envolve®
Benefit Options

Credentialing Packet

Packet may be submitted via the following:

Email: DentalNetwork@EnvolveHealth.com

Fax: 1-855-475-4374

Mail: Envolve Dental, Inc.
P.O. Box 25656
Tampa, FL 33622

Checklist:

- ☐ Provider Credentialing Application
- ☐ Malpractice Insurance
- ☐ DEA and/or CDS Certificate or copy DEA/CDS Waiver
- ☐ State License
- ☐ Disclosure of Ownership Form (If Applicable)
- ☐ Electronic Health Record Form (If Applicable)
- ☐ Copy of Anesthesia Permit (If Applicable)
- ☐ Copy of EBO Statement of Inpatient Admission Coverage (if Oral Surgeon does not have hospital privileges

MISSISSIPPI DEPARTMENT OF INSURANCE
REGULATION NO. 98-1, AS AMENDED
HEALTH CARE PROFESSIONAL CREDENTIALING VERIFICATION

Table of Contents

Section 1. Authority

This Regulation is promulgated pursuant to the authority vested in the Commissioner of Insurance under Article 7 and Article 9 of Chapter 41 of Title 83 of the Mississippi Code of 1972, Annotated, and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, said Regulation being the Rules of Practice and Procedure Before the Mississippi Insurance Department.

Section 2. Purpose and Intent

This Regulation requires a managed care entity to establish a comprehensive health care professional credentialing verification program to ensure that its participating health care professionals meet specific minimum standards of professional qualification. The standards set out in this Regulation address the initial credentialing verification and subsequent recredentialing process.

Section 3. Definitions

For purposes of this Regulation:

A. "Commissioner" means the Commissioner of Insurance.

B. "Credentialing verification" is the process of obtaining and verifying information about a health care professional, and evaluating the professional credentials of that health care professional, when that health care professional applies to become a participating provider in a managed care plan offered by a managed care entity.

C. "Health care professional" means a physician or other health care practitioner licensed or certified by the state to perform specified health services.

D. "Health care services" or "health services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

E. "Managed care contractor" means a person or corporation that:

(1) Establishes, operates or maintains a network of participating providers-,

(2) Conducts or arranges for utilization review activities; and

(3) Contracts with an insurance company, a hospital or medical service plan, an employer or employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

F. "Managed care entity" means a licensed insurance company, hospital or medical service plan, health maintenance organization (HMO), an employer or employee organization, or a managed care contractor as defined under G. above, that operates a managed care plan.

G. "Managed care plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(1) Arrangements with selected providers to furnish health care services;

(2) Explicit standards for the selection of participating providers,-

(3) Organizational arrangements for ongoing quality assurance, utilization review programs and dispute resolution; and

(4) Financial incentives for persons enrolled in the plan to use the participating providers, products and procedures provided for by the plan.

H. "Participating provider" means a health care professional licensed or certified by the state, that has entered into an agreement with a managed care entity to provide health care services, products or supplies to a patient enrolled in a managed care plan.

I. "Physician" means one who is educated and trained to practice the art and science of medicine and who has received the degree of doctor of medicine or osteopathy from an accredited and recognized school or college of medicine or osteopathic medicine.

J. "Primary verification" means verification by the managed care entity of a health care professional's credentials based upon evidence obtained from the issuing source of the credential.

K. "Secondary verification" means verification by the managed care entity of a health care professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of certificates provided by the applying health care professional).

Section 4. Applicability and Scope

This Regulation shall apply to managed care entities that offer, operate or participate in managed care plans.

Section 5. General Responsibilities of the Managed Care Entity

A. A managed care entity shall:

(1) Establish written policies and procedures for credentialing verification of all health care professionals with whom the managed care entity contracts and apply these standards consistently;

(2) Verify the credentials of a health care professional when entering into a contract with that health care professional. The medical director of the managed care entity or other designated health care professional shall have responsibility for, and shall participate in, health care professional credentialing verification;

(3) Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification;

(4) Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures; and

(5) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

B. Nothing in this regulation shall be construed to require a managed care entity to select a provider as a participating provider solely because the provider meets the managed care entity's credentialing verification standards, or to prevent a managed care entity from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

Section 6. Verification Responsibilities of the Managed Care Entity

A managed care entity shall:

A. Obtain primary verification of at least the following information about the applicant:

(1) Current license or certification to practice in this and all other states and history of licensure or certification;

(2) Status of primary admitting hospital privileges, if applicable;

(3) Specialty board certification status, or, if not board certified, the highest level of education obtained;

(4) Malpractice history within the last five (5) years.

B. Obtain by either primary or secondary verification at the managed care entity's discretion:

(1) Current level of professional liability coverage;

(2) Practice history for at least five (5) years;

(3) Status of hospital privileges other than the primary admitting hospital, if applicable;

(4) Completion of medical, health care professional and/or post graduate training, other than the highest level of education obtained;

(5) Current Drug Enforcement Agency (DEA) registration certificate, if applicable,

C. Every two (2) years obtain primary verification of a participating health care professional's:

(1) Current license or certification to practice in this and all other states;

(2) Status of primary admitting hospital privileges, if applicable;

(3) Speciality board certification status, if applicable;

(4) An update regarding the health care professional's malpractice history.

