Dear Behavioral Health Provider:

RE: Direct Contracting Opportunity for Select Behavioral Health Clinicians

Inland Empire Health Plan (IEHP) is committed to improving Behavioral Health Services and wellness for our Members by developing direct relationships with Behavioral Health Clinicians and inviting select Behavioral Health Clinicians to join our network.

As a local public health plan, IEHP now has more than 1.25 million Members throughout Riverside and San Bernardino Counties and is focused on developing direct partnerships with Psychiatrists, Psychologists, LCSWs, LMFTs, Psychiatric-mental Health Nurse Practitioners and other Behavioral Health Care Providers who share our vision of providing high quality and Behavioral Healthcare to our Members.

Behavioral Health Clinicians are essential to helping our Members achieve recovery from mental illnesses and behavioral difficulties and are an essential, as well as an integrated partner with primary care practitioners. IEHP's Direct Behavioral Health Program offers Behavioral Health Specialists many benefits, including:

- **Streamlined Authorization & Claims Submission** – via IEHP's fast and secure Provider Portal
- **Competitive Reimbursement Rates** – based on current Medicare rates
- **Speedy Payment** –payment is an average of less than 3 weeks (in most cases)
- **Personal, Friendly Service** – IEHP wants to ensure a successful and lasting working relationship with its Providers
- **Meeting the Needs of an Underserved Population** – your clinical work can have significant and lasting impact on improving the lives of Members of our community

We would like to hear from you and better understand your interests, availability and your preferences. If you are unsure of your availability to receive referrals, we still welcome your feedback and would like to know a little more about your practice.

To learn more about Behavioral Health at IEHP, visit our Behavioral Health Section at www.iehp.org.

Please feel free to contact Provider Services at (909) 890-2054 or e-mail our Contract Department at Contract@iehp.org.

Yours in good health,

Contracts Department

Inland Empire Health Plan

Behavioral Health Provider Network
Participation Request Form

Application Instructions to Physicians/Licensed Health Care Professionals:

- Please note that completion of this form and/or credentialing application does not guarantee acceptance in the IEHP Direct Provider Network.
- Your IEHP Behavioral Health Provider Network Participation Request Form will be reviewed and a response will normally be emailed within two weeks.
- IEHP will review your request to ensure you meet initial participation criteria.
- Electronic signatures are not accepted.

Please type or print legibly and submit all the following forms;

1. Completed Ownership Form (see attached)
2. Complete the Area of Expertise form along with this request (see attached)
3. Credentialing Application complete all pages in their entirety, refer to Credentialing Checklist and Provider Credentialing Tip forms (see attached)
4. W-9 (see attached)
5. Provider questionnaire for Transgender Members (see attached)
6. Certificate of Professional Liability
7. License
8. CV (Curriculum Vitae) if there is a 6 month or longer work history gap, please attach a brief description
9. Copy of Medi-Cal participation Letter. If you do not have one please enroll, https://ww3.iehp.org/en/providers/join-our-provider-team/screening-and-enrollment/

Please complete all forms, write N/A where not applicable, sign and date. Incomplete forms will be returned and the application will not be considered.

Sec. I:	**Individual Provider Requesting Contract:**
New Contract Name:	
Provider Name:	
Contact Name:	Contact Phone:
Contact Email:	
TIN:	Individual/Group NPI:
Please submit all the requested forms to:	**Attn: Contracting Department** Via Email: BHContracts@iehp.org or Via Fax: (909)477-8547

CREDENTIALING CHECKLIST

To help streamline the Credentialing process, Inland Empire Health Plan (IEHP) has developed a checklist that will identify which documents are **not applicable** to each provider type.

Should you have any questions or concerns regarding the application or checklist, please contact Credentialing at credentialing@iehp.org.

If any required information is NOT received the entire application will be RETURNED, which will delay processing.

	MALPRACTICE INSURANCE FACE SHEET - COPY	II. Identifying Information	III. Practice Information	IV. Pre-Medical Education	V. Medical/Professional Education	VI. Internship/PGYI	VII. Residency/Fellowships	VIII. Board Certification	IX. Other Certifications	X. Medical Licensure/Registrations	XI. All Other State Medical Licenses	XII. Professional Liability	XIII. Current Hospital & Other Institutional Affiliations	XIV. Peer References	XV. Work History	XVI. Attestation Questions	Information Release/Acknowledgments	**ADDENDUM A** (Health Plans and IPA's Medical Groups)	**ADDENDUM B** (Professional Liability Action Explanation)	**ADDENDUM C** (Confidential Questions – Health History)	**ADDENDUM D** (Notice to Practitioners of Credentialing Rights /Responsibilities)	**HIV/AIDS PHYSICIAN SPECIALIST FORM**	**W-9**	**BEHAVIORAL HEALTH** (Areas of Expertise Form)
M.D.																								
D.O.																								
D.P.M.																								
D.D.S., D.M.D.																								
O.D.																								
P.T.																								
S.P., AU.																								
O.T.																								
D.C.																								
L.A.c																								
L.M.F.T., L.C.S.W.																								
Ph.D, Psy.D.																								

PROVIDER
CREDENTIALING TIPS

To help streamline the credentialing process, we developed a tip sheet to help our providers complete the application and help identify common issues that cause delays in your application processing.

All areas of the application should be completed. For all areas that do not pertain to you, please indicate N/A under the respective area.

