agrees to comply with any such requirements.

**2.3** **Prior Authorization and Referrals.** Provider agrees to comply with any Prior Authorization and/or Referral requirements that are set forth in the Provider Manual.

**2.4** **Privacy Act and Health Information Portability and Accountability Act of 1996 (HIPAA) Compliance.** Provider agrees to safeguard Beneficiary privacy and confidentiality as required by applicable law, including, but not limited to the Privacy Act of 1974 and the United States Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information promulgated pursuant to the administrative simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in 45 C.F.R. Subtitle A, Subchapter 3, Parts 160 and 164.


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## III. COMPENSATION

**3.1 Payment.** As compensation for the delivery of Covered Services to Beneficiaries, limited as described above, Provider shall be paid by HNFS in accordance with the rates in Exhibit A-1.

**3.2 Billing.**

3.2.1 The Provider will comply with HNFS billing rules and regulations.

3.2.2 Provider agrees to comply with HNFS policies, as applicable, when billing and collecting and/or appealing payment for Covered Services rendered pursuant to this Program Attachment.

**SIGNATURES ON NEXT PAGE**


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**IN WITNESS WHEREOF**, the parties have executed this Agreement to be effective on the first day of the month after HNFS has executed this Agreement.

| **Provider** | **HNFS** |
| --- | --- |
| ______________________ | **Health Net Federal Services, LLC** |
| Provider Name | |
| ______________________ | ______________________ |
| Signature | Signature |
| ______________________ | ______________________ |
| Print Name | Print Name |
| ______________________ | ______________________ |
| Title | Title |
| ______________________ | ______________________ |
| Date | Date |

**RATES FOR COMPENSATION (EXHIBIT A-1) ON NEXT PAGE**

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**EXHIBIT A-1**
**TRICARE COMPENSATION SCHEDULE**

PROFESSIONAL & ANCILLARY SERVICES

HNFS will reimburse Provider for Covered Services the lesser **100%** of the maximum allowable by TRICARE/ CHAMPUS or **85%** of billed charges.

**Provider acknowledges and agrees that the maximum amount reimbursed for services provided by the Provider under this Agreement is prescribed by TRICARE/CHAMPUS regulations as published in the Federal Register, and regardless of what is stated in this Agreement and/or Compensation Schedule, the Provider shall not receive or accept any reimbursement in excess of the TRICARE/CHAMPUS Maximum Allowable, as determined by the category or type of provider the Provider was, per the TRICARE/CHAMPUS regulations, at the time Covered Services were rendered.**

**CONFIDENTIAL, PROPRIETARY AND TRADE SECRET**


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Fill out the information below and use this page as a cover sheet for your Provider Information Form (PIF).

**Do not return** the "Dear Applicant" page of the form.

If you are completing more than one PIF, you **must** include a cover sheet with each PIF.

| Tax Identification Number | |
|---|---|
| Type I National Provider Identifier (NPI) | |
| Social Security Number | |
| CAQH ID (if applicable) | |


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Dear Provider Applicant:

Thank you for your interest in participating in the Health Net Federal Services, LLC (HNFS) TRICARE Provider Network. HNFS utilizes the Council for Affordable Quality Healthcare (CAQH®) Universal Credentialing DataSource® for the application and credentialing process. CAQH is a not-for-profit alliance of the nation's leading health plans, including HNFS. CAQH has developed a free, secure, online database for the collection of provider credentialing data where providers submit one standard application to a single database. All authorized health plans can access the information at any time.

Please complete and return the attached Provider Information Form (PIF) so we may add you to HNFS' roster of CAQH providers. If you do not already have one, we will alert CAQH to assign you a provider ID and send it to you, along with instructions for how to set up your CAQH profile. Once we receive the completed PIF, **you will have up to thirty (30) days to complete your CAQH online application**; failure to do so will result in the discontinuation of the credentialing process with HNFS until you resubmit a new PIF.

HNFS' policies require the following additional requisites for individual provider applicants to ensure we maintain quality of care standards for patients. Please be aware these are minimum standards. Failure to meet minimum standards may render an applicant ineligible for participation in the network. Network providers must be recredentialed every three years to maintain network status.

Note: Employees/contractors of contracted corporate service providers do not need to be credentialed. The full credentialing process may take anywhere from 60 days to 180 days from the time we receive a complete application, depending on third party responses to our inquiries. When the credentialing process is complete, you will receive written notification from HNFS of the results. If you are approved for TRICARE network participation, we will send a fully executed copy of your participation agreement.

Thank you for your interest in the TRICARE program. We look forward to partnering with you in providing health care services to our active duty service members, retirees and their families.