D. Every two (2) years obtain, by either primary or secondary verification, at the managed care entity's discretion:

(1) Status of the health care professional's hospital privileges other than the primary admitting hospital, if applicable;

(2) Current level of professional liability coverage;

(3) Current DEA registration certificate, if applicable;

E. Require all participating providers to notify the managed care entity of changes in the status of any of the items listed in this Section at any time and identify for participating providers the individual to whom they should report changes in the status of an item listed in this Section.

Section 7. Uniform Application for Physician Credentialing and Recredentialing

A. In order to simplify the application process for physicians who are applying to multiple managed care entities, the Commissioner hereby adopts a basic uniform credentialing application which shall be used by all managed care entities performing physician credentialing and recredentialing activities in Mississippi. The uniform application is attached hereto as Exhibit "A" and hereby made a part of this Regulation.

B. The uniform application may be augmented by an individual managed care entity for the purpose of obtaining additional necessary and material information which is not requested in the uniform application, and further, for the purpose of providing more detailed instructions regarding the completion and submission of the application. The additional information/instructions may only be requested/provided on supplemental sheets which are attached to the uniform application. Any proposed supplemental sheets must be submitted by the managed care entity to the Commissioner for prior approval.

C. The form prescribed by this Section shall apply only to the credentialing and recredentialing of physicians.

Section 8. Health Care Professional's Right to Review Credentialing Verification Information

Subject to the provisions of Subsections A-, B , C., and D. of this Section, a managed care entity shall provide a health care professional with the sources from which credentialing information is received, notification of any information that varies substantially from the information the health care professional provided, and the opportunity to correct information received from a third party that is incorrect or misleading.

A. Each health care professional who is subject to the credentialing verification process shall have the right to request information regarding the sources utilized by the managed care entity to verify credentialing information, including a summary of information obtained by the managed care entity to satisfy the requirements of this Regulation.

B. A managed care entity shall notify a health care professional of any information obtained during the managed care entity's credentialing verification process that does not meet the managed care entity's credentialing verification standards or that varies substantially from the information provided to the managed care entity by the health care professional, except, that the managed care entity shall not be required to allow the health care professional to (1) review the contents of a primary source verification, (2) identify the source of information, or (3) provide a summary of differing information, if the information is not obtained to meet the requirements of this Regulation or if

disclosure is prohibited by law. Responses provided by personal or professional references shall not be available to the health care professional.

C. A health care professional shall have the right to correct any erroneous information submitted by a third party when the health care professional feels that the managed care entity's credentialing verification committee has received information that is incorrect or misleading. The managed care entity shall have a formal process by which the health care professional may submit supplemental or corrected information to the managed care entity's credentialing verification committee. Supplemental information shall be subject to confirmation by the managed care entity.

D. Nothing in this Section 8 shall prohibit a managed care entity from denying an application or re-application or terminating privileges, employment or a provider participation agreement where a health care professional intentionally withholds material information, intentionally omits material information, or intentionally submits material false or misleading information in a credentialing or re-credentialing application which is submitted to a managed care entity.

Section 9. Contracting

Whenever a managed care entity delegates the credentialing functions required by this Regulation to another entity, the commissioner shall hold the managed care entity responsible for monitoring the activities of the delegatee entity in order to ensure that the requirements of this Regulation are met.

Section 10. Separability

If any provision of this Regulation, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Regulation, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 11. Effective Date

This Regulation shall become effective February 1, 2000.

GEORGE DALE
COMMISSIONER OF INSURANCE
STATE OF MISSISSIPPI

Instructions For Completing The Mississippi Participating Physician Application

To effectively use the Application, the following is suggested:

- Type or legibly complete the Application in black ink.

- Complete all of the Application except for line **1**, "This application is submitted to: ....,". **Do not sign and date the original**. Keep the completed original on file and keep a blank original for future up-dates. Sign and date as directed below.

- When submitting the Mississippi Participating Physician Application to a credentialing entity:
  1. copy the original Application and any addenda the credentialing entity has requested;
  2. fill in the name of the IPA, medical group, health plan, hospital, etc., to which the Application is being submitted on the top of page 1;
  3. sign and date the copy in the spaces provided;
  4. mail the signed and dated copy to the requesting organization.

  By doing the above, your signature will be an original and the date will be current. Remember that the information on the Application must be complete and accurate. An incomplete Application may delay processing.

- Submit completed Applications and do not rely on attached information unless requested.

- If an item in the Application does not apply to you, write N/A in the box provided.

- Attach copies of the documents requested on page 1 of the Application <u>each time</u> the Application is submitted.

- For your convenience and to ensure information accuracy, keep Application current at all times.

If you have any questions, please call the Managed Care Entity to which you are submitting this Application.

Mississippi Participating Physician Application

Please check one:

☐ Original Application

☐ Reapplication

This application is submitted to: _____, herein, this Managed Care Entity[1].

