Provider Information

Return to: PO Box 5406, Boise ID 83705
Fax to: 208-433-4605
Email to: ipn@ipnmd.com
Website: www.ipnmd.com

The information provided on this form is required for claims processing and directory information.
Please use additional forms for additional practice locations or practitioners/organizations.

EFFECTIVE DATE OF CHANGE: **PLEASE NOTE: IPN IS UNABLE TO GUARANTEE A RETROACTIVE PAYOR IMPLEMENTATION DATE**

☐ Add Provider to Group ☐ Change Information ☐ Add a New Location ☐ Add Provider to Hospital Based Location[1]

☐ Termination **Reason:**

Provider Information (name as shown on CMS 1500 Field 31 OR UB box 1)

☐ Individual Practitioner ☐ Organizational Provider	Name:			
NPI:	SSN (TRICARE required):	Degree:	DOB:	☐ Male ☐ Female
License No.:	DEA No.:	Is Practitioner Currently Active Military or Reserve? ☐ Yes ☐ No		

Practice Location Information (for patient visits and directory listing)

Practice Name (as it should appear in directories):	
Physical Address (Address, City, State, Zip):	County:
Practitioner Specialty (as practicing at this location):	
Location to appear in a directory for this practitioner? ☐ Yes ☐ No	
Location NPI:	Tax ID No. (Attach IRS W9):
Practice Phone (where patients call to make an appointment):	Practice Fax:
☐ Clinic Hours of Operation (complete specific hours below) (*ex. 8-5 – do not include midday closures*) ☐ Hospital Based Location[1] (hours are 24/7)	
Mon |Tues |Wed |Thurs |Fri |Sat |Sun	
Practice Contact Name:	Practice Contact Email:

Billing Information (as billed on CMS 1500 Field 33 OR UB box 2)

Billing Name (as it should appear on claims):	
Billing Address (Address, City, State, Zip):	County:
Billing Contact Name:	Billing Contact Email:
Billing Contact Phone:	Billing Contact Fax:

Summary of Changes/Notes

Form completed by (Name):	Email:	Phone:

[1]**Hospital-Based Provider:** An individual participating practitioner who provides health care services exclusively at an IPN-participating hospital. A *credentialing application is not required*.

ORGANIZATIONAL PROVIDER
CREDENTIALING/RECREDENTIALING APPLICATION

Type of Facility:

INSTRUCTIONS

This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.
IPN maintains a program to select and re-evaluate all organizational providers (facilities/entities) that provide service within its delivery system. All organizational providers must successfully complete the process to be approved. The provider has the right to review information obtained in the process of evaluating the application exclusive of peer review information.

List ALL Organizational Provider NPIs you wish to credential. Include all applicable attachments for each NPI.
NOTE: IPN only credentials for the following Organizational Provider types:

- Ambulatory Surgery Center
- Clinical Laboratories
- Durable Medical Equipment
- Hospitals
- Portable X-Ray Supplier
- Federally Qualified Health Center
- Behavioral Health/Mental Health Facility
- Comprehensive Outpatient Rehabilitation Facility
- Home Health/Hospice
- Outpatient Physical Therapy and Speech Pathology Provider
- Rural Health Clinic
- Skilled Nursing Facility

PLEASE INCLUDE THE FOLLOWING WITH YOUR APPLICATION

☐ Completed W-9
☐ Current Insurance face sheets which meet or exceed minimum limits acceptable by IPN:
  - Professional Liability $1,000,000 per occurrence $3,000,000 aggregate

☐ Listing of all locations
☐ Evidence of Credentialing Program (REQUIRED FOR ALL FACILITY TYPES)
☐ Complete the *Credentialing Program* section or provide Policy on Credentialing Program
☐ Policy on Seclusion & Restraint (REQUIRED FOR ALL FACILITY TYPES)
☐ Policy on Patient Visitation (Hospitals Only)
☐ Copy(s) of all Federal, State, and/or local professional licenses, certifications and/or registrations specifically required to operate as a health care facility.
☐ Copy(s) of all Federal, State, and/or local business licenses, certifications and/or registrations specifically required to operate as a health care facility.
☐ Copy(s) of all Accreditation Certificates and copy of most recent survey results (A list of Acceptable Certifying entities can be found on pages 6 & 7).
☐ Copy(s) of most recent CMS survey, including corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied, if no CMS exemption provision applies.
☐ IRS documents confirming the tax identification number and legal business name (e.g., CP 575).
☐ Description of credentialing and clinical staff privileging program for health care professionals.
☐ Identify the health care related organization(s) to which this application is being submitted in the space provided on page 4.
☐ Explanations provided in response to questions in the *Action History Questions* section of the application must be complete as they relate to dates, incident explanations and results, i.e., dismissal, judgment/settlement including amount and date of payment. Failure to provide the necessary information may be considered failure to meet credentialing criteria.

