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

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

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

☐ Other (see instructions) ►

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

ARKANSAS STATE MEDICAL BOARD

Centralized Credentials Verification Service

1401 West Capitol, Suite 340 • Little Rock, AR 72201 • (501) 296-1802 • Fax (501) 296-1806

CCVSMonitor@armedicalboard.org • www.armedicalboard.org

CCVS ATTESTATION & RENEWAL FORM

DO NOT ALTER THE QUESTIONS ON THIS ATTESTATION FORM!!!

1. Do you currently maintain individual or group malpractice insurance coverage? ☐ Yes ☐ No

   If NO, list reason: _____

   Policy Number(s): _____ Coverage Amounts: _____

   Expiration Date: _____ Insurance Carrier Name(s): _____

   If Group Policy, list Group Name: _____

2. Will you be providing telemedicine services from another state (an act that is part of patient care through electronic means)? ☐ Yes ☐ No

3. *Since your last attestation*, has your primary practice location changed? ☐ Yes ☐ No

   If YES, list the following: Current location: _____

   Position/Title: _____ Specialty: _____ Effective Date: _____

4. *Since your last attestation*, have your privileges or medical staff membership at any hospital or other healthcare organization been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

5. *Since your last attestation*, have you been charged or convicted of (including a plea of guilty or nolo contendere) a felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.) *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

6. *Since your last attestation*, has your license or certificate to practice medicine or Drug Enforcement Administration registration in any jurisdiction (state or country) been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, reprimanded, received a written warning, or otherwise sanctioned, or is any such action pending? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

7. *Since your last attestation*, have you been or are you presently being treated for alcoholism or substance abuse due to an Order of the Arkansas State Medical Board or an Order of the medical licensing authority of any other state? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

8. *Since your last attestation*, have you been advised or required by the Arkansas State Medical Board or any other licensing board to seek treatment for a physical or mental health condition? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

9. *Since your last attestation*, do you currently, or have you had since your last renewal, any physical or mental health condition, including alcohol or drug dependency, which, with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

10. *Since your last attestation*, are you presently involved in the use of any illegal substance? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

11. *Since your last attestation*, have any malpractice claims or professional liability lawsuits been filed against you, or have you received notification of a suit alleging you have committed medical malpractice? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

    Claim Date: _____ **Claimant's Initials:** _____ **(ASMB requirement per Medical Practices Act 17-95-103)**

12. *Since your last attestation*, have any malpractice judgments been entered against you, or settlements been agreed to, in professional liability lawsuits or malpractice claims? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

    Claim Date: _____ **Claimant's Initials:** _____ **(ASMB requirement per Medical Practices Act 17-95-103)**

I affirm and attest that I am the license holder and all information contained in the original application or most recent update is true, correct, current, and complete in all respects to the best of my ability. I accept the responsibility to keep the Arkansas State Medical Board advised of any change or appropriate addition to any information contained in this form between now and the time such information is updated by subsequent renewals or updates.

_____ _____

Licensee's Signature (Required) (no rubber stamps) **Date Signed (Month/Day/Year – Required)**

_____ _____

Licensee's Printed/Typed Name (Required) **Arkansas Medical License Number (Required)**

Disclosure of Ownership and Control Interest Statement for the NovaSys Health network maintained by Arkansas Health and Wellness

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted to the NovaSys Health network maintained by Arkansas Health and Wellness within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

Practice Information

Check one that describes you: ☐ Individual Practitioner ☐ Group Practice ☐ Disclosing Entity	
Name of Individual Practitioner, Group Practice, or Disclosing Entity ("Provider")	
DBA Name:	
Address:	
TIN or SSN:	NPI:

Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the Provider (e.g. an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the Definition of "person with ownership or control interest" in the Instructions), list the name, address, date of birth (DOB) and Social Security Number (SSN) for each such individual.

For entities with an ownership or control interest in the Provider, list the name, Tax Identification Number (TIN), and each address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if an individual) TIN (if an entity)

Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the Provider has an ownership or control interest of 5% or more? ☐ Yes ☐ No

If yes, list the name, address, DOB and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if listing an individual) TIN (if listing an entity)

Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other? ☐ Yes ☐ No

If yes, list the individuals who are related to each other, and the type of relationship (spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

Names	Type of relationship

Section IV: Convictions

Has any person who has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN

Section V: Business Transactions

Has the Provider had any financial transactions with any subcontractors totaling more than $25,000 with any subcontractors during the previous 12 months? ☐ Yes ☐ No

Has the Provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous 5 years? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the previous twelve month period, and any significant business transactions between the Provider and any wholly owned supplier or between the Provider and any subcontractor during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI: Managing Employees

Does the Provider have any managing employees? ☐ Yes ☐ No

If yes, list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and percent of interest. (42 CFR 455.104) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN	% Interest

If "Group Practice" or "Disclosing Entity" is checked in the Practice Information section above, the undersigned hereby represents that he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate, and on behalf of each physician and practitioner listed on Exhibit A attached to this Statement, and the undersigned represents that he, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed physician and practitioner.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading, inaccurate, or incomplete data may result in a denial of participation for the affected providers.

Signature

Title (or indicate if authorized Agent)

Name (please print)

Date

Please return by fax to **844-357-7890**, by email to **arkcredentialing@centene.com**, or by mail in the enclosed postage paid envelope to:
P.O. Box 25538
Little Rock, AR 72221