Please review the descriptions below that will assist you in completing the forms that follow this page.

1. CAQH ProView Authorization – please complete form as applicable and sign
2. CAQH Standard Authorization, Attestation and Release – please only sign at the bottom
3. DEA Addendum – please complete if applicable and sign at the bottom
4. Section 4 Provider Info Questions/Answers – please answer questions 1-14 and provide explanation for any "yes" responses
5. Section 5 Provider application/agreement – please only sign at the bottom
6. Ohio BWC Request to Change Provider Information – please only sign at the bottom
7. Form W-9 – please only sign in the middle of the form, we will complete the top portion
8. Section 15 – Certification Statement for Medicare application, please sign in "blue" ink
9. Section 6A – Reassignment of Benefits for Medicare application, please sign in "blue" ink
10. Hospital Coverage Agreement Attestation Form – please only sign at the bottom
11. Summa Health Network Hospital Coverage Agreement – please only sign at the bottom
12. Summa Health Network Release Form – please only sign at the bottom

NOTE: Please return all completed and signed forms to the following address, some payers require original signatures, so scanned/faxed documents will not be accepted.

Mail to: **Summa Health**
Attn: CVO Payer Enrollment
1077 Gorge Blvd.
Akron, OH 44310-2408

CAQH ProView Authorization

Dear Provider,

The Council for Affordable Quality Healthcare (CAQH) includes health plans, insurers and their trade associations who work together to improve the healthcare experience for more than 100 million Americans and their doctors. CAQH has built the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and providers. This database is also called CAQH.

In order to make the credentialing and enrollment process easier and more efficient, the Summa Health Credentialing and Verification Office (CVO) is requesting permission to access your CAQH account. Once permission is granted, we will access the account and update the practice address, phone numbers and any other information that is necessary for the enrollment process. The CVO will continue to maintain this account on your behalf as long as you are a provider with Summa Health Medical Group. If you should have any questions, please contact Tracy Fuller, Supervisor, Payer Enrollment at 234-312-5961 or fullert@summahealth.org.

NOTE If you do not have your CAQH login and/or password information, this can be obtained by contacting CAQH directly at 1-888-600-9802. This information will only be released directly to the provider.

CAQH Account Number: _____

☐ I give permission for Summa Health Credentialing and Verification Office to access and change information on my CAQH account.

Login: _____

Password: _____

☐ I **DO NOT** give permission for Summa Health Credentialing and Verification Office to access and change information on my CAQH account.

☐ To my knowledge, I do not have a CAQH account at this time. If you do not have a CAQH account, we will create one for you during the credentialing process.

Provider Signature: _____ Date: _____

Print Name: _____

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree thata facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Std. App. v.5.0
Reprinted on 11/2/2007

DEA ADDENDUM

IF YOU <u>DO NOT HAVE A DEA OR DO NOT HAVE ALL SCHEDULES</u> (2, 2N, 3, 3N, 4 AND 5), YOU <u>MUST</u> COMPLETE THIS SECTION. ***FAILURE TO COMPLETE THIS ADDENDUM MAY RESULT IN A DELAY IN THE PROCESSING OF YOUR APPLICATION.***

1. Please explain why you have elected to either not carry a DEA or to not carry all the schedules:

2. Please describe the policy in place to ensure that patients requiring the medications that fall under the missing schedules have access to those medications:

_____

Provider's signature

_____

Date

Section 4 – Provider information questions and answers

Answer the questions below. Please explain any yes answer in the space below. Attach a separate sheet if needed. All yes answers must have a written explanation.