NOTICE

☐ The IPN Credentialing Department, or its designee, may do a site visit for any facility. Site visits may be done at the discretion of the IPN Credentialing Department whether or not the provider has accreditation status and or an existing site visit. Credentialing of a facility headquarters and or corporate location may incorporate satellite facilities owned and operated by the applying facility. IPN retains the right to individually credential and re-credential satellite facilities which may require independent compliance to IPN Policies and Procedures for credentialing and re-credentialing. This decision is at IPN's discretion.

☐ Every three years, IPN may confirm that the facility and or its satellite or mobile locations continue to be in good standing. This includes but is not limited to, state and federal regulatory bodies, malpractice insurance remains current and meets appropriate limits, most recent malpractice history for the three most recent and consecutive years and, if applicable, accreditation entities.

☐ The provider has the right to review submitted credentialing application information, be notified of any information that is substantially different from what is submitted, the right to correct erroneous information and the right, upon request, to be informed of the status of their application. The credentialing department will make every effort to provide status at the time of request and, if unable, will respond within three working days.

☐ IPN maintains a policy and procedure for health care providers and organizational providers (facilities) when denied network participation for reasons other than a failure to meet or maintain credentialing/recredentialing criteria. The policy and procedure is available by request from the IPN Credentialing Department.

☐ Complete the application in its entirety.
☐ Sign and date pages 11 & 13.
☐ Mail application to:

IPN Credentialing
PO Box 5406
Boise, ID 83705
Fax: (208) 433-4604
credentialing@ipnmd.com

ORGANIZATION INFORMATION *(Provide physical location information on the following page)*				
Corporate Identification Information (Controlling interest information required by CMS in order to comply with Federal Law)				
Legal Name of Organization: (Legal name listed with the IRS)				
DBA Name of Organization: (if applicable)				
Organization Owner:			Organization Administrator:	
Select all that apply	☐ Privately Owned ☐ Corporation ☐ Investor owned	☐ Government owned ☐ Partnership ☐ Limited Partnership	**Select one**	☐ For profit ☐ Non-profit
List any person that has direct or indirect ownership interest of 5% or more:				
In case of corporation or partnership, list the officers and directors or the partners:				
List any managing employees: *(Managing employees are individuals who exercise operational or managerial control over the entity or part thereof who directly or indirectly conduct the daily operations of this entity)*				

Mailing Address		
Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Phone:	Fax:	

Billing Address		
Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Phone:	Fax:	
Billing Contact Person:	Email:	

ORGANIZATION INFORMATION *(continued)* *(Provide physical location information on the following page)*						
Physical Location(s) Information: *(Include additional information relevant to this location on a separate sheet – provided at end of application)*						
Practice Location Name:						
Is this location Medicare Certified:	☐ Yes ☐ No		**Is this the primary address?**	☐ Yes ☐ No		
Federal TIN:		Long Term Care provider # (if applicable):				
NPI #:		Is this location wheelchair accessible? ☐ Yes ☐ No				
Site-specific Medicare #		Describe your service area (States, Counties, Cities, etc.):				
Site-specific Medicaid #						
Address Line 1:						
Address Line 2:						
City:	State:	Zip:	County:			
Phone:	Fax:	E-mail:				
Primary Contact Name:		Contact Title:				
Phone:	Fax:	E-mail:				
Please list any languages spoken by office personnel:						
Practice Limitations (e.g. age, gender, etc):						
Office Hours (Open to Close)						
M	**Tu**	**W**	**Th**	**F**	**Sat**	**Sun**

Mailing/Correspondence Address *(This must be an address where provider can be contacted directly)*		
Check here ☐ if all correspondence can be directed to the practice location provided above.		
Mailing Address Line 1:		
Mailing Address Line 2:		
City:	State:	Zip:
Phone:	Email:	

PRIMARY CONTRACTED SPECIALTY & TAXONOMY

(If each location offers different services, please indicate this on a separate sheet or attachment)

(If there are multiple primary CONTRACTED specialties, check ALL that apply)