Health Net Federal Services
Credentialing Department

Steps for submission:

1. Have an existing network participation agreement on file, or attach a new HNFS agreement.
2. Complete and sign the PIF and Credential Attestation, Authorization and Release.
3. Return PIF and all relevant materials to the address provided at the footer of your Provider Agreement cover letter.
4. If you do not already have a CAQH provider ID, we will alert CAQH to assign you one and send it to you, along with instructions for how to set up your CAQH profile.
5. Once you receive notification from CAQH that you have been added to the HNFS roster, log on to CAQH, complete the CAQH application and ensure you authorize HNFS to access your information.
6. Ensure all CAQH information is complete and current, **including an image of Professional Liability Insurance.**
7. When the credentialing process is complete, we will send you written notification of the results.

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# Provider Information Form (PIF)

HEALTH NET FEDERAL SERVICES | TRICARE®

*This form should be completed electronically or legibly printed in blue or black ink. All fields are required, unless otherwise noted.*

**Note: Behavioral health providers should not complete this form. Contact MHN at 1-800-541-3353 or visit www.mhn.com.**

## Identifying Information *(Must match CAQH application)*

| Last Name | First Name | MI | Title/Degree |
|---|---|---|---|
| DOB | ☐ Male ☐ Female | Individual Medicare ID Number | |
| SSN (No dashes) | Individual NPI (Type I) (No dashes) | CAQH ID (If applicable) | |
| Primary Directory Specialty | | Secondary Directory Specialty (If applicable) | |
| Email Address | | | |

Will you accept Civilian Health and Medical Program of the Department of Veterans Affairs patients? ☐ Yes ☐ No

Will you accept assignment of Department of Veterans Affairs patients? ☐ Yes ☐ No

Are you participating as a primary care manager (PCM), and/or specialist (Spec), or as a hospital-based specialist? ☐ PCM ☐ Spec ☐ Hospital-based specialist

Are you accepting new patients? ☐ Yes ☐ No

## Practice Information *(Must match CAQH application)*

| Practice Name | | | |
|---|---|---|---|
| Primary Office Physical Address | City | State | ZIP |
| Primary Office Phone | Primary Office Referral /Authorization Fax | Primary Office Fax | |
| Practice/Office Manager Name | Practice/Office Manager Phone | | |
| Primary Billing Address | City | State | ZIP |
| TIN/EIN | NPI (Type II) | Billing Phone | Billing Fax |

Do you currently file medical claims electronically? ☐ Yes ☐ No

Does your office meet all state and federal handicap access requirements? ☐ Yes ☐ No





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## *Credentialing Point of Contact Information*

| Point of Contact Name | Email Address | Hours Available |
|---|---|---|
| | | |

| Mailing Address | ☐ Check if mailing address is same as primary office address | City | State | ZIP |
|---|---|---|---|---|
| | | | | |

| Phone | Fax |
|---|---|
| | |

### *Important Information—Criminal History Review*

As part of the Managed Care Support Contract for the TRICARE program in the T2017 West Region, HNFS is required to perform Criminal History Reviews of certain physicians and non-physician network providers. Contractors may search federal, state and county records in performing criminal history checks and may subcontract for these services.

Criminal History Reviews are performed on physicians with anomalies in their licensure history (four or more active and/or expired licenses) or who have been disciplined. Contractors also shall perform Criminal History Reviews on all non-physician providers who practice independently, and who are not supervised by a physician.

HNFS has chosen to subcontract for these services. Please note, a credit history is not being performed; however, as our reviews are considered investigative, they fall under the requirements of the Fair Credit Reporting Act. Therefore, this information has been provided as part of the Fair Credit Reporting Act.

A Summary of Your Rights Under the Fair Credit Reporting Act can be found online at:
http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre35.pdf.

### *Important Information—Investigative Consumer Report Disclosure*

In connection with your employment or application for employment (including contract for services), an investigative consumer report and consumer reports, which may contain public record information, may be requested. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, academic history, professional credentials, drug/alcohol use, information relating to your character, general reputation, personal characteristics, mode of living, educational background or any other information about you which may reflect upon your potential for employment gathered from any individual, organization, entity, agency or other source, which may have knowledge concerning any such items of information. Such reports may contain public record information concerning your driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies that maintain such records. You have the right to receive, upon a written request made within 60 days, a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to AbsoluteHire, upon proper identification, for the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that AbsoluteHire has previously furnished within the two-year period preceding your request. AbsoluteHire may be contacted by mail at 101 Creekside Ridge Ct., 2nd Floor, Riverside, CA 95678 or by phone at 1-800-943-2589.