1. Have you ever been or are you now dependent on, impaired by, being treated for alcohol or any other drug substance? ☐ Yes ☐ No
2. Do you have any emotional or physical disabilities or impairments that may limit your ability to practice, or that may jeopardize a patient's health? ☐ Yes ☐ No
3. Have you ever (submit five-year history) had a malpractice judgment entered against you, have any pending malpractice suits against you in any court proceeding or arbitration hearing, or have you ever been a party to an out-of-court settlement involving actual or claimed malpractice? ☐ Yes ☐ No
4. Have you ever voluntarily surrendered or had your license or certificate to practice suspended, revoked or denied, or subject to disciplinary restrictions, (including but not limited to disciplinary restrictions related to chemical dependency or substance abuse) that affect your ability to treat patients or that compromise patient care? ☐ Yes ☐ No
5. Have you ever been subject to disciplinary action by any state or local medical society, state board of medical examiners or any other professional organization? ☐ Yes ☐ No
6. Have you ever been excluded or removed from participation in Medicare or Medicaid? ☐ Yes ☐ No
7. Have you ever been excluded or removed from participation in any other health-care plan or third-party payer (i.e. HMO, PPO) for cause? ☐ Yes ☐ No
8. Have you ever had your hospital privileges suspended, restricted, revoked or denied for cause? ☐ Yes ☐ No

Do you have a history of:

9. A felony conviction in any jurisdiction; a conviction under a federal controlled substance act; a conviction for an act involving dishonesty, fraud, or misrepresentation; a conviction for a misdemeanor committed in the course of practice or involving moral turpitude; or court supervised intervention or treatment in lieu of conviction pursuant to Section 2951.041 of the Ohio Revised Code or the equivalent law of another state (including expunged convictions); ☐ Yes ☐ No
10. A conviction or plea of guilty to a violation of Sections 2913.48 (workers' compensation fraud) or 2923.31 to 2923.36 (corrupt activity) of the Ohio Revised Code; or any other criminal offense related to the delivery of or billing for health-care benefits by the provider, or any person having a 5 percent or greater ownership interest in the provider, or an officer, authorized agent, associate, manager, or employee of the provider (including expunged convictions); ☐ Yes ☐ No
11. An entry of judgment against the provider, or its owner, or an officer, authorized agent, associate, manager, or employee with proof of the specific intent of the provider, or any person having a 5 percent or greater ownership interest in the provider, or an officer, authorized agent; associate, manager, or employee of the provider, in a civil action involving payment by deception brought pursuant to Section 4121.444 of the Ohio Revised Code; ☐ Yes ☐ No
12. An entry of judgment against the provider, or any person having a 5 percent or greater ownership interest in the provider, or an officer, authorized agent, associate, manager, or employee of the provider in a civil action brought pursuant to Sections 2923.31 to 2923.36 (corrupt activity) of the Ohio Revised Code? ☐ Yes ☐ No
13. Do you refer patients for testing or treatment to any facility with which you or an immediate family member have a 5 percent or greater ownership or investment interest, or a compensation arrangement? ☐ Yes ☐ No
14. I am accepting: new ☐ (or) existing patients only ☐ in my practice.

Explanation: _____

Contact person *(person completing form)*		Title
Telephone number ( )	Fax number ( )	Email address

Section 5 – Provider application/agreement

By signing this application/agreement, the provider agrees to, and may be decertified pursuant to Ohio Administrative Code (OAC) 4123-6-02.5 and OAC 4123-6-17 for failure to adhere to conditions below.

Provider agrees to abide by the Ohio Revised Code (ORC) and rules promulgated thereunder by BWC and the Industrial Commission of Ohio. In addition, provider agrees to accept and abide by all billing and/or other policies, procedures and criteria as set forth and amended from time to time in BWC's *Provider Billing and Reimbursement Manual*, which is incorporated by reference into this application/agreement, and all other terms of this application/agreement.

Provider agrees to notify BWC within 30 days of any change in the provider's business address/location, business name, National Provider Identifier (NPI) number, Social Security number (if applicable), employer ID number, tax identification number and/or ownership, or any change in the provider's status regarding any of the credentialing criteria of paragraphs (B) or (C) of OAC 4123-6-02.2.

Provider agrees to provide health services that are applicable to a work-related injury and not to substantially engage in the practice of experimental modalities of treatment; provide adequate on-call coverage for patients; use BWC-certified providers when making referrals to other providers; and timely schedule and treat injured workers to facilitate a safe and prompt return to work.