Hospital: # of beds_____		**Mental Health/Substance Abuse: # of beds**	
☐ General Acute Care	(282N00000X)	☐ Mental Health – *Inpatient*	(323P00000X)
☐ Psychiatric	(283Q00000X)	☐ Mental Health – *Outpatient*	(261QM0801X)
☐ Rehabilitation	(283X00000X)	☐ Substance Abuse – *Inpatient*	(324500000X)
☐ Critical Access	(282NC0060X)	☐ Substance Abuse – *Outpatient*	(261QR0405X)
Ambulatory:		**Custodial Care Specialties:**	
☐ Ambulatory Surgery Center	(261QA1903X)	☐ Skilled Nursing Facility	(314000000X)
☐ Dialysis Center	(261QE0700X)	# of beds _____	
☐ Ambulance	(3416L0300X)	☐ Home Health Agency	(251E00000X)
☐ Air Ambulance	(3416A0800X)	☐ Hospice Care	(315D00000X)
☐ Diagnostic Imaging – *Radiology*	(3416L0300X)	☐ In Home Supportive Care	(261QR0405X)
Other:		**Medical Suppliers:**	
☐ IV Home Infusion Therapy	(251F00000X)	☐ Durable Medical Equipment	(332B00000X)
☐ Laboratory	(291U00000X)	☐ DME – Sleep Supplies	(332B00000X)
☐ Collection Site		☐ Prosthetic/Orthotic Supplier	(335E00000X)
☐ Independent Diagnostic Testing (IDTF)	(293D00000X)		
☐ Diabetes Management & Education			
☐ Sleep Disorder Center	(261QS1200X)		
☐ Public Health or Welfare	(251K00000X)		
☐ Federally Qualified Health Center (FQHC)		☐ Rural Health Clinic (RHC)	

Scope of Services			
Select all that apply *(attach accreditation and/or certification or licensure for each service)*	☐ Acute Care ☐ Ambulance ☐ Anesthesiology ☐ Emergency Department (Level I, II, III, IV, V) ☐ Birthing Center ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Radiology ☐ CT Scan ☐ Echocardiography ☐ Mammography ☐ Magnetic Resonance Imaging (MRI) ☐ Nuclear Medicine	☐ Nuclear Cardiology ☐ PET ☐ Dialysis ☐ Lithotripsy ☐ Laboratory/Pathology ☐ Skilled Nursing ☐ Outpatient Surgery ☐ Hospice ☐ Infusion Therapy ☐ Home Health ☐ Adult Day Care ☐ Home Companion Care ☐ Homemaker Services ☐ Incontinent Supplies	☐ Home Environment Consultant ☐ Home Rehab Services ☐ Personal Care Aide ☐ Social Worker ☐ Pharmacy ☐ Phlebotomy ☐ Bereavement Counseling ☐ Sleep Study Services ☐ Telemedicine
Other Specialty:		**Taxonomy:**	

Specialty Designation Notes:

***Attach a roster of all providers, with credentials, who will offer services to patients seen at this facility.*

CERTIFICATION AND ACCREDITATION

(Attach a copy of the most recent accreditation certificate for each accrediting body)

Is this provider accredited by a national accreditation organization? ☐ Yes ☐ No ☐ Pending

If Yes, please complete the following:

☐ **Medicare Certification (CMS)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **The Joint Commission (TJC)** Date of original certification: _____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **American Association Accreditation of Ambulatory Surgery Facilities (AAAASF)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Accreditation Association for Ambulatory Health Care (AAAHC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Community Health Accreditation Program (CHAP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Accreditation Commission for Health Care (ACHC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **AOA's Healthcare Facilities Accreditation Program (AOA-HFAP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Association of Ambulatory Surgery Centers (AAASC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **American Academy of Orthotics & Prosthetics (AAO&P)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Board for Certification in Orthotics & Prosthetics (ABCOP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **American College of Radiology (ACR)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Diabetes Association (ADA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Board of Certification/Accreditation International (BCIA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Commission on Accreditation of Rehabilitation Facilities (CARF)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____