APPLICATION	NOTES/COMMENTS
II. Identifying information • Last Name, First Name M.I. • Other Names used • Birth Date • SSN# • Gender • Specialty • Subspecialties	Please make sure these data elements are completed to the best of your ability. These elements are used as identifying information to conduct primary source verifications on your application. If any information is missing, it will delay your application until it has been completed.
III. Practice Information • Office Manager/Administrator (we will list this person as your main contact for obtaining Credentialing documents) • Name affiliated with TIN & TIN	This applies to all locations where IEHP patients will be treated. *If you have multiple offices with different Tax ID#'s, we will require a copy of each W-9 for your credentialing file
IV. Premedical Education **V. Medical/Professional Education** • School Name • Degree • Graduation Date	Please complete the following fields
VI. Internship/PGY1 **VII. Residencies/Fellowships** • Institution Name • Address, City, State ZIP • Type of Training • Specialty • Start Date (mm/yy) • End Date (mm/yy) • Successfully complete the program, Yes or No.	If the facility is not an ACGME program, we would need to the address information, to verify your training with the school directly It is essential that the specialty and dates are reported accurately. Any discrepancies will be delay your application until it has been clarified If you did not successfully complete a training program, you must provide an explanation to support your response.
VII. Board Certification If not certified, describe your intent for certification, if any, and date of eligibility for certification on a separate sheet	The acceptable board certifications are recognized by the following organizations: • American Board of Medical Specialties (ABMS) • American Osteopathic Association (AOA) • American Board of Foot and Ankle Surgery (formerly the American Board of Podiatric Surgery) • American Board of Podiatric Orthopedics and Primary Podiatric Medicine • American Board of Multiple Specialties in Podiatry
X. Medical Licensure/Registration • California License Practice information • DEA Information • ECFMG Information (If applicable) • NPI	State Licensures, DEA Certificates, and NPI registry information must reflect California addresses. DEA's with an exempt fee is only valid at the exempting institution. If the provider is not treating IEHP patients at that facility, the provider needs to obtain a paid status DEA. The NPI registry should list the provider's practice information Any discrepancies will delay the credentialing process until the issues are addressed

PROVIDER
CREDENTIALING TIPS

APPLICATION	NOTES/COMMENTS
XII. Professional Liability	Professional Liability information on the application must be supported with a copy of the insurance certificate (Binders and Declarations are not acceptable) Malpractice Insurance Face sheet should indicate the covered practice location, specialty coverage, policy coverage amounts, effective and termination date and should cover all locations the provider will be treating IEHP patients. If any information is missing from the certificate, the credentialing coordinator will attempt to verify this information with your insurance carrier directly
XIII. Current Hospital and Other Institutional Affiliations Please include all hospitals and other institutional institutions the provider has current affiliations during the past 10 years (i.e. hospitals, surgery centers)	If the practitioner does not have clinical privileges, the provider must provide a written statement delineating the inpatient coverage arrangement. If the provider is a PCP utilizing IEHP's Hospitalist program, they must identify which hospital and hospitalist they will be referring patients to on their application. These arrangements can be arranged with IEHP's Contracting Department Specialists (in the appropriate specialties) must have a formal inpatient coverage arrangement, which is subject to IEHP review and approval.
X. Work History	Please provide your work history activities for the past five (5) years. Any gaps of six (6) months or more must be explained on a separate page. Your work history activities must also include the start date you began at your current practice
XVI. Attestation Questions If your answer is Yes to questions A through L, please provide full details on a separate sheet.	Please be sure that all questions are answered. All responses will be compared to our findings through primary source verifications. If there is a discrepancy, it will delay your application until the issue(s) are addressed
Provider Signatures and dates	Stamped and typed signatures are not accepted and applications must have a current date. Any discrepancies, you will be contacted by a coordinator regarding the non-compliant pages for your review, to re-sign and re-date

ADDENDUM A	NOTES/COMMENTS
I. Identifying information	Please indicate whether you intent to serve as a Primary Care Provider or Specialist and identify your practice type
III. Practice Information Allied Health Professionals	Please list ANY allied Health professionals (e.g. nurse practitioners, physician assistants, certified nurse midwives) you employ.
Age limitations	Please specify any age limitations for your practice
Office Hours	Please indicate the office hours for each of your office locations. • PCP's are required to practice in each practice location for a minimum of twenty (20) hours, to receive membership assignment to that location
Continuity of Care	Please provide your written plan for continuity of care, if you do not have hospital privileges
Languages	Please provider languages spoken FLUENTLY by the Physician and/or Staff • If Spanish is listed, IEHP will conduct a Language Competency audit to confirm if the office met the requirements to be listed as a Spanish site in our Provider Directory

ADDENDUM B	NOTES/COMMENTS
Professional Liability Action Explanation	Please complete the Addendum B for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you in which you were named in the past seven (7) years.

PROVIDER
CREDENTIALING TIPS

ADDENDUM C	NOTES/COMMENTS
Confidential Questions – Health History	If you are a certified Worker's Compensation Provider, please provide a copy of your QME Evaluator certificate

ADDENDUM D	NOTES/COMMENTS
Notice to Practitioners of Credentialing Rights/Responsibilities	Please complete, sign and date

ADDENDUM E	NOTES/COMMENTS
Primary Care Experience – Attestation	Applicable to General Practice and Obstetrics/Gynecology PCP's only Please contact credentialing@iehp.org regarding additional information required for your specialty.