Provider agrees to practice in a managed care environment and to adhere to managed care organization (MCO) and BWC procedures and requirements concerning provider compliance, outcome measurement data, peer review, quality assurance, utilization review, bill submission, dispute resolution and reporting of injuries and occupational diseases of employees.

Section 5 – Provider application/agreement (cont.)

Provider agrees to acknowledge and treat injured workers in accordance with BWC recognized treatment guidelines and the vocational rehabilitation hierarchy, adhere to BWC's confidentiality and sensitive data requirements, and to use information obtained from BWC by means of electronic account access for the sole purpose of facilitating treatment and no other purpose, including but not limited to engaging in advertising or solicitation directed to injured workers.

Provider agrees to maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable. Provider agrees to maintain adequate, current professional malpractice and liability insurance (commercial liability insurance if applicable).

Provider agrees to bill BWC, self-insuring employer, appropriate certified MCO and/or qualified health plan (QHP) in accordance with the statute of limitations only for services and supplies that the provider has delivered, rendered or directly supervised and that are medically necessary, cost-effective and reasonably related to the claimed or allowed condition related to the industrial injury or occupational disease. Provider understands BWC, self-insuring employer, appropriate certified MCO and/or QHP does not reimburse for failed or missed appointments (no-shows).

Provider agrees to charge BWC, self-insuring employer, appropriate certified MCO and/or QHP no more than the usual fee billed non-industrial patients for the same service. Provider further agrees not to seek additional payment from the injured worker or employer for the difference between the amount allowed and the provider's billed charge when a provider's fee bill for services or supplies has been approved for payment by BWC, self-insuring employer, appropriate certified MCO and/or QHP. Provider agrees to assume responsibility for the accuracy of all bills submitted for payment to BWC, self-insuring employer, appropriate certified MCO and/or QHP by provider, or any employee or agent of provider.

Provider agrees to create, maintain and retain sufficient records, papers, books and documents in such form to fully substantiate the delivery, value, necessity and appropriateness of goods and services provided to injured workers under the Health Partnership Plan (HPP) or of significant business transactions, as provided by OAC 4123-6-45.1. Provider further agrees to make such records available for review by BWC, self-insuring employer, appropriate certified MCO and/or QHP within 30 days or such time as agreed to by the parties, in accordance with OAC 4123-6-45.

Provider agrees to keep injured worker patient records (including but not limited to those records set forth under OAC 4123-6-45.1) confidential, and to maintain the confidentiality of injured worker patient records in accordance with all applicable state and federal statutes and rules, and prevent such information from further disclosure or use by unauthorized persons.

If the provider is of a type listed in Section 1 as requiring malpractice and liability insurance coverage, provider attests that it presently has adequate, current malpractice and liability insurance, and that it shall maintain such coverage at all times during the course of this contract. Provider agrees to provide proof of such coverage to BWC upon request.

Conflict of interest and ethics law compliance certification

Provider affirms it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict, in any manner or degree, with the performance of services that are required to be performed under this contract. In addition, provider affirms a person who is or may become an agent of provider not having such interest upon execution of this contract shall likewise advise BWC in the event it acquires such interest during the course of this contract.

Provider agrees to adhere to all ethics laws contained in chapters 102 and 2921 of the ORC governing ethical behavior, understands such provisions apply to persons doing or seeking to do business with BWC and agrees to act in accordance with the requirements of such provisions; and warrants that it has not paid and will not pay, has not given and will not give, any remuneration or thing of value directly or indirectly to BWC or any of its board members, officers, employees, or agents, or any third party in any of the engagements of this contract or otherwise, including, but not limited to a finder's fee, cash solicitation fee, or a fee for consulting, lobbying or otherwise.

Certification statements

I certify the information submitted by me in this application is true, accurate and complete to the best of my knowledge and belief, and that the application is without misrepresentation, misstatement or omission of a relevant fact, or other acts involving dishonesty, fraud, or deceit.