Section A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **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 (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number:	E-Mail Address:	
Home Fax Number:	Pager Number:	
Birthday Date: Birth Place (City/State /Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security #:	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):				Department Name (if Hospital based):			
Primary Office Street Address:				Primary Office Mailing Address if different from Street Address:			
City:	State:	County:	Zip:	City:	State:	County:	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/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the 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:
Teritary Office Street Address:	City: State: ZIP:
Office Manager/Administrator:	Telephone Number: Fax Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Handicap Access: ☐ Yes ☐ No	24-Hour Coverage: ☐ Yes ☐ No
Will you accept new patients? ☐ Yes ☐ No	Back Office Telephone Number:

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

Name of Network	**Address**	**Reason for Denial or Deselection**

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc.? ☐ Yes ☐ No

If yes, please list:

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

Do you intend to serve as a primary cam 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 ☐ Single Specialty

☐ Group Practice ☐ Multi Specialty

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:

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

Name:	Mississippi 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:

Is your practice limited to certain ages? ☐ Yes ☐ No If yes, specify limitations:

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) ☐ Medicare Certification
☐ Mississippi Department of Health Licensure ☐ Other_____

IV. BILLING INFORMATION

Billing Company:

Street Address:

City:

State: ZIP:

Contact:

Telephone Number:

Name Affiliated with Tax ID Number:

Federal Tax ID Number:

V. OFFICE HOURS - Please indicate the hours your office is open:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays
#1:								
#2:								
#3:								

VI. COVERAGE OF PRACTICE

(List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title.)

Answering Service Company: Telephone 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:

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VIII. 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:

IX. 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:

X. 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)

XI. RESIDENCES/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, state, country, zip code and dates. Including <u>all</u> programs you attended, whether or not completed.

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:

Type of Training (e.g. residency, etc.):	Specialty:	From: (mm/yy)	To:(mm/yy)
Residency			

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution:	Program Director.		
Mailing Address:	City:		
	State & Country:	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 & Country:	ZIP:	
Type of Training (e.g. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which an 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 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:	Certification Number:	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 admissibility for certification on separate sheet.

Have you taken or failed a board exam? ☐ Yes ☐ No If yes, provide details.

XIII. 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:

XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents.)

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: ☐ Yes ☐ No
Drug Enforcement Administration (DEA) Registration Number: Unlimited? ☐ Yes ☐ No If no, please explain on separate sheet		Expiration Date:	
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):	Date Issued:	Valid Through:
Visa Number:	Date Issued:	Valid Through:

Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:

XV. 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:	Active: ☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No

XVI. PROFESSIONAL ORGANIZATIONS

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

ORGANIZATION NAME	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Are you an Officer or Director of any of the professional organizations listed above? ☐ Yes ☐ No
If yes, please list;

XV II. PROFESSIONAL LIABILITY (Attach copy o f professional liability policy or certification face sheet.)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State & Country:	ZIP:
Telephone Number:	Fax Number:	
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.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

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

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

XVIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include 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.

B. PREVIOUS AFFILIATIONS (Limit to 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:	

XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates m practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

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

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:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (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)	

Section B.

Professional Liability Action Explanation

Please complete this Section 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 five (5) 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 void delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

I. 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 claim identification number of insurance company or other lability 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 to serve as your authorization:

Name_____ Phone Number _____

Name_____ Phone Number _____

II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (Circle 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

Section C.

Certification

I certify that the information in Sections A and B of this application and any attached documents (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 intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided bylaw, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or 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 Managed Care Entity 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 in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here _____

Physician Signature _____ Date_____

(Stamped Signature Is Not Acceptable)

Section D.
Attestation Questions

Please answer the following questions "yes" or "no". If your answer to any question is "yes," please provide full details on separate sheet.

1. 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 ☐

2. 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 ☐

3. 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 ☐

4. 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 ☐

5. 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 ☐

6. 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 ☐

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?

Yes ☐ No ☐

8. Have you ever been convicted of my crime (other than a minor traffic violation)?

Yes ☐ No ☐

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks proceeding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)

Yes ☐ No ☐

10. Have any judgments or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or am them any filed and served professional liability lawsuits/arbitrations against you pending?

Yes ☐ No ☐

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?

Yes ☐ No ☐

12. 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 ☐

13. Are you capable of performing all the services required by your agreement with, or the professional staff by laws of, the Managed Care Entity 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, yourself or others?

Yes ☐ No ☐

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services?

Yes ☐ No ☐

I hereby affirm that the information submitted in this Section D 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 intentionally withholding or omitting material information or intentionally submitting material false or misleading information 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)

Section E.
Information Release/Acknowledgements

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 Managed Care Entity" 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[3] 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 Managed Care Entity engaged in quality assessment, peer review and credentialing on behalf of this Managed Care Entity and all persons and entities providing credentialing information to such representatives of this Managed Care Entity from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Managed Care Entity 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 Managed Care Entity as may be required by state and federal law and regulation.

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 Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (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 Managed Care Entity 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 Mississippi Board of Medical Licensure 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 Managed Care Entity or Healthcare Organization which has resulted in the filing of 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 Managed Care Entity or 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 understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photo copy or facsimile of this document shall be as effective as the original, however, original signatures and current dates am required on pages 10, 11 and 12 of this application.

Print Name Here _____

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

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements should be addressed to the Managed Care Entity requesting them.