HIV/AIDS SPECIALIST FORM	NOTES/COMMENTS
Verification of Qualifications for HIV/AIDS Specialist	If you wish to be designated as a HIV/AIDS Specialist, please check all criterion that apply to you and provide the supporting documents

W-9	NOTES/COMMENTS
Tax Identification Number and Certification	Please provide a complete, signed and dated W-9 for each TIN you will be billing with for each IEHP member

AREAS OF EXPERTISE FORM	NOTES/COMMENTS
Behavioral Health Area(s) of Expertise Form	Applicable to Behavioral Health Provider's only (i.e. Practitioners who specialize in Psychiatry, Psychology, Licensed Clinical Social Workers, Marriage Family Therapists)

CREDENTIALING CONTACT INFORMATION:

To help streamline your credentialing process and avoid delays, please let us know where you would like us to send your credentialing application and correspondence to:

Contact Name: _____

Contact Title: _____

Mailing Address: _____

_____

Office Phone: _____

Cell Phone: _____

Fax _____

Email address: _____

Email cc: (optional) **Additional email(s) to include on your email communications.**

1. _____

2. _____

3. _____

P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Tel (800) 440-IEHP (4347) • TTY (800) 718-4347 • Fax (909) 890-5756 email: credentialing@iehp.org
Visit our website at: www.iehp.org

California Participating Physician Application

This application is submitted to:_____ , herein, this Healthcare Organization[1]

I. INSTRUCTIONS:

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

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: Home Fax Number: ( )	E-Mail Address: Pager Number:	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security #:	Gender[1]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If Hospital Based):	
Primary Office Street Address:	City:	
	State:	ZIP:
Telephone Number:	Fax Number:	
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

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

[2] This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		

IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:

V. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Medical School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution**:**	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:
Type of Internship :		
Specialty:	From: (mm/yy)	To: (mm/yy

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title)

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

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

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			

VIII. BOARD CERTIFICATION

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

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

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

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

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

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

IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)
(Attach additional sheets if necessary. Reference This Section Number and Title)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

California State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued: Valid Through:
Medicare UPIN / National Physician Identifier (**NPI):**		MediCal/Medicaid Number:

XI. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held.
(Attach additional sheets if necessary. Reference This Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date
State:	License Number:	Expiration Date:

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

Current Insurance Carrier:	Policy Number**:**	Original effective date:	
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount $	Aggregate Amount: $	Expiration Date:	
Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.			

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

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

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

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

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

Current Practice:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Name of Practice /Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Name of Practice /Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

XVI. ATTESTATION QUESTIONS

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

A.	Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	Yes ☐ No ☐
B.	Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	Yes ☐ No ☐
C.	Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	Yes ☐ No ☐
D.	Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Yes ☐ No ☐
E.	Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes ☐ No ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Yes ☐ No ☐
G.	Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	Yes ☐ No ☐
H.	Have you ever been convicted of any crime (other than a minor traffic violation)?	Yes ☐ No ☐
I.	Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs?	Yes ☐ No ☐
J.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.**	Yes ☐ No ☐
K.	Have any judgements been entered against you or settlements been agreed to by you within the last **seven (7)** years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?	Yes ☐ No ☐
L.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged) or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	Yes ☐ No ☐
M.	Is your professional liability insurance valid and current?	Yes ☐ No ☐
N.	Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?	Yes ☐ No ☐

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

Print Name Here: _____

Physician Signature: _____ **Date:** _____
(Stamped Signature Is Not Acceptable) (Not Acceptable If Not Dated)

INFORMATION RELEASE/ACKNOWLEDGMENTS

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

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

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

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

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

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

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

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 8 and 9.

Print Name Here _____

Physician Signature_____ Date: _____
(Stamped Signature Is Not Acceptable)

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

Addenda Submitting (Please check the following):	*This Application and Addenda A and B were created and are endorsed by:*
☐ Addendum A - Health Plan and IPA/Medical Group ☐ Addendum B - Professional Liability Action Explanation	• American Medical Group Association - (310/430-1191 x223) • California Association of Health Plans - (916/552-2910) • California Healthcare Association - (916/552-7574) • California Medical Association - (415/882-5166) • National IPA Coalition - (510/267/1999) • The Medical Quality Commission - (310/936-1100 x230)

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Reapplication nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the health care organization from which it was provided.

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to: _____, herein, this Healthcare Organization[3]

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:

Medical Group (s) / IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No

Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s)) _____

Please check all that apply:

- ☐ Solo Practice
- ☐ Group Practice
- ☐ Single Practice
- ☐ Multi Specialty

II. BILLING INFORMATION

Billing Company:

Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No

If so, please list:

Name:	Type of Provider:	License Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are a Physician Assistant Supervisor, please include State License Number: _____

Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐ Yes ☐ No

If so, please list:

Name:	California Medical License Number:
_____	_____
_____	_____

Please list any clinical services you perform that are not typically associated with your specialty: _____

Please list any clinical services you do not perform that are typically associated with your specialty: _____

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

Is your practice limited to certain ages: ☐ Yes ☐ No

If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐ Yes ☐ No

Do you participate in EDI (electronic data interchange)? ☐ Yes ☐ No

If so, which Network? _____

Do you use a practice management system/software: ☐ Yes ☐ No

If so, which one? _____

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify)

_____

Has your office received any of the following accreditations, certifications or licensures?

- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ California Department of Health Services Licensure
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Other _____

IV. OFFICE HOURS – Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number: ( )	Fax Number: ( )
Mailing Address:	City:	
	State:	ZIP:
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	

If you do not have hospital privileges, please provide written plan for continuity of care:

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VII. LABORATORY SERVICES

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

Tax ID #	Billing Name:	Type of Service Provided:

Do you have a CLIA certificate?	☐ Yes	☐ No
Do you have a CLIA waiver?	☐ Yes	☐ No

Certificate Number:	Certificate Expiration Date:

VIII. PROFESSIONAL ORGANIZATIONS

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

Organization Name	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

Print Name Here : _____

Physician Signature _____ Date _____

(Stamped signature is Not Acceptable)

California Participating Physician Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to**:**_____, herein, this Healthcare Organization[4]

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

I. IDENTIFYING INFORMATION

Patient Last Name:	First	Middle:
Street Address:	City:	
	State:	Zip

II. CASE INFORMATION

City County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of Patient:	Age of Patient:

Location of Incident:

☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center

☐ Other (please specify) _____

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

Allegation:

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

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

_____

_____

_____

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

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

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

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

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

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

SUMMARY

_____

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

Print Name Here: _____

Physician Signature _____ Date _____
(Stamped signature is Not Acceptable)

California Participating Physician Application

Addendum C

This Addendum is submitted to**:**_____, herein, this Healthcare Organization[5]

SECTION A	CONFIDENTIAL QUESTIONS – HEALTH HISTORY		
1.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations that could reasonable be made to facilitate your performance of such functions without risk of compliance**	☐ YES	☐ NO
2.	Are you a certified Worker's Compensation provider?	☐ YES	☐ NO
3.	Are you a reservist? If yes, what branch of the military? Anticipated date of separation from reserve duty? ____/____/____	☐ YES	☐ NO
4.	Medicaid/Medi-Cal#		

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

Print Name Here: _____

Physician Signature _____ Date _____
(Stamped signature is Not Acceptable)

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

California Participating Physician Application

Addendum D

Notice to Practitioners of Credentialing Rights/Responsibilities

I. Right of Review

As an applicant for credentialing/recredentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure. You have a right to be informed, upon request, of the status of your credentialing application; and the right to correct erroneous information submitted by another party, provided the information is not peer-review protected.

You may request to review such information at any time by sending a written request via fax or letter to Credentialing Department at: P.O. Box 1800, Rancho Cucamonga, CA 91729-1800, fax number (909) 890-5756. Following receipt of your request, you will be contacted by the Credentialing Department, within five (5) working days in order to arrange a date and time for review of the information in the Credentialing Department.

II. Notification of Discrepancy

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

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to Inland Empire Health Plan by primary sources, you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) days of notification of discrepancy.

Upon receipt of your notification, Inland Empire Health Plan will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter or fax. You will be requested to provide proof of correction by the primary source to the Credentialing Department via letter or fax as cited above within ten (10) days. Subsequently, a second reverification of primary source information will be performed by Inland Empire Health Plan. If, after ten (10) working days, primary source information remains inconsistent and in dispute, you will be subject to adverse action up to administrative termination from Inland Empire Health Plan.

Print Name Here: _____

Physician Signature _____ Date _____
(Stamped signature is Not Acceptable)

Addendum E
General Practice Providers & Obstetrics/Gynecology PCP's only
Primary Care Experience – Attestation

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

- ☐ Pediatrics (0 to 18 years of age)
- ☐ Pediatrics (0 to 21 years of age)
- ☐ Adults (14 years of age and above)
- ☐ Adults (18 years of age and above)
- ☐ Adults (21 years of age and above)
- ☐ Ob/Gyn PCP (14 years and above, restricted to females)
- ☐ If you desire age limits different from above, please specify:

_____

_____

NOTE: If your desire age limits different from above, you will not receive member auto-assignment.

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

Physician's Name: _____

Physician's Signature: _____ ___ Date: _____
(Stamped signature is not acceptable)

Verification of Qualifications *for* HIV/AIDS PHYSICIAN SPECIALIST

Health plans and healthcare organizations must implement regulations related to AB2168 (Ch. 426, 2000). This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently definite an HIV/AIDS specialist under Regulation LS-34-01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

Please check <u>ANY and ALL</u> of the criteria listed below that apply to you.

☐ No, I do not wish to be designated as an HIV/AIDS Specialist

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as a "HIV Specialist" by the American Academy of HIV Medicine (attached AAHIVM Certification);

OR

☐ I am Board Certified in Infectious Disease **AND** in the preceding **twelve (12)** months have clinically managed a minimum of **twenty-five (25)** HIV patients **and** have successfully completed **fifteen (15)** hours of category 1 continuing medical education (CME) in HIV medicine, **five (5)** hours of which was related to antiretroviral therapy;

OR

☐ In the past **twenty-four (24)** months, I have provided clinical management of **twenty (20)** patients; **and** in the past **twelve (12)** months completed board certification in Infectious Disease

OR

☐ In the past **twenty-four (24)** months I have provided clinical management to **twenty (20)** HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV Medicine;

OR

☐ In the past **twenty-four (24)** months I have clinically managed at least 20 HIV patients and in the past **twelve (12)** months have completed 15 hours of category of 1 CME in HIV Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine (attach copies of the CME credits and Exam verification)

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

Name of Practitioner (Please print): _____ Date: _____

Practitioner's Signature: _____ License No: _____

Office Telephone _____ Office Fax: _____

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

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

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

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

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

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

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

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

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

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

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

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

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

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

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

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

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

Backup Withholding

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

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

Payments you receive will be subject to backup withholding if:

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

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

Also see *Special rules for partnerships* above.

What is FATCA reporting?

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

Updating Your Information

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

Penalties

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

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

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

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

Specific Instructions

Line 1

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

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

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

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

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

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

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

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

Line 2

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

Line 3

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

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

Line 4, Exemptions

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

Exempt payee code.