I hereby authorize BWC to consult with persons, companies, governmental authorities, organizations and others who may have any information or documents regarding my character, background qualifications, professional competence and credentials. I hereby consent to the release of any such information or documents to BWC for purposes of its evaluation of me in connection with the HPP.

I hereby release from liability any such person, company, government authority, organization and others that provide information as part of this credentialing process.

Any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled is subject to a felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Applicant signature ***(Required)***	Date
Please print or type name	

Ohio | **Bureau of Workers' Compensation**

30 W. Spring St.
Columbus, OH 43215-2256

Request to Change Provider Information

Instructions

- **Please print or type.**
- **Return completed form to: Ohio Bureau of Workers' Compensation, Provider Enrollment Unit, P.O. Box 15249, Columbus, OH 43215-0249, or submit by fax: 614-621-1333**

Questions?

Call **1-800-644-6292** to reach BWC's provider relations department

Points to review before completing this form

- You must determine if you are updating an individual person's provider number or a business/organizational provider number, and complete a separate form for each number to be updated. Submit National Provider Identifier (NPI) verification if applicable.
- Business/Organization providers:
  - If you have a new tax ID without change of ownership, complete this form and send us a new W-9 Internal Revenue Service (IRS) form for our records. This form is found at **www.irs.gov/pub/irs-pdf/fw9.pdf.** Include the date former number became invalid, and the date new number became effective. (Note: no bills will be payable for dates of service after the termination date of the previous provider number).
  - If you are new owners of a tax ID already established in our database, please complete a new provider application (MEDCO-13 or MEDCO-13A) for our files to show authorized agreement signature and ownership information. You do not need to complete this form.

Date effective	New tax identification number ☐ or Social Security number ☐ *(Attach a copy of the IRS form W-9. This number will be used for IRS purposes).*
Legal name associated with tax identification number *(Must appear as recognized by the IRS)*	
DBA name of group/business or individual provider name	
Business type ☐ Individual ☐ Sole proprietor ☐ Partnership ☐ Corporation ☐ S Corporation ☐ LLC ☐ Non-profit	
NPI number *(attach Fox Systems, Inc. verification)*	Taxonomy code *(attach Fox Systems, Inc. verification)*

Previous demographic information

Current BWC provider number	Date no longer valid	
Previous owner name(s)		
Practice location street address *(Indicate the address where you render services, including suite, floor, etc. We will accept a P.O. Box only if you include additional street address information.)*		
City, State, ZIP code		
Telephone ( )	Fax ( )	E-mail address
Reimbursement address *(Indicate the address to which we should send all payments, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		
Correspondence address *(Indicate the address to which we should send all correspondence, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		

New information

New owner name(s)		
Practice location street address *(Indicate the address where you render services, including suite, floor, etc. We will accept a P.O. Box only if you include additional street address information.)*		
City, State, ZIP code		
Telephone ( )	Fax ( )	E-mail address
Reimbursement address *(Indicate the address to which we should send all payments, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		
Correspondence address *(Indicate the address to which we should send all correspondence, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*		
City, State, ZIP code		

Applicant or authorized personnel signature ***(Required)*** Reimbursement change information requires provider's signature	Title
Please print or type name	Date

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

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

☐ Other (see instructions) ►

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

SECTION 5: CONTACT PERSON INFORMATION (Optional)

If questions arise during the processing of this reassignment, the designated MAC will contact the individual indicated below. If a contact person is not furnished, the MAC will contact the individual practitioner is Section 3.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Melanie	L	Ball	

Contact Person Address Line 1 *(Street Name And Number)*
1077 Gorge Blvd

Contact Person Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code +4
Akron	OH	44312-2408

Telephone Number	Fax Number *(if applicable)*	Email Address *(if applicable)*
(234) 312-6418	(234) 312-2322	BallMel@summahealth.org

Relationship or Affiliation to Individual or Organization/Group *(Spouse, Secretary, Attorney, Billing Agent, etc.)*
Coordinator, Payer Enrollment

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this reassignment. The designated MAC will not discuss any other Medicare issues about the organization/group or individual practitioner beyond this reassignment application with the above Contact Person.