This Application is endorsed by:
- ***Mississippi Association of Health Plans***
- ***Mississippi State Medical Association***
- ***Mississippi Hospital Association***

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

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DEA/CDS RELEASE

I, _____, NPI # _____, do not hold a DEA/CDS license; therefore, I will not prescribe any Schedule II – V medications while practicing in this state.

Please describe your process for handling instances when a patient requires a controlled substance. Select **one** of the options below and complete any applicable fields:

☐ ***I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management***

☐ I am eligible for a DEA or CDS, but do not have a current certificate. Therefore, I have an arrangement in place with the following provider and/or office, who currently holds an active DEA/CDS license:

_____

Provider Signature: _____ Date: _____

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To whom it may concern-

Please see the attached Disclosure of Ownership form for your location. The State has requested that this document be filled out and returned to us as quickly as possible as the final step in credentialing for your providers.

Only one copy of the Disclosure of Ownership form needs to be completed per tax entity.

Please return the completed form

to: Fax: 844-847-9807

-Or-

Email: dentalcredentialing@envolvehealth.com

Your assistance is greatly appreciated with this matter. If you have any questions please call our toll-free number at 855-434-9245.

Sincerely,

Credentialing Department

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Disclosure of Ownership and Control Interest Form for Envolve Benefit Options Providers and Vendors

Complete Sections A and B. A separate Disclosure Form must be completed for each TIN.
For complete Instructions and Definitions see pages 5-6.

Section A (Please answer all of the following):

If you answered Yes to any questions, complete the Table(s) indicated, then sign the Attestation (Section B) on page 4

If you answered No to all questions, complete and sign the Attestation (Section B) on page 4

Section 1. Disclosure Regarding Managing Employees **Does the provider/vendor have any Managing Employees** (CEO, Administrator, Director, COO, CFO, etc.)? (42 C.F.R. § 455.104)	☐ **No**	☐ **Yes** *Complete Table 1*
Section 2. Criminal Offense Disclosure **Has the provider/vendor,** or any Person (individual or entity) Who Has Ownership or Controlling Interest in the provider/vendor, or who is an Agent or Managing Employee of the provider/vendor, ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), or Title XX (Social Services Block Grants) since the inception of those programs? ***Verify exclusion through the applicable federal and state specific exclusion databases.*** (42 C.F.R. § 455.106)	☐ **No**	☐ **Yes** *Complete Table 2*
Section 3. Person(s) with Ownership or Control Interest Disclosure **Are there any Persons (individual or entity) With an Ownership or Control Interest** in the provider/vendor? (42 C.F.R. 455.104)	☐ **No**	☐ **Yes** *Complete Table 3*
Section 4. Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure **Does the provider/vendor have an** Ownership Interest or Indirect Ownership Interest of 5% or more in any Subcontractor? (42 C.F.R. 455.104)	☐ **No**	☐ **Yes** *Complete Tables 4, 4A*
Section 5. Other Disclosing Entity Disclosure **Does the provider/vendor** or any one named in **Table 3** have an Ownership or Control Interest in any other Medicaid provider? (42 C.F.R. 455.104)	☐ **No**	☐ **Yes** *Complete Table 5*
5A. Does the provider/vendor or any one named in **Table 3** have an Ownership or Control Interest in any other disclosing entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVIII (Medicare), XX (Block Grants to States for Social Services), or Title XXI (State Children's Health Insurance Program) of the Social Security Act? (42 C.F.R. 455.104)	☐ **No**	☐ **Yes** *Complete Table 5*
Section 6. Business Transactions Disclosure **Business Transactions - Subcontractors**: Has the provider/vendor had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period (12- month period ending as of the date on this request)? (42 C.F.R. 455.105)	☐ **No**	☐ **Yes** *Complete Table 6*
Section 7. Significant Business Transaction Disclosure **Significant Business Transactions**: Has the provider/vendor had any Significant Business Transactions with a Wholly Owned Supplier or Subcontractor during the previous 5-year period (5-year period ending as of the date on this request)?	☐ **No**	☐ **Yes** *Complete Table 7*

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Table 1 Disclosure Regarding Managing Employees (Section 1; 42 C.F.R. § 455.104)

Provide the following details for any Managing Employee of the provider/vendor (See the definition of Managing Employee)

Name (First, Middle, Last)	**SSN**	**Birthdate**	**Complete Address** (Street, City, State, Zip)	**NPI** (If applicable)	**Position**

Table 2 Criminal Offense Disclosure (Section 2; 42 C.F.R. § 455.106)

Provide the following details and a description of offense(s). Use additional pages if necessary as set forth on page 4.

Name (First, Middle, Last)	**SSN/TIN**	**Birthdate**	**Description**

Table 3 Person(s) with Ownership or Control Interest Disclosure (Section 3; 42 C.F.R. § 455.104)

Provide the following details and include the title (for example, CEO, CFO, COO, owner, board member etc.). Please attach additional pages if necessary as set forth on page 4. *For corporations/entities that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address. (See the definition of a person with an ownership or control interest.)

Name (First, Middle, Last)	**SSN/TIN**	**Birthdate**	**Title**	**Complete Address** (Street, City, State, Zip)	**% Ownership Interest**

Table 3A Relationship Disclosure of Person(s) with Ownership (Section 3; 42 C.F.R. § 455.104)

Are any of the individuals disclosed in **Table 3** related to each other as a spouse, parent, child, or sibling?