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

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

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

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

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

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

5—A corporation

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

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

8—A real estate investment trust

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

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

11—A financial institution

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

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

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

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

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

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

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

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

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

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

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

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

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

G—A real estate investment trust

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

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

J—A bank as defined in section 581

K—A broker

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

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

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

Line 5

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

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

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

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

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

Part II. Certification

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

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

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

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

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

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

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

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

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

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

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

Privacy Act Notice

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

ATTACHMENT D

OFFICERS, OWNERS, STOCKHOLDERS AND CREDITORS

CONTRACT NAME

List, by category, all of the above:

Name	Title	*Ownership % (as applicable)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

* If corporation is publicly traded on a US stock market, indicate "Publicly Traded Corp."
Please indicate how your organization is legally organized (circle one): **Corporation**

Other (please describe): N/A

Inland Empire Health Plan

Behavioral Health
Areas of Expertise Form

Provider Name: _____

Last First M

License Number: _____ ☐ PhD/PsyD ☐ LMFT ☐ LCSW ☐ Psychiatric Mental Health NP

Patient Population- Indicate the age range that apply to each below.

Accepting New Patients: ☐ Yes ☐ No

Pediatric Ages:	**Adolescents Ages:**
Adult Ages:	**Geriatric Adult Ages:**

Psychiatrist: Board Certification(s):
☐ General ☐ Child and Adolescents ☐ Psychosomatic Medicine ☐ Addiction Medicine ☐ Geriatric ☐ N/A

Individual Therapy- Select all that apply below:

☐ 12 Step Recovery	☐ HIV/ AIDS Issues
☐ Non- 12 Step Recovery	☐ Life Transitions Issues
☐ Addiction: Chemical	☐ Maternal Mental Health
☐ Addiction: Non-Chemical	☐ Men's Issues
☐ Adjustment Disorder	☐ Military related PTSD
☐ Adoption Issues	☐ Obsessive Compulsive Disorder
☐ Adult Children of Alcoholics	☐ Pain Management
☐ Anger Management	☐ Parenting Issues
☐ Anxiety Disorder	☐ Personality Disorder
☐ Attention Deficit Disorder	☐ Post-Traumatic Stress Disorder
☐ Autism Spectrum Disorder	☐ Psychological Testing- **Intellectual**
☐ Behavioral/ Conduct Disorder	☐ Psychological Testing- **Personality**
☐ Bi-Polar Disorder	☐ Psychological Testing- **Projective**
☐ Cancer Survivor	☐ Psychotic/ Schizophrenic Mood Disorder
☐ Christian Counseling	☐ Reactive Attachment Disorder
☐ Chronic Illness	☐ Sexual Dysfunction
☐ Clinical Hypnosis	☐ Sexual/ Physical Abuse Perpetrators
☐ Codependency	☐ Sleep/ Wake Disorder
☐ Disability Related Mental Health Issues	☐ Somatoform Disorder
☐ Disruptive, Impulse Control & Conduct Disorder	☐ Stres Management
☐ Eating Disorder Spectrum	☐ Substance/ Addictive Disorder- **Naltrexone**
☐ EMDR - Certified	☐ Substance/ Addictive Disorder- **Suboxone**
☐ Factitious Disorder	☐ Substance/ Addictive Disorder- **Vivitrol**
☐ Family Counseling	☐ Women's Issues
☐ Gender Dysphoria	☐ Trauma
☐ Grief/ Loss	

Group Therapy- Select all that apply below:

☐ 12 Step Recovery	☐ Mood Disorders
☐ Non- 12 Step Recovery	☐ Men's Issue
☐ Addiction: Non-Chemical	☐ Parenting
☐ Anger Management	☐ Sexual/ Physical Abuse
☐ Anxiety Disorder	☐ Social Skills
☐ CBT	☐ Trauma
☐ Depression	☐ Women's Issues
☐ Grief/ Loss	☐ Other (specify):
☐ Medication Education Group	

Signature:

Print Full Name:

Provider's Signature:	**Date:**

QUESTIONNAIRE FOR:
PROVIDERS FOR TRANSGENDER MEMBERS

IEHP is interested in identifying Providers who have experience and interest in providing high quality care to Transgender Members. Please complete the following survey.

NPI: _____

LAST NAME: _____ **FIRST NAME:** _____

SPECIALTY: _____ **EMAIL:** _____

PHONE: _____ **FAX:** _____

1. Are you willing to be listed in our Provider Directory as a provider available to our Transgender Members?

☐ Yes ☐ No, (You may stop survey)

2. Please assess your ability in providing high quality care to Transgender Members:

☐ Advanced ☐ Moderate ☐ Minimal ☐ No experience (Move to Question 6)

3. What services do you provide to Transgender patients? (Select all that apply)

☐ Hormone Treatment ☐ Mental Health Services ☐ Integrated mental and physical health service model

☐ Procedures (surgical, office-based) and what type: _____

☐ Other _____

4. Approximately how many Transgender patients have you serviced in the past twelve (12) months?

☐ None ☐ 1 – 2 ☐ 3 – 9 ☐ 10 – 25 ☐ Over 25

5. How long have you been providing care to Transgender patients?

☐ Under 1 year ☐ 1 – 5 years ☐ 5 – 9 years ☐ Over 10 years

6. What training, if any, have you received to treat Transgender patients? (Select all that apply)

☐ CME events. Please list organization that provided CME: _____

_____

☐ Member of World Professional Association for Transgender Health (WPATH)?

☐ Transgender certifications through WPATH?