SECTION 6: CERTIFICATION STATEMENTS AND SIGNATURES

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 CFR § 424.73 and 42 CFR § 424.80. All individual practitioners who allow another individual or organization/group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group or individual identified in Section 2 to receive Medicare payments on your behalf.

The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 3 and the organization/group shown in Section 2.

The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 CFR § 424.80.

These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits.

A. Individual Practitioner Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Delegated or Authorized Official of Organization/Group Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Lydia		Alexander- Cook	M.D.

Delegated or Authorized Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

Hospital Coverage Agreement Attestation Form

Admitting physician/practitioner must practice in the same or similar specialty field as the referring physician/practitioner.

I, _____, (the referring physician/practitioner) practice in the specialty of _____. I confirm that if any of my patients should require admission to the hospital, they will be admitted to _____ (name of hospital) by _____ (please state admitting hospitalist group, or physician/practitioner's full name) who agrees to admit my patients and provide care appropriate to my specialty.

By signing below I am attesting that:

1. The above information is correct and current.
2. The admitting physician or group is aware of the above arrangement.
3. I will notify all payers/organizations in which I participate of any change in my coverage arrangement within 10 calendar days of the change.

Print name: _____
(Referring physician/practitioner)

Signature: _____
(Referring physician/practitioner)

Date: _____

Note: This form is applicable to all MD's, DO's, Oral Surgeons, Podiatrists, and CNM's.

Summa Health Network

Fax to: (330) 996-8504
Email: zitkewiczm@summahealth.org

Network Hospital Coverage Agreement Attestation Form

Admitting physician/practitioner must practice in the same or similar Specialty field as the referring physician/practitioner and have admitting privileges themselves.

I, _____, (the referring physician/practitioner) practice in the specialty of _____. I confirm that Summa Health Network Payer enrollees will be admitted to

_____

(name of hospital in the Summa Health Network panel) by

_____ (please state hospitalist group, or physician/practitioner's full name) who agrees to admit any of my patients and provide care appropriate to my specialty.

My specialty is Obstetrics only:	Yes ☐	No ☐
If above is "Yes," I have delivery privileges at the above-referenced hospital:	Yes ☐	No ☐

By signing below I am attesting that:

1) The above information is correct and current.

2) The admitting physician or group is aware of the above arrangement.

3) I will notify Summa Health Network of any change to my coverage arrangement via fax to (330) 996-8504, or via email to zitkewiczm@summahealth.org within 10 calendar days the change.

Print Name: _____
(Referring Physician/Practitioner)

Signature: _____
(Referring Physician/Practitioner)

Date: _____

Note: This form is applicable to all MDs, DOs, Oral Surgeons, Podiatrists, and CNMs.

If you are <u>NOT</u> registered with CAQH, please provide the following additional information, which is necessary to register you with the CAQH Universal Credentialing DataSource.

Primary Fax No.:	Email Address:
Social Security No.:	DEA Certificate No.:
State License No.:	Licensed State:
UPIN:	Tax ID:

If you have already completed your application with CAQH, please ensure that you have authorized Summa Health Network to access your data. Using the CAQH Universal Credentialing DataSource does not automatically grant participation on the Summa Health Network. If you have any questions regarding the credentialing process or this form, please contact the Credentialing Department at (330) 996-8559.

I understand that I have the right to review any information submitted in support of my credentialing application except for information that is protected by peer review or law. All requests to review information must be made in writing and directed to: *Summa Health Network Credentialing, P.O. Box 2090, Akron, OH 44309-2090.*

I also understand that I have the right to correct any erroneous information. If information is received in the credentialing process that varies substantially from the information supplied by me, I will be notified in writing of the variance and the procedure to be followed for correction.

I acknowledge that I have the right to be informed of the status of my credentialing application by calling (330) 996-8559.

Applicant Signature	**Date**