☐ **No** ☐ **N/A**

☐ **Yes -** Provide the following details. Use additional pages if necessary as set forth on page 4.

Name (From Table 3)	**How is the person in Table 3** related to the other person who has ownership or controlling interest?	**Name of Related Person** listed in Table 3?

Table 3B Relationship Disclosure (Related to 4A) (Section 3; 42 C.F.R. § 455.104)

Are any of the individuals disclosed in **Section 3** related to any of the individuals disclosed in **Table 4A** as a spouse, parent, child, or sibling?

☐ **No** ☐ **N/A**

☐ **Yes -** Provide the following details. Use additional pages if necessary as set forth on page 4.

Name (From Table 3)	**How is the person from Table 3** related to the person from Table 4A	**Name of Related Person** listed in Table 4A

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Table 4 Direct or Indirect Ownership of 5% or more in a Subcontractor Disclosure (Section 4; 42 C.F.R. § 455.104)

Provide the following details about the Subcontractor.

Name of Subcontractor (First, Middle, Last)	**SSN/TIN**	**Birthdate**	**Complete Address** (Street, City, State, Zip)	**% Ownership Interest**

Table 4A Subcontractor Disclosure, Cont'd (Section 4; 42 C.F.R. § 455.104)

Provide the information below about any Person (individual or entity) with an Ownership or Control Interest in any Subcontractor in which the provider/vendor has a 5% or more Ownership Interest or Indirect Ownership or Control Interest. (See the definition of the following terms: Person (individual or entity) with an Ownership or Control Interest, Subcontractor and Indirect Ownership Interest.)

Name of Subcontractor (From Table 4)	**Name of Person(s)** with an ownership or control interest in the Subcontractor	**SSN/TIN of Person(s)** with an ownership or control interest in the Subcontractor	**Birthdate of Person(s)** with an ownership or control interest in the Subcontractor	**Complete Address** (Street, City, State, Zip) of Person(s) with an ownership or control interest in the Subcontractor	**% Ownership Interest or Control**

Table 5 Other Disclosing Entity Disclosure (Sections 5, 5A; 42 C.F.R. § 455.104)

Provide the following details. (See the definition of the following terms: Other Disclosing Entity and Ownership Interest.)

Name(From Table 3)	**Name** of other disclosing entity or other Medicaid Provider	**SSN /TIN** of the other disclosing entity or other Medicaid Provider

Table 6 Business Transactions Disclosure (Section 6; 42 C.F.R. § 455.105)

Provide the following details. (See the definition of Subcontractor.)

Name of Subcontractor	**TIN or SSN,** of Subcontract	**Birthdate**	**Complete Address** (Street, City, State, Zip)	**Transaction Amount**

Table 7 Significant Business Transactions Disclosure (Section 7; 42 C.F.R. § 455.104)

Provide the following details. (See the definition of the following terms: Subcontractor, Wholly-owned Supplier, and Significant Business Transactions.)

Type of entity (Wholly Owned Supplier OR Subcontractor)	**Name**	**TIN/SSN**	**Birthdate**	**Complete Address** (Street, City, State, Zip)	**Transaction Amount**

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Section B – Attestation

Name of Provider/Vendor (Disclosing Entity) Being Contracted:
Tax ID # of Provider/Vendor:
Complete Business Address (Street, City, State, Zip)
By signing below, I hereby certify that all information contained in this form is true, correct, and complete in all aspects. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract.
Name: (Print or Type: First/Middle/Last)
Title: (Print or Type)

Authorized Signature:	**Date:**

❒ By checking this box, I acknowledge I have completed the Provider Listing Form.

Additional Documentation

Are you uploading additional pages to this Form?	☐ **Yes** ☐ **No**
If you have indicated "Yes" above, attach additional pages using the link below:	

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Appendix A - Instructions

1. Read all definitions and instructions outlined throughout this Form before completing. Terms that have regulatory definitions, and in some cases helpful examples, are underlined throughout this Form. These Definitions can be found in Appendix B on page 6. Please review the applicable definitions before responding to the question.

2. Answer all questions as of the current date.

3. If "No" is marked in any section, the corresponding table may be left blank. If "Yes" is marked in any section, all information must be completed in the corresponding table. If there is no information to include in the table, indicate "None" or "N/A" in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. An incomplete Form will be returned to the provider/vendor.

4. If more space is needed, please indicate at the bottom of page 4 that additional pages are attached, and use the link on page 4 to upload the necessary file.

5. Business & Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. Individuals must provide their home address.

6. This Form should be submitted at the time of contracting and within 35 calendar days of any change to the information reported on this Form.

7. Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing agreements and contract.

8. The following procedure and examples should be used to assist in determining direct and indirect ownership or control (42 C.F.R. § 455.102):

   (a) **Determining Indirect Ownership Interest**. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

   (b) **Determining person with an ownership or control interest**. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

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Appendix B – Definitions (42 C.F.R. § 455.101)

Agent

Any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR §§ 1001.2, 1001.1001).

Disclosing Entity

The provider or vendor contracting with Envolve Benefit Options (other than an individual practitioner).