☐ None ☐ Other: _____

7. What clinical practices guidelines/resources do you use in proving transgender care? (Select all that apply)

☐ WPATH Standards of Care

☐ UCSF Center of Excellence for Transgender Health – Guidelines for the Primary and Gender – Affirming Care of Transgender and Non-Binary People

☐ Endocrine Society Clinical Practice Guidelines ☐ None

☐ Other, please list: _____

8. What steps have you taken to make your practice trans-friendly? (Select all that apply)

- ☐ Staff Trainings? When was the last training? _____
- ☐ Office policies/procedures?
- ☐ Bathroom policies
- ☐ Unique gender identification/name/pronoun capture in EMR?
- ☐ None

9. Have you ever written a letter to support the acquisition of gender affirming surgery?

☐ Yes ☐ No

10. Are you willing to write letters to support the acquisition of gender affirming surgery?

☐ Yes ☐ No

11. How many of these letters have you written in the past twelve (12) months?

☐ None ☐ 1 – 3 ☐ 3 – 10 ☐ Over 10

12. What resources would you recommend IEHP offer to support you in your efforts at providing high quality transgender care? Any other comments:

A Public Entity

Inland Empire Health Plan

EFT ENROLLMENT REQUEST REFERENCE GUIDE

The following is a reference guide and does not need to be included with your request.

☐	**Ready to get started? Download the fillable EFT Enrollment Form.** • Go to the following link to access the most current version of the EFT Form: https://www.iehp.org/en/providers/provider-resources?target=forms#EFTandERA
☐	**Are you using one enrollment form per tax ID?** • Enrollment forms containing more than one tax ID will be returned. • Please wait to submit your enrollment until a claim has been processed and finalized under your tax ID
☐	**Did you remember to put the NPI # on the enrollment form?** • Multiple NPI's with the same information? Only one form is needed and attach an NPI listing.
☐	**If enrolling for EFT or making a change to your bank information, have you attached a voided check or bank letter?** • Enrollment requests cannot be processed without this information. • A voided check must accompany the form; a "starter check" or a copy of a deposit slip will not be accepted. • If requesting an EFT change, please be sure to provide the banking information for both the existing bank account as well the new account
☐	**If enrolling to receive EFT email notification, have you indicated an authorized email address?** • Please type or print your email address information clearly.
☐	**Has the form been signed by the appropriate individuals?** • Your enrollment form will be returned if there is no signature.
☐	**Have you filled out all the sections?** • To ensure form is legible, please type or print all requested information clearly.
☐	**Have a completed form to submit?** You have the following options to send your completed form: • Email to: vendormaintenance@iehp.org • Fax to: (909) 890-5752 • Mail to: Accounts Payable, PO Box 1800, Rancho Cucamonga, CA 91729-1800

FORMS WITH MISSING OR INCOMPLETE INFORMATION WILL BE RETURNED.

Inland Empire Health Plan

ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT FORM

This form is being completed in response to:

☐ Fax ☐ Outreach via Mail/E-mail ☐ IEHP's website ☐ New Contract with IEHP

Directions: **Complete all information below and attach required document(s).** (See "*Include with Enrollment Submission*" section on page 2). You have the option: (1) mailing the completed form to: Accounts Payable, PO Box 1800, Rancho Cucamonga, CA 91729-1800, (2) faxing it to (909) 890-5752 or (3) e-mail it to vendormaintenance@iehp.org. If you have questions, please contact our Accounts Payable Department at (909) 294-3928, Option 1.

Application and Authorization for Vendor/Provider Direct Deposits

REASON FOR SUBMISSION

☐ New Setup ☐ Cancellation ☐ Change Financial Institution ☐ Change Account Number

PAYEE IDENTIFICATION (*all fields required*)

Vendor/Provider Name	
Vendor/Provider TIN (Tax Identification Number)	**Provider NPI**
Vendor/Provider E-mail	**Vendor/Provider Contact Phone Number**
Vendor/Provider Street Address	
Vendor/Provider City	**Vendor/Provider State and Zip Code**

FINANCIAL INFORMATION (*all fields required*)

Financial Institution (Depository) Name	
Transmit/ABA (Routing) Number (9 digits)	**Account Number**
Account Type ☐ CHECKING ☐ SAVINGS	**Requested EFT Start/Change/Cancel Date**

We authorize Inland Empire Health Plan to initiate credit entries to the account indicated above and the financial institution named above hereinafter called Depository, to credit the same to such account. It is our responsibility to notify IEHP Vendor Maintenance at vendormaintenance@iehp.org or (909) 294-3928, Option 1 within a reasonable time if we become aware of any changes in status or banking information. It is our responsibility to notify IEHP within a reasonable time if we believe there is a discrepancy between the amount deposited directly to our bank account and the amount of the invoices paid. This authority is to remain in full force and effect until IEHP has received written notification from us of its termination in such time and in such manner as to afford IEHP and Depository a reasonable opportunity to act on it.