# *Credentials Attestation, Authorization and Release*

*I acknowledge and agree that Health Net Federal Services, LLC (HNFS) has a valid interest and legal requirement to obtain and verify information concerning my professional competence, therefore:*

1. I authorize HNFS and/or any entity with which it may contract for verification services to consult with hospital administrators, physicians, malpractice carriers and other persons or entities to obtain and verify information concerning my professional competence, character, moral and ethical qualifications. I release HNFS and its employees, managers, agents and consulting committees form any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluating such information.

2. I consent to and authorize the release by any person or entity to HNFS of all information and documents that may be relevant to an evaluation of my professional competence, character, morality and ethical qualifications, including any information or material relating to any disciplinary or criminal action, professional competence, suspension or curtailment of medical or surgical privileges (including malpractice claims and/or coverage). I hereby release any such person or entity providing such information from any and all liability for doing so. If I have contracted with a medical group, Individual Physician Association or similar entity as a participating provider with HNFS or such other health plans, they also may receive the credentialing information or quality assurance data relating to me.

3. I understand that I have the burden and legal responsibility of providing adequate information to HNFS to demonstrate my professional competence, character, moral ethics and other qualifications.

4. I attest to the fact the information submitted by me in this application is true, correct and complete to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from, this application may constitute cause for denial of participation or cause for summary dismissal from the HNFS Provider Network, or be subject to applicable state or federal penalties for perjury.

5. If any material changes occur affecting my professional status, I agree to notify HNFS within five days, as per Section 2.16 of the Professional Provider Agreement.

6. I have attached my Professional Liability Insurance (PLI) with this form, or I have posted a current copy of my PLI on CAQH, which expires:

**Note: Application will be returned if there is no current copy of PLI on CAQH.**

Date of Professional Liability Insurance Expiration

Provider Name
(Type or use block print)

Provider Signature

Date

**Note: Must be signed and dated within 30 days of submittal.**

Print Form

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

# Request for Taxpayer Identification Number and Certification

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

*Print or type*
*See Specific Instructions on page 2.*

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

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

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

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

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

**Social security number**

☐☐☐ – ☐☐ – ☐☐☐☐

**or**

**Employer identification number**

☐☐ – ☐☐☐☐☐☐☐

## Part II Certification

Under penalties of perjury, I certify that:

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

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

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

# General Instructions

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

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

## Purpose of Form

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

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

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

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

By signing the filled-out form, you:

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

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

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

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

**Note.** If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

***Example.*** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

## Backup Withholding

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

## What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

## Updating Your Information

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

## Penalties

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

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

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

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

# Specific Instructions

### Line 1

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

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

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

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

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

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

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

## Line 2

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

## Line 3

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

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

## Line 4, Exemptions

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

**Exempt payee code.**

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

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

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

| IF the payment is for . . . | THEN the payment is exempt for . . . |
|---|---|
| Interest and dividend payments | All exempt payees except for 7 |
| Broker transactions | Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012. |
| Barter exchange transactions and patronage dividends | Exempt payees 1 through 4 |
| Payments over $600 required to be reported and direct sales over $5,000[1] | Generally, exempt payees 1 through 5[2] |
| Payments made in settlement of payment card or third party network transactions | Exempt payees 1 through 4 |

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

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

**Exemption from FATCA reporting code.** The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

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

## Line 5

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

## Line 6

Enter your city, state, and ZIP code.

# Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

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

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

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

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

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

## What Name and Number To Give the Requester

| For this type of account: | Give name and SSN of: |
|---|---|
| 1. Individual | The individual |
| 2. Two or more individuals (joint account) | The actual owner of the account or, if combined funds, the first individual on the account[1] |
| 3. Custodian account of a minor (Uniform Gift to Minors Act) | The minor[2] |
| 4. a. The usual revocable savings trust (grantor is also trustee) | The grantor-trustee[1] |
| b. So-called trust account that is not a legal or valid trust under state law | The actual owner[1] |
| 5. Sole proprietorship or disregarded entity owned by an individual | The owner[3] |
| 6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A)) | The grantor* |
| **For this type of account:** | **Give name and EIN of:** |
| 7. Disregarded entity not owned by an individual | The owner |
| 8. A valid trust, estate, or pension trust | Legal entity[4] |
| 9. Corporation or LLC electing corporate status on Form 8832 or Form 2553 | The corporation |
| 10. Association, club, religious, charitable, educational, or other tax-exempt organization | The organization |
| 11. Partnership or multi-member LLC | The partnership |
| 12. A broker or registered nominee | The broker or nominee |
| 13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments | The public entity |
| 14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B)) | The trust |

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

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

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

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

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

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

## Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

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

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

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

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

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.