CERTIFICATION AND ACCREDITATION *(continued)*	
(Attach a copy of the most recent accreditation certificate for each accrediting body)	
☐ **National Committee for Quality Assurance (NCQA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **College of American Pathologists (CAP)** Date of original certification: _____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Det Norske Veritas (DNV)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Healthcare Quality Association on Accreditation (HQAA)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **National Association of Boards of Pharmacy (NABP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Academy of Sleep Medicine (AASM)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **The Compliance Team (TCT)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Prescription Drug Plan Sponsor (URAC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Department of Health and Welfare Quality Assurance Rev (BLTC)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **American Academy of Craniofacial Pain (AACP)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
☐ **Commission on Accreditation of Ambulance Services (CAAS)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____	☐ **Commission on Accreditation of Medical Transportation Services (CAMTS)** Date of original certification:_____ Date of last recertification:_____ Date of last survey:_____ Level of Certification:_____
***IPN only accepts accreditation by CMS considered bodies. This list is subject to change.*	

Has the provider ever been denied accreditation? ☐ Yes ☐ No
If yes, please explain:

LICENSURE *(Attach a copy of all licenses)*					
☐ Please check here if this location does not require a license by an appropriate State agency.					
License Type:		**State:**		**Number:**	
Issue Date:		**Expiration Date:**			
Current Survey Date:					
License Type:		**State:**		**Number:**	
Issue Date:		**Expiration Date:**			
Current Survey Date:					
License Type:		**State:**		**Number:**	
Issue Date:		**Expiration Date:**			
Current Survey Date:					

Has your licensure ever been revoked or otherwise limited? ☐ Yes ☐ No
If yes, please explain:

REGISTRATION(S) AND CERTIFICATE(S) *(Attach a copy of all that apply)*					
DEA Number:		**Issue Date:**		**Expiration Date:**	
CS/CDS Number:		**Issue Date:**		**Expiration Date:**	
CLIA Number:		**Issue Date:**		**Expiration Date:**	
Lab Registration *(if applicable)***:**		**Issue Date:**		**Expiration Date:**	
Other Registration(s)/Certificate(s):					

CURRENT INSURANCE COVERAGE *(Attach a copy of liability insurance face sheet)*			
Commercial General Liability Insurance *(Complete all information below or provide copy of policy face sheet)*			
☐ Check here if your facility is not insured. (Attach explanation)			
Coverage Type: ☐ Claims Based	☐ Occurrence Based	☐ Tail Coverage	☐ Umbrella
Carrier Name:		Policy #:	
Carrier Address:			
City:	State:	Zip:	
Effective Date:		Expiration Date:	
Per Incident: $		Aggregate: $	

CREDENTIALING PROGRAM		
Credentialing Contact Person:	Title:	
Phone:	Fax:	Email:

1. Do you verify the credentials of all licensed and non-licensed staff that you employ? ☐ Yes ☐ No
For YES: How frequently is this verified?
For YES: Please check method(s) of verification for **licensed** staff: ☐ Online directly with the appropriate State Board ☐ Obtaining a current copy of the license ☐ Other_____
For YES: Please check method(s) of verification for **non-licensed** staff: ☐ Background check agency ☐ Previous employer(s) ☐ Other_____
2. Do you ensure that each of the LICENSED staff practicing at your facility renews his/her State License before it expires? ☐ Yes ☐ No
3. Do you perform background checks on all staff before hiring? ☐ Yes ☐ No
For YES: Please check all method(s) utilized: ☐ Federal and/or State Criminal Background Check(s) ☐ Background Check agency ☐ Search a State 'Misconduct Registry' or equivalent ☐ Other_____
4. Are subcontractors required to carry individual medical malpractice/professional liability insurance? ☐ Yes ☐ No
For YES: What amounts?
5. If you use Telemedicine, do you verify licensure of the individual providers? ☐ Yes ☐ No
For YES: How often?
6. Is there 24 hour health provider coverage in the facility? ☐ Yes ☐ No
For YES: What type of provider?
7. Are inpatient services available? (non-hospital only) ☐ Yes ☐ No ☐ N/A
For NO: Do you have written agreements with local hospitals for immediate acceptance of patients that require care? ☐ Yes ☐ No
For YES: List hospital(s):
8. Does the facility have a licensed Anesthesiologist or CRNA? ☐ Yes ☐ No ☐ N/A
9. Is a physician and Anesthesiologist/CRNA required to remain present during surgical procedures? ☐ Yes ☐ No ☐ N/A
10. Are RN's available for patient care at all times in the operating and recovery rooms? ☐ Yes ☐ No ☐ N/A