Printed Name of Person Submitting Enrollment	Printed Title of Person Submitting Enrollment
Signature of Person Submitting Enrollment	Submission Date

Inland Empire Health Plan

Instructions for completing the *EFT Enrollment form*

Please type or print legibly.
Use only black ink or blue ink to complete paper form.
Online form can be accessed at www.iehp.org

For questions about the electronic funds transfer enrollment process, send an email to Vendor Maintenance at vendormaintenance@iehp.org

Reason for Submission
New Setup – New EFT enrollment
Cancellation – Cancel current enrollment
Change Financial Institution – Change Bank Information
Change Account Number – Account number change only

Payee Identification - **Please fill out completely**
Vendor/Provider Name – Complete legal name of institution, corporate entity, practice, individual name or DBA, if applicable
Vendor/Provider Federal Tax Identification Number (TIN) – A TIN is used to identify business entity
Vendor/Provider Email Address – An electronic mail address at which the health plan might contact the provider
Vendor/Provider Contact Telephone Number – Telephone number of vendor contact with extension, if applicable
Vendor/Provider Physical Street Address – The number and street where a person or organization can be found
City – City associated with provider address field
State – ISO 3166-2 two-character code associated with the state
Zip Code/Postal Code – System of postal-zone codes
Provider National Provider Identifier (NPI) - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The HPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Financial Information
Financial Institution Name – The official name of the vendor's financial institution
Transmit/ABA (Routing) Number – A 9-digit identifier of the financial institution where the vendor maintains an account to which payments are to be deposited
Account Number – Vendor's account number at the financial institution to which EFT payments are to be deposited
Financial Institution Physical Street Address - The number and street associated with receiving depository financial institution name field
City – City associated with provider address field
State – ISO 3166-2 two-character code associated with the state
Zip Code/Postal Code – System of postal-zone codes
Requested EFT Start/Change/Cancel Date – Date the vendor wishes to begin receiving EFTs, change data, or cancel the EFT process

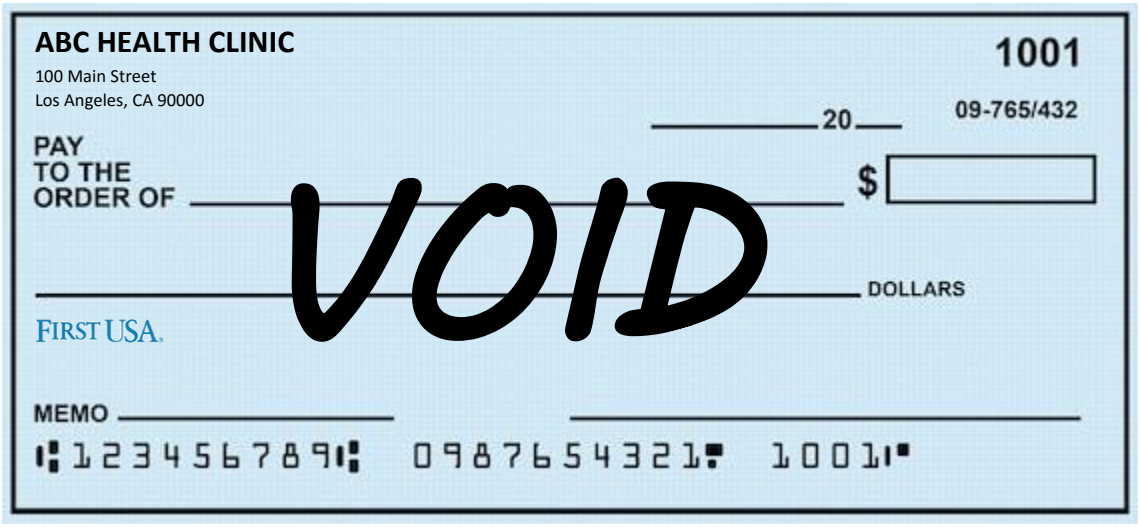
Include with Enrollment Submission
Voided Check – A voided check is attached to provide confirmation of identification and account numbers
Bank Letter – A letter on bank letterhead that formally certifies the account owners routing and account numbers

Authorized Signature
Printed Name of Person Submitting Enrollment – The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
Signature of Person Submitting Enrollment – A (electronic or cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Title of Person Submitting Enrollment – The printed title of the person signing the form; may be used with electronic or paper-based manual enrollment
Submission Date – The date on which the enrollment form is submitted

SAMPLE

VOIDED CHECK COPY:

- Voided check copy must have business name printed on (cannot be a starter check)



LETTER FROM FINANCIAL INSTITUTION (BANK):

- If a valid voided check cannot be provided, business must obtain a letter from financial institution on the banks letterhead and signed by a bank officer.
- Bank letter must include:
  - DBA name on account
  - Routing number
  - Account number

FIRST USA.

123 Bank Road
Los Angeles, CA 90000
(310) 123-4567

SAMPLE

August 14, 2020

To Whom It May Concern,

This letter is to certify that the below listed customer has established a Business Checking Account with First USA Bank as follows:

Account Name: ABC Health Clinic
Account Number: 0987654321
Routing/ABA Number: 123456789

If you have any questions or concerns in regard to this letter, please feel free to contact me at the number listed above.

Thank you,

Bank Officer Signature

AVP/Lead Banking Specialist II

IEHP Vendor Direct Deposit

Frequently Asked Questions (FAQs)

- What is a direct deposit payment?
    - Direct deposit is a method of payment where your funds are deposited directly into your bank account. No paper check is issued.
- How do I sign up for direct deposit payments?
    - You will need to complete the IEHP Application and Authorization for Vendor Direct Deposit Payments form. If the forms are completed correctly, IEHP will set up your record within two business days. IEHP will then request verification of the bank account information from your financial institution. This verification takes approximately two weeks. When the verification has been completed, you can then be paid by direct deposit.
- Do I need any special software to receive direct deposit payments?
    - No. All you need is a valid account at any United State bank or credit union that participates in direct deposit.
- What format is used to transmit the direct deposit payment?
    - IEHP currently makes direct deposit payments using the CCD (Cash Concentration or Disbursement) format.
- How will I know that I have received a direct deposit payment?
    - You will receive a direct deposit notification, either by e-mail or US mail, detailing the payor, all invoice/claims numbers, the dollars amounts in each day's deposit, and the date of the deposit. Notification is mailed two days before the deposit is made.
- Will my bank notify me that I have received a direct deposit payment?
    - Each bank has its own internal procedures. Please contact your bank to find out its process.
- How soon will the direct deposit be in my account?
    - The funds become available three business days or sooner, depending on your banking institution, after the payment has been processed by IEHP.

