



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon Practitioner Credentialing Application

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

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

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

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

To begin the credentialing verification process, please:

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

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

First Name:	
Last Name:	
Email:	

2. Complete this application online in its entirety and print it.
3. Sign pages 11 and 12 and return them along with any required supporting documentation to Regence via one of the following methods:
 - a. Email: Sign and scan pages 11 and 12. Use the Submit Form by Email button to create an email. Attach the signed, scanned pages and supporting documentation to the email and send to **regence_credentialing@regence.com**. Your email should have three attachments: The completed application, page 11 and 12 which have been signed and supporting documentation.
 - b. Fax: Use the Print and Fax button to print your completed application. Sign pages 11 and 12 and fax the entire application together with supporting documentation to the appropriate number below:
 - Medical: 1 (888) 335-3002
 - Dental: 1 (800) 331-3505
4. Retain the printed application for your records.

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

OREGON PRACTITIONER CREDENTIALING APPLICATION



- **APPLICATION**
- **PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)**
- **GLOSSARY OF TERMS AND ACRONYMS**

PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RE-CREDENTIAL PRACTITIONERS WITHIN THE STATE OF OREGON.

OREGON PRACTITIONER CREDENTIALING APPLICATION

Prior to completing this credentialing application, please read and observe the following:

I. INSTRUCTIONS

This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.**
- **Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 10, Attestation Questions and page 11, Authorization and Release of Information Form (and Attachment A, Professional Liability Action Detail, if applicable).**
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Identify the health care related organization(s) to which this application is being submitted in the space provided below.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you, please check the provided box at the top of the section.**
- **Mail application to the requesting organization(s).**

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

I am applying to (please list: Hospital Staff, HMO, IPA): _____

for: _____ (i.e., staff membership, network participation, if applicable).

***Note: Please return completed application to the health care related organization to which you are applying not to the State of Oregon.**

V. OTHER CERTIFICATIONS*Please attach copy of certificate(s), if applicable.*

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.

Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:

*For additional certifications, please attach a separate sheet.***VI. PRACTICE INFORMATION**

Name of Practice/Affiliation or Clinic:		Department Name (if hospital based):	
<i>Primary Clinical Practice</i> Street Address:			Effective Date at Location, Month / Year:
City:	County:	State:	Zip:
Primary Office Telephone Number: () - Ext	Primary Office Fax Number: () -	Patient Appointment Telephone Number: () - Ext	
Mailing Address (if different from above):			
Attn:			
Office Manager:	Office Manager's Telephone Number: () - Ext	Office Manager's Fax Number: () -	
Exchange / Answering Service Number: () - Ext	Pager Number: () -	Office E-mail Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: () - Ext	Credentialing Contact's Fax Number: () -	Credentialing Contact's E-mail Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:		Name Affiliated with Tax ID Number:	
Name of Secondary Practice/Affiliation or Clinic:		Department Name (if hospital based):	
<i>Secondary Clinical Practice</i> Street Address:			Effective Date at Location, Month / Year:
City:	County:	State:	Zip:
Secondary Office Telephone Number: () - Ext	Secondary Office Fax Number: () -	Patient Appointment Telephone Number: () - Ext	
Mailing Address (if different from above):			
Attn:			
Office Manager:	Office Manager's Telephone Number: () - Ext	Office Manager's Fax Number: () -	
Exchange / Answering Service Number: () - Ext	Pager Number: () -	Office E-mail Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: () - Ext	Credentialing Contact's Fax Number: () -	Credentialing Contact's E-mail Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:		Name Affiliated with Tax ID Number:	

Please list other office locations with above information on a separate sheet.

VII. PRACTICE CALL COVERAGE		<i>Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.</i>
NAME:	SPECIALTY:	
1.		
2.		
3.		
4.		
5.		

VIII. UNDERGRADUATE EDUCATION			<i>Please attach additional sheets, if necessary.</i>
Complete School Name:	Degree Received:	Month / Year of Graduation:	
City:	State:	Course of Study or Major:	

IX. GRADUATE EDUCATION			<i>Please attach additional sheets, if necessary.</i>	Does Not Apply <input type="checkbox"/>
Complete School Name:	Degree Received:	Month / Year of Graduation:		
City:	State:	Course of Study or Major:		

X. MEDICAL / PROFESSIONAL EDUCATION					<i>Please attach additional sheets, if necessary.</i>
Complete Medical / Professional School Name and Street Address:					
City:		State		Zip:	
Degree Received:		Phone Number: () -		Fax Number, if available () -	
From Month / Year:		To Month / Year:		Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)					
Complete Medical / Professional School Name and Street Address:					
City:		State:		Zip:	
Degree Received:		Phone Number: () - :		Fax Number, if available () -	
From Month / Year:		To Month / Year:		Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)					

XI. POST-GRADUATE YEAR 1 / INTERNSHIP			Does Not Apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary.</i>			
Complete Institution Name and Street Address:			
City:	State:	Zip:	
Type of Internship / Specialty:	Phone Number: () - :	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

XII. RESIDENCIES			Does Not Apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary.</i>			
Complete Institution Name and Street Address:			
City:	State:	Zip:	
Specialty:	Phone Number: () - :	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			
Complete Institution Name and Street Address:			
City:	State:	Zip:	
Specialty:	Phone Number: () - :	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