Indirect Ownership Interest

An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an Indirect Ownership Interest in the disclosing entity. Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR §§ 1001.2, 1001.1001).

Managing Employee

A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

Other Disclosing Entity

Any other disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare;
b. Any Medicare intermediary or carrier; and
c. Any entity (other than an individual practitioner) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Ownership Interest

The possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in:

a. The capital, the stock or the profits of the entity, or
b. Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity. (42 CFR §§ 1001.2, 1001.1001).

Person with an Ownership or Control Interest

A person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a disclosing entity;
b. Has an Indirect Ownership Interest equal to 5 percent or more in a disclosing entity;
c. Has a combination of direct and Indirect Ownership Interests equal to 5 percent or more in a disclosing entity;
d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
e. Is an officer or director of a disclosing entity that is organized as a corporation; *or*
f. Is a partner in a disclosing entity that is organized as a partnership?

Significant Business Transaction

Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor

a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier

An individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly Owned Supplier

A supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

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Exhibit B
List of Contracted Providers
(List all Entities/Providers Affiliated with this Agreement)

Line of Business: ☐ Medicaid ☐ Ambetter ☐ Allwell (Medicare) ☐ Ascension

Primary Practice Information

Address _____
City _____
State _____
Zip Code _____
Telephone _____
Fax _____
Email _____

Office Contact Name _____
Contact Telephone _____
Contact Email _____
Number of Office Locations _____
(If you have more than one location, please use the Location Roster Form - Excel Format.)

Office Hours **Monday** _____ **Tuesday** _____ **Wednesday** _____ **Thursday** _____ **Friday** _____ **Saturday** _____

Provider Name	Location Name	Practice Tax ID	Provider NPI	Group NPI	CAQH #	Provider Medicaid ID	Group Medicaid ID (Ohio Only)	Board Certified Yes or No	Sub-Specialty (You must have a Completion Certificate)	Age Limitation Children & Adults	Office Handicap Accessible Yes or No	Sees patients with special needs Yes or No	Languages Spoken

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ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

To enroll in Envolve Dental's EFT payment program, complete this form and return it with a **voided check** via one of the following:

Mail: Envolve Dental
P.O. Box 25656
Tampa, FL, 33622-5656

Fax: 855-475-4374

Email: providerrelations@envolvehealth.com

I – CHECK APPLICABLE REASON FOR SUBMISSION

❑ New EFT Authorization OR ❑ EFT setup revision (e.g. account number or bank changes)

II – PROVIDER/PAYEE INFORMATION

Payee name: _____

Tax Identification Number (TIN): (Designate SSN ❑ or EIN ❑) _____

Payee street address, City, State, Zip Code: _____

III – DEPOSITORY INFORMATION (Financial Institution)

Your bank/depository name: _____

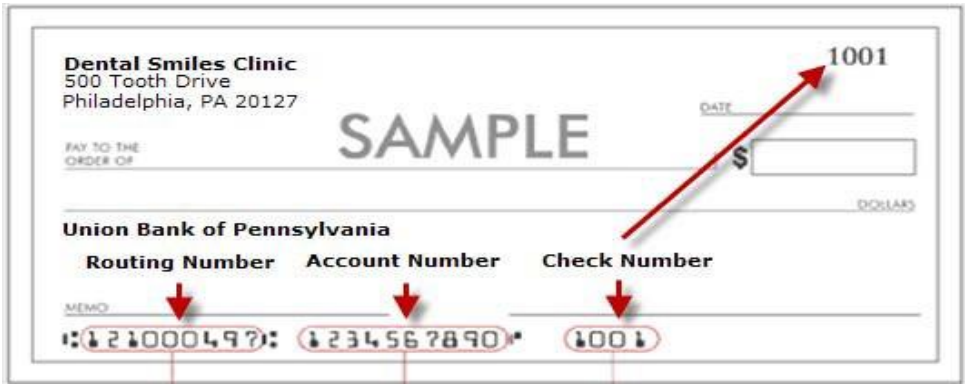
Account type (check one):
❑ Checking ❑ Savings

Depository routing transit number
(Nine digits. Include any leading zeroes):

_____

Depositor account number
(Include any leading zeroes):

_____



IV – CONTACT INFORMATION

Name of billing contact person:_____

Phone number of billing contact:_____

Email address of billing contact:_____

V – AUTHORIZATION

I hereby authorize Envolve Dental to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of authorized billing contact: _____ Date: _____