DME Only:
1. Is this a Dental Office? ☐ Yes ☐ No ☐ N/A
2. Do you provide dental sleep medicine oral appliances for patients with sleep apnea? ☐ Yes ☐ No ☐ N/A
3. Is there a physician advisor at each location? ☐ Yes ☐ No
4. Do you require patients provide orders from a medical doctor prior to accessing these services? ☐ Yes ☐ No ☐ N/A
5. Are the providers at your facility members of the American Board of Dental Sleep Medicine or the American Academy of Craniofacial Pain? If so, please attach certificates. ☐ ABODSM ☐ AACP

PATIENT VISITATION - *HOSPITAL*
Does your facility have written *policies and procedures regarding the visitation rights of patients **(**CMS-3228**)?** ☐ Yes ☐ No ☐ N/A
For YES: Provide policy and procedure for *visitation rights of patients.*
***Policy must include:* • *Identifying any clinically necessary or reasonable restriction or limitation the hospital may need to place on such rights, and* • *The reasons for the clinical restriction or limitation.*

RESTRAINT AND SECLUSION
Does your facility have a policy and procedure related to the use of seclusion and restraint as required under the Code of Federal Regulations CFR, 438.100 section V *"be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation."* ☐ Yes ☐ No
For YES: Provide policy and procedure for *restraint and seclusion.*

ACTION HISTORY QUESTIONS	
Please respond to the following questions *YES* or *NO*. If your answer to any of the following questions is *YES* provide a detailed explanation, as specified in each question, on a separate sheet. Sign and date each additional sheet. *****Modification to the wording or format will invalidate the application.***	
1. Has this provider, under any current or former name or business identity, ever had any felony convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?	☐ Yes ☐ No
2. Has this provider, under any current or former name or business identity, ever had any felony convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
3. Has this provider, under any current or former name or business identity, ever had any felony convictions under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201?	☐ Yes ☐ No
4. Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
5. Has this provider ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	☐ Yes ☐ No
6. Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended?	☐ Yes ☐ No
7. Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?	☐ Yes ☐ No
8. Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	☐ Yes ☐ No
9. Has this provider, under any current or former name or business identity, ever had the malpractice insurance terminated or revoked except by request or consent?	☐ Yes ☐ No
10. Has this provider, under any current or former name or business identity, ever had or currently have pending, any legal actions excluding medical malpractice?	☐ Yes ☐ No

Printed Name of Authorized Representative

Signature of Authorized Representative

Authorized Representative's Title

Date Signed

AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this application, it is agreed and understood that:

1. As a representative of the health care provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions indicated in this application is upon the contracted provider or its representative.
2. I further understand and acknowledge that IPN, or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the HIPDB reporting and information as required by law as a part of the verification and credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated and all professional liability insurers with which the provider(s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with IPN or designated agent.
4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of IPN or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to IPN's cycle of recredentialing provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with IPN or its respective agent(s).
6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of IPN or its respective agent(s) before initiating judicial action.
7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.
8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with IPN.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as an IPN Participating Provider or cause for summary dismissal from IPN or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with IPN and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by IPN.

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

***This provider complies with all Federal, State and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).*

Printed Name of Authorized Representative	Signature of Authorized Representative
Authorized Representative's Title	Date Signed

As the authorized representative for the following provider(s)/supplier(s), I grant permission for the release of information related to licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions for the following provider(s)/supplier(s):

Facility Name	City, State
Facility Name	City, State

ADDITIONAL LOCATIONS OR SPECIALTIES

(if applicable)

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

Name:		Specialty:
Address:		Suite #:
City:	State:	Zip:
Phone:		Fax:
TIN:		NPI:

LIST OF ADDITIONAL LOCATIONS ON FILE WITH IPN

Organizational Provider Credentialing Application Addendum

Please supply description(s) for restraint and seclusion action and credentialing and clinical staff privileging below. *If copies or descriptions for each of these polices are attached to this application, this page can be left blank.*

Restraint and Seclusion Action

If restraint and/or seclusion of an individual visiting our location were to become necessary, the healthcare professional(s) working for our organization would (*please check one*):

☐Contact local law enforcement authorities for intervention/assistance.
☐Other (*Provide a description below if there is another plan of action for restraint and seclusion and a policy has not been provided.*)

Credentialing and Clinical Staff Privileging

When a licensed professional is hired at this facility, who ensures they are licensed upon hire and that their license stays current?

What other screening activities are done to ensure the person is competent for the position they hold?

Form **W-9**
(Rev. January 2005)
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.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note. *If the account is in more than one name, see 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. person (including a U.S. resident alien).

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

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

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

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

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

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