XIII. FELLOWSHIPS, PRECEPTORSHIPS, OR OTHER CLINICAL TRAINING PROGRAMS			Does Not Apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary.</i>			
Complete Institution Name and Street Address:			
City:	State:	Zip:	
Specialty:	Phone Number: () -	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			
Complete Institution Name and Street Address:			
City:	State:	Zip:	
Specialty:	Phone Number: () -	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

XIV. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES & ID NUMBERS		
<i>Please attach additional sheets, if necessary.</i>		
Oregon License or Registration Number:	Type:	Month / Day / Year of Expiration:
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Month / Day / Year of Expiration:
Controlled Substance Registration (CSR) Number (if applicable):		Month / Day / Year of Issue:
UPIN:	Medicare Number:	DMAP Number:
Individual NPI Number:		

XV. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES		Does Not Apply <input type="checkbox"/>
<i>Please include all ever held.</i>		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
<i>Please attach additional sheets, if necessary.</i>		

XVI. HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). **If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History.**

A. CURRENT AFFILIATIONS

Does Not Apply

Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Appointment		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Appointment		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Appointment		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Appointment		

If you do not have hospital admitting privileges, check here:

Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.

B. APPLICATIONS IN PROCESS

Does Not Apply

Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Submission:		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Submission:		

C. PREVIOUS AFFILIATIONS

Please attach additional sheets, if necessary.

Does Not Apply

Facility Name:	Phone Number: () - :	Fax Number, if available () -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			
Facility Name:	Phone Number: () - :	Fax Number, if available () -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			
Facility Name:	Phone Number: () - :	Fax Number, if available () -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			

XVII. PROFESSIONAL PRACTICE / WORK HISTORYDoes Not Apply *A curriculum vitae is not sufficient.*

A. Please account for all periods of time from the date of entry into medical/professional school to present. Chronologically list all work, professional and practice history activities since completion of postgraduate training, including military service. Please explain in section B any gaps greater than two (2) months. Please attach additional sheets, if necessary.

Name of Current Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:

B.	Please explain any gaps greater than two (2) months. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.	Does Not Apply <input type="checkbox"/>
	Activities and/or Names:	From Month / Year: To Month / Year:

XVIII. PEER REFERENCES		
Please list three (3) references, from peers who through recent observations are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.		
Name of Reference:		Complete Address, include Department if applicable:
Specialty:		
Professional Relationship:		
Telephone Number: () - Ext	Fax Number: () -	E-mail Address, if available:
Name of Reference:		Complete Address, include Department if applicable:
Specialty:		
Professional Relationship:		
Telephone Number: () - Ext	Fax Number: () -	E-mail Address, if available:
Name of Reference:		Complete Address, include Department if applicable:
Specialty:		
Professional Relationship:		
Telephone Number: () - Ext	Fax Number: () -	E-mail Address, if available:

XIX. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Please list all previous professional liability carriers within the past five (5) years. Please attach additional sheets, if necessary.

Does Not Apply

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

XX. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you ever been fined or received a letter of reprimand or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
B.	Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C.	Have you ever been denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
D.	Have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* ever been withdrawn on your request prior to the organization’s final action?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G.	Have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
H.	Have you ever had board certification revoked?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
I.	Have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
J.	Have you ever been charged with a criminal violation (felony or misdemeanor)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
K.	Do you presently use any illegal drugs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
L.	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
M.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
N.	Have any professional liability claims or lawsuits ever been closed and/or filed against you? If yes, please complete Attachment A, Professional Liability Action Detail , for each past or current claim and/or lawsuit.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
O.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

***e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system**

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:

Date:

OREGON PRACTITIONER CREDENTIALING APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system] indicated on this application, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed Name:	
Signature:	Date:

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Please list any past or current professional liability claim or lawsuit, which has been filed against you in the past five (5) years. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's Name (print or type):

Month / Day / Year of the incident: and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month / Day / Year the suit or claim was filed:

Name and address of insurance carrier/professional liability provider that handled the claim:

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

Current status of suit or other action:

Month / Day / Year of settlement, judgment, or dismissal:

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

I verify the information contained in this form is correct and complete to the best of my knowledge.

Signature:

Date:

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

Request for Taxpayer Identification Number and Certification

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

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

Part I Taxpayer Identification Number (TIN)

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

Social security number									

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

Employer identification number									

Part II Certification

Under penalties of perjury, I certify that:

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

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

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

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

Purpose of Form

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

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

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

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

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

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

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

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

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

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

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

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

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

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

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

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

Payments you receive will be subject to backup withholding if:

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

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

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

Updating Your Information

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

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

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

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

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

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

Exempt Payee

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

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

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

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

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

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

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

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

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

Part II. Certification

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

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

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

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

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

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

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

Protect yourself from suspicious emails or phishing schemes.

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

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

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

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

Privacy Act Notice

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

TRICARE Supplemental Questions

Date: _____ Provider Name: _____

Physical Address: _____

City, State, Zip code: _____

I. Provider Capability/Services

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

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

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

Dental:

- TMJ

Dermatology:

- MOHS Surgery only

Infectious Disease:

- HIV

Neurology:

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

Obstetrics/Gynecology

- High Risk OB/Pregnancy

Ophthalmology:

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

Pain Management:

- Short Term Pain Management

Radiology:

- Professional Services
- Ultrasound Only

Speech Pathology:

- Autism (speech)
- Developmental Disabilities

Surgery (Orthopedic):

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

Surgery (Other):

- Bariatric Surgery
- Breast Surgery
- Gastric Banding

Other:

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

II. Military Status

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

Signature

Date Signed