ELECTRONIC FUNDS TRANSFER (EFT) Terms of Use

The following terms and conditions, as amended from time to time ("Agreement") apply to all use of the Envolve Dental's Electronic Funds Transfer solution, and the use of any service provided in connection therewith (collectively the "EFT Services"). In this Agreement, the words "you", "your" and "yours" means the individual(s) entity or entities identified on the attached Electronic Fund Transfer (EFT) Authorization Agreement, and the words "we," "our," "us" refers to Envolve Dental affiliates and designees. Your enrollment or use of the EFT Services signifies your agreement to be legally bound by the terms and conditions set forth herein. **ACH and Wire Transfers.** This Agreement is subject to Article 4A of the Uniform Commercial Code -- Funds Transfers. By signing this Agreement, you authorize Envolve Dental, acting on behalf of any third party administrator, health care coalition, or health plan carrier (each a "Carrier") that participates in the EFT Services, to credit or debit the accounts listed on your Enrollment Form (the "Accounts") in connection with processing transactions between you and the Carriers. We may rely upon all Account information and identifying numbers provided by you on the Authorization Agreement to receive payment. We may rely on the routing and account numbers you provided even if they identify a financial institution, person or account other than the one named on the Enrollment Form You agree to be bound by National Automated Clearing House Association (NACHA) rules. These rules provide, among other things, that payments made to you, are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the Uniform Commercial Code. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your Account and the Carrier that originated or instructed such payment will not be considered to have paid the amount so credited. We are not required to give you any notice of debits or credits to your Accounts. We may make adjustments to your Accounts whenever a correction or change is required. For example, if we make an error with respect to your Account, you agree that we may correct such error immediately and without notice to you. Such errors may include, but are not limited to, reversing an improper credit to your Account, making adjustments for returned items, and correcting calculation and input errors. Our right to make adjustments shall not be subject to any limitations or time constraints, except as required by law. **Accounts.** You represent and warrant that (a) you are the owner of each of the Accounts and (b) none of the Accounts is used primarily for personal, family or household purposes. **Confidentiality.** During the term of this Agreement, from time to time, we may disclose or make available to you, whether orally, electronically or in physical form, confidential or proprietary information concerning us and/or our business, products or services in connection with this Agreement(together, "Confidential Information"). Confidential Information includes, without limitation, business plans, health plan relationships, acquisition plans, systems architecture, information systems, technology, data, computer programs and codes, processes, methods, operational procedures, finances, budgets, policies and procedures, customer, employee, provider, member, patient and beneficiary information, claims information, vendor information(including agreements, software and products), product plans, projections, analyses, plans, results, and any other information which is normally and reasonably considered confidential. You agree that during the term of this Agreement and thereafter: (i) you will use Confidential Information belonging to us solely for the purpose(s) of this Agreement; and (ii) you will take all reasonable precautions to ensure that you do not disclose Confidential Information belonging to us to any third party (other than to your employees, contractors and/or professional advisors on a need-to-know basis who are bound by obligations of nondisclosure and limited use precautions at least as stringent as those contained herein) without first obtaining our written consent. **Confidentiality Exclusions.** For purposes hereof, "Confidential Information" will not include any information that you can establish by convincing written evidence: (i) was independently developed by you without use of or reference to any Confidential Information belonging to us; (ii) was acquired by you from a third party having the legal right to furnish same to the you without disclosure restrictions; or (iii) was at the time in question (whether at disclosure or thereafter) generally known by or available to the public (through no fault of you).**Amendments and Termination.** Envolve Dental may add, remove, change or otherwise modify any term of this Agreement at any time. We may also terminate or discontinue some or all of the EFT Services at any time without notice to you. **Governing Law and Venue.** The laws of the State of WI shall govern this Agreement and all disputes arising hereunder. You hereby consent that jurisdiction and venue are proper in the State of WI for the resolution of any dispute arising under this Agreement. **Severability.** If any provision of this document is found to be unenforceable according to its terms, all remaining provisions will continue in full force and effect. **Headings.** Headings in this document are for convenience or reference only and will not govern the interpretation of the provisions. **Construction.** Except where it would be unreasonable or illogical to do so, words and phrases used in this document should be construed so the singular includes the plural and the plural includes the singular. **Cooperation.** You agree to cooperate fully with us in furnishing any information, documentation or performing any action requested by us. You shall furnish us, upon forty-eight (48) hours notice, with true, accurate and complete copies of such records, documentation or any other information we or our authorized employees, representatives, agents and any regulatory agencies may request; provided, however, that you shall not be required to divulge any records to the extent prohibited by applicable law. **Ownership.** Except as provided in this Agreement, Envolve Dental shall have and own all rights, title and interests in the EFT Services and any information arising from or in connection therewith. You hereby acknowledge the specific ownership interests of Envolve Dental as set forth herein and you shall not acquire any ownership rights by virtue of this Agreement. **Assignment.** You agree not to assign this Agreement, directly or by operation of law or subcontract, delegate or appoint any third-party agent to perform any or all of its duties obligations or services hereunder without our written consent, and any such attempted assignment, subcontracting, delegation or appointment without such consent shall be void. All written notices shall be delivered by registered or certified mail, return receipt requested, and shall be deemed effective seventy-two (72) hours after the same is mailed via certified mail as described above with postage prepaid. Notice sent by any other method shall be effective only upon actual receipt. The parties to this Agreement, by notice in writing, may designate another to whom notices shall be given pursuant to this Agreement. **Relationship of the Parties.** The relationship between both parties under this Agreement is that of independent contractor. Nothing herein contained shall be construed as constituting a partnership, joint venture or agency between the parties hereto. **Entire Agreement.** This Agreement, which is an integral part hereof and are incorporated herein as a part of this Agreement, constitute the only agreement between the parties hereto relating to the subject matter hereof, except where expressly noted herein, and all prior negotiations, agreements and understandings relating to the subject matter hereof, whether oral or written, are superseded or canceled hereby. **Force Majeure.** Envolve Dental shall not be liable for a delay in performance or failure to perform any obligation under this Agreement to the extent such delay is due to causes beyond our control, including, but not limited to, governmental requests, regulations or orders, utility or communications failure, delays in transportation, national emergency, war, civil commotion or disturbance, war conditions, fires, floods, storms, earthquakes, tidal waves, failure or delay in receiving electronic data, equipment or systems failure or communication failures. **Warranties.** ENVOLVE DENTAL HEREBY DISCLAIMS ALL WARRANTIES WITH RESPECT TO THE SERVICES AND PRODUCTS PROVIDEDHEREUNDER, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING WITHOUT LIMITATION ANYWARRANTY OFMERCHANTABILITY OR FITNESS FOR USE FOR A PARTICULAR PURPOSE. Under no circumstances shall the financial responsibility of Envolve Dental for any failure of performance by us under this Agreement exceed the fees or charges paid by you to Envolve Dental for the transaction, or activity that is or was the subject of the alleged failure of performance. IN NO EVENT SHALL ENVOLVE DENTAL, ITS PARENT,AFFILIATES, SUBSIDIARIES, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES BE LIABLE FOR SPECIAL,INCIDENTAL OR CONSEQUENTIAL DAMAGES OR CLAIMS BY YOU OR ANY THIRD PARTY RELATIVE TO THE TRANSACTIONS HERE UNDER. **Indemnification.** You shall be liable to and shall indemnify, defend and hold Envolve Dental its directors, officers, employees, representatives, successors and permitted assigns harmless from and against any and all claims, demands by third parties, losses, liability, cost, damage and expense, including litigation expenses and reasonable attorneys' fees and allocated costs for in-house legal services, to which Envolve Dental, its directors, officers, employees, representatives, successors and permitted assigns may be subjected or which it may incur in connection with any claims which arise from or out of or as the result of (a) your breach of this Agreement; (b) your performance, duties and obligations under this Agreement; or (c) the negligence or willful misconduct of you, your directors, officers, employees, agents and affiliates in the performance of their duties and obligations under this Agreement. You shall bear all risk of loss of items, records, data and materials during transit from you to Envolve Dental's location or that of Envolve Dental's agents or sub-contractors. **Waiver.** No waiver or failure to exercise any option, right, or privilege under the terms of this Agreement on any occasion or occasions shall be construed to be a waiver of the same or any other option, right or privilege on any other occasion.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