IEHP Vendor Direct Deposit

- Is my bank account information secure?
    - Yes. IEHP has only a few designated staff that has access to update and read vendor bank account information.
- How do I notify IEHP of changes to my bank account?
    - To update your account, call Provider Relations Team at (909) 890-2054. Please provide a week's notice before you close an account and provide us with a replacement account.
- Can I get my claims remittance advice electronically?
    - Due to HIPAA regulations, we are not offering this service at this time.
- Can I get my claims remittance advice faxed to me?
    - We do not offer that service at this time. We will consider adding it if enough vendors request it.
- Who do I contact if I have additional questions?
    - You can contact the Provider Relations Team at (909) 890-2054.

ERA (835) Enrollment Form

Complete form and email to: EDISpecialist@iehp.org

Type of Electronic Submission ☐ **835/ERA** ☐ **Web Portal** ☐ **Both**

Provider Information

Provider Name _____ Doing Business As (DBA, if Applicable) _____

Provider Physical Address _____

City _____ State _____ Zip Code _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) _____ or Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____
(Group NPI, if applicable)

Other Identifiers

Trading Partner Identifier (ID) _____

Provider Contact Information

Provider Contact Name _____ Title _____

Telephone Number with Extension _____ Email Address _____ Fax Number _____

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)
(Must match EFT Preference)

☐ Provider Tax Identification Number _____

☐ National Provider Identifier _____

Method of 835Retrieval: ☐ From health plan ☐ Download from health plan website ☐ From clearinghouse

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name _____

Telephone Number _____

Email Address _____

Reason for Submission

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorized Signature

Electronic/Written Signature of Person Submitting Enrollment	Printed Title of Person Submitting Enrollment
Submission Date	Requested ERA Effective Date

Consent to Access Remittance Advice (RA) via IEHP Provider Website Only

IEHP's goal is provide our Trading Partners with a convenient method of receiving the remittance advice (RA). We are requesting your consent to discontinue mailing paper RAs. After your authorization is received, you will obtain access to your RA through the IEHP secure website, www.iehp.org. To view your RA on the secure provider website, you must have access to the internet as well as the current version of Adobe Acrobat Reader. Our Trading Partner's security is important. Only contracted partners with upgraded web security will be able to access RAs online. If your security has not been upgraded, you may do so by following the directions on our website or calling the IEHP Provider Relations Team at (909) 890-2054.

Provider Name	Tax Identification Number (TIN)

I _____ (print name and title) authorize IEHP to discontinue mailing the paper Remittance Advice (RA) and agree to access IEHP Claims RAs online only.

Signature	Date

Instructions for completing the *ERA Enrollment form*

Please type or print legibly.
Use only black ink or blue ink to complete paper form.
Online form can be accessed at www.iehp.org
Please allow 4 weeks for enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving ERA files, you may contact the EDI Specialist Team at 909.890.2025 or send an email to EDISpecialist@IEHP.org.

For questions about the paper or electronic enrollment process, contact the EDI Specialist Team at 909.890.2025 or send an email to EDISpecialist@IEHP.org

Provider Information- **Please fill out completely**
Provider Name – Complete legal name of institution, corporate entity, practice, individual name or DBA, if applicable
Provider Physical Address – The number and street where a person or organization can be found
City – City associated with provider address field
State – ISO 3166-2 two character code associated with the state
Zip Code/Postal Code – System of postal-zone codes

Provider Identifiers
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) – A TIN or EIN is used to identify business entity.
National Provider Identifier (NPI) - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The HPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Other Identifiers
Trading Partner ID – The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor

Provider Contact Information
Provider Contact Name – Name of contact in provider office for handling ERA issues
Provider Contact Title – Title of the contact for handling ERA issues
Provider Contact Telephone Number – Telephone number of provider contact with extension, if applicable
Provider Email Address – An electronic mail address at which the health plan might contact the provider
Provider Fax Number – A number at which the provider can receive facsimiles

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): Provider preference for grouping (bulking) claim payments – must match preference for EFT payment
Must fill out one of the two options below
Provider's Tax Identification Number (TIN)
National Provider Identifier (NPI)

Method of Retrieval – Method in which provider will receive the ERA from the health plan

Clearinghouse Information
Clearinghouse Name – Official Name of the provider's clearinghouse
Telephone Number – Telephone Number of contact
Email Address – An electronic mail at which the health plan might contact the provider's clearinghouse

Reason for Submission – Must select from below
New Enrollment
Change Enrollment
Cancel Enrollment

Instructions for completing the *ERA Enrollment form*

Authorized Signature
The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

Electronic/Written Signature of Person Submitting Enrollment – A (electronic or cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Title of Person Submitting Enrollment – The printed title of the person signing the form; may be used with electronic or paper-based manual enrollment
Submission Date – The date on which the enrollment form is submitted
Requested ERA Effective Date – Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advise (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.

Email the completed form to: EDISpecialist@IEHP.org

For questions about this form, please send an email to the EDI Unit at: EDISpecialist@IEHP.org

Researching Missing/Late Files
ERA files that have not been received after 4 business days of the corresponding EFT file can be researched by sending an email to the EDI Specialist Team at EDISpecialist@IEHP.org