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

☐ Other (see instructions) ▸

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

Exempt payee code (if any)

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

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,* later, 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 Pub. 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 24% 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 instructions for Part II 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,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

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,* later, 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 (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a 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 on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on 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. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

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.

If you are a single-member LLC that is disregarded as an entity separate from its owner, 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 *What Name and Number To Give the Requester,* later, 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. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

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 item 1, 4, or 5 below indicates 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), ABLE accounts (under section 529A), 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) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. 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]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. 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:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. 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
15. 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,* earlier.

***Note:** The 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 Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic 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 report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* 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.

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Provider Web Portal (PWP) Registration

Complete the following steps to create your PWP user account.

1. New User? Register Now

Visit https://pwp.envolvedental.com and click the **New User? Register Now** button.

2. Select Payee

On the Registration page, click the **Payee Registration** button.

3. Enter Information

On the Payee Registration page, enter all required information.

- Payee ID is listed on the Welcome Letter.
- Username cannot be the same as Payee Name.
- Password cannot be the User Name.

4. Create Account

After all information is entered correctly, click **Create** button to create your PWP user account.*

*At initial login, you will be prompted to verify the email address provided. If you do not receive your verification code within 5 minutes, please check your spam folder.

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STATEMENT OF INPATIENT ADMISSION COVERAGE

COMPLETION OF THIS FORM IS REQUIRED IF PROVIDER/GROUP DOES NOTE HAVE ADMITTING PRIVILEGES

Individual Providers (if this statement applies to more than one provider, do not list providers here):

Provider Name: _____ NPI:_____

Provider Groups (list provider names and NPIs below):

Practice Name: _____ Tax ID:_____

To be considered for panel participation with Envolve Dental, Inc. (Envolve Dental) an applicant that does not have hospital staff privileges must refer patients to a provider with admitting privileges or a participating facility.

I acknowledge that I have the responsibility to notify Envolve Dental of any hospital privilege change.

_____ _____

PREPARED BY (PRINT) **DATE**

_____

SIGANATURE

Submit this form with credentialing or recredentialing materials to Envolve Dental's Credentialing Department:

- **Fax Number**: 844-847-9807
- **Email**: dentalcredentialing@envolvehealth.com

Provider Groups: List provider names and National Provider Identifier (NPI) associated with this statement below.

Name: _____ NPI:_____

Name: _____ NPI:_____

Name: _____ NPI:_____

Name: _____ NPI:_____

Name: _____ NPI:_____

Name: _____ NPI:_____

Name: _____ NPI:_____

Name: _____ NPI:_____

Name: _____ NPI:_____

Envolve Benefit Options, Inc. does not exert economic pressure to persuade institutions to grant privileges that would not otherwise be granted or pressure health care providers/institutions to render care beyond the scope of their training or experience.