Return this completed enrollment packet to:
EDS Provider Enrollment
PO Box 23
Boise, ID 83707

Phone: (208) 383-4310 Toll-free (800) 685-3757
Fax: (208) 395-2198

DO NOT WRITE HERE

Enrollment Tracking #:_____

Sanction DUPL New ReEn

EDS:_____ Entered:_____ Effective:_____

Provider #:_____

Type :**007** Specialty:_____ **0** Ind PPI **C**

DEA Pharmacy Unit Appr: _____ MAS Appr: _____

Medicare Pend Email

Idaho Medicaid Provider Enrollment Packet
Pharmacy

Welcome to the Idaho Medicaid Program. This enrollment packet has been prepared for use by Pharmacy service providers.

To complete the application process, you will need the following documents. Except for the attachments, all of these documents are included in this enrollment packet. See the instructions in Part 3 for information on attachments.

_____ **Pharmacy Provider Application** (Part 1)

_____ **Additional Documentation** (Part 2)

_____ **Medicaid Provider Agreement** (Part 2)

_____ **Disclosure of Ownership and Control Interest Statement** (Required)

_____ **Signature-on-File form** (Part 2, Optional)

_____ **Authorization for Electronic Funds Transfer form** (Part 2, Optional)

_____ **Electronic Claims Submission Certification and Authorization form** (Part 2, Optional)

_____ **Attachments** (Part 3)

_____ **W-9 form** (Required)

Before you begin filling out this enrollment packet, first complete the W-9 form (Request for Taxpayer Identification Number and Certification) that is included at the end of the packet. This is a four page form that includes directions for completion. It must be signed and dated by the provider. You will use the name, address, and tax identification number entered on the W-9 form to complete this application. The name on the W-9 form is the name under which you report to the IRS. It is the same name used for the Pay-to address on page 4 of the application. It must be signed and dated by an authorized representative of the provider. This form is required.

Once you have assembled and completed all of the required materials, take a moment to check off each of the pieces listed above. Incomplete applications are returned to the provider. Take a second look to be sure that you have remembered to date and sign all forms.

Make a copy of this enrollment packet for your records. Send the original to EDS at the address found on the top of this page. If you have questions about the status of your application, and you received this application from EDS, use the enrollment tracking number written at the top of this page, and call EDS Provider Enrollment at: (208) 383-4310 or (800) 685-3757.

Note: Do not include claims with this enrollment packet. They will be returned.

All forms must be completed in black ink.

1. **Provider Name and Service Location:** This is the name and address that the provider will use to submit claims. This name is also entered on the Medicaid Provider Agreement in Part 2 of this enrollment packet. The address is the physical address of the individual or business. While you may include a separate mailing address for this service location, you must provide the physical street address. If you have additional service locations, enter them on page 4, Additional service locations of Part 1.

Name: _____

Street Address: _____

City: _____ **State:** ____ **Zip+4:** _____

Phone: (_____) _____ **Email:** _____

Mailing Address for this Physical Location (if different from above)

Street Address: _____

City: _____ **State:** ____ **Zip+4:** _____

Phone: (_____) _____ **Email:** _____

2. **Medicaid Participation:** Have you been an Idaho Medicaid provider at any time in the past?

YES **NO**

3. **Federal Employer Identification Number (FEIN):** You may use either a Social Security Number (SSN) or FEIN as a tax identification number. Whichever number is used, it must match the number on the W-9 form.

FEIN Number: _____

4. **Fiscal Year End:** Enter the fiscal year end for the facility. **Month:** _____ **Day:** _____

5. **Medicare Number:** Providers enrolled with Medicare may enter their Medicare number. This field is optional.

Medicare Number: _____

6. **Remittance Advice (RA):** When you begin to bill Medicaid for claims, you receive a RA every week that you have a claim in the system. The RA explains the status of your claim. On this application, you are asked if you want to have pended claims included on your RA. A pended claim is a claim that has not been paid or denied but is being held for further review. Select YES if you want to be informed of the status of pended claims.

Do you want pended claims information printed on your RA? **YES** **NO**

7. **Provider Specialty and Practice Definition:** All Medicaid providers are identified by provider specialty. Refer to the provider specialty list and select the specialty that best describes your practice.

Select only one specialty.

Select	Code	Provider Specialty
	092	Pharmacy
	093	Unit dose pharmacy (see note)

Note: For Title XIX payment purposes, unit dose dispensing is defined as a system of providing individually sealed and appropriately labeled unit dose medication that ensures no more than a 24-hour supply in any participant's drug tray at any given time. Delivery of drug cabinets containing each day's medication is to be at a minimum of a five day per week basis.

Within these specialties there are four practice definitions. Refer to the list of definitions given below and select the definition that best describes your practice.

Select only one practice definition.

Select	Code	Practice Definition
	07	Chain owned pharmacy
	08	Hospital based pharmacy
	09	Mail order pharmacy
	10	Independently owned pharmacy

8. **License Number:** Enter the number on your license, the effective and end dates, and attach a copy to this application. This field is required.

Pharmacy License Number: _____

Effective Date: _____

End Date: _____

9. Name, Address, Telephone, and Email: Providers may have different addresses and telephone numbers for different purposes. The Pay-to name and address may be the same as the Provider Name and Primary Service Location used on page 1 of this Pharmacy Provider application.

Pay-to (required) PRAD01
This is the name that will appear on your check and is reported to the IRS. It must match the name entered on the W-9 form. Checks and RA will be mailed to this address. This is a required field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ___ Zip: _____

Phone: (_____) _____

Email: _____

Mail-to addresses (optional) PRAD02
This is the name and address where correspondence is mailed including newsletters, provider handbooks, and updates. The Pay-to name and address will be used if the Mail-to address is left blank. This is an optional field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ___ Zip: _____

Phone: (_____) _____

Email: _____

Billing service address (optional) PRAD03
This is the name and addresses that is used if a billing service handles your claims.
This is an optional field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ___ Zip: _____

Phone: (_____) _____

Email: _____

Contact address (optional) PRAD13
This is the name and address used for the specific person to be contacted for questions about claims if it is different from the provider.
This is an optional field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ___ Zip: _____

Phone: (_____) _____

Email: _____

Additional service location(s) (optional) PRAD04
This is the name and address of additional service locations that the provider will use to submit claims. While you may include a post office box, you must use a street address.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ___ Zip: _____

Phone: (_____) _____

Email: _____

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ___ Zip: _____

Phone: (_____) _____

Email: _____

If there are additional service locations please list them on a separate piece of paper.

Idaho Medicaid National Provider Identifier (NPI) Registration Form - Organization

NPI Account Contact Information

First Name _____ Last Name _____ Title _____

Telephone Number _____ Extension _____

Fax Number _____ E-Mail Address _____

Provider Information

Organization Name _____ Federal Tax Identification Number _____

Mailing Address _____

Mailing City _____ State _____ Zip+4 _____

NPI number to be linked to this Idaho Medicaid number _____

Certification Statement

My signature on this form certifies that:

☐ I am the owner of this NPI

☐ I am authorized by the owner of this NPI to register this NPI with Idaho Medicaid

Signature _____ Date _____

Additional Documentation

Included in this enrollment packet are five additional documents. To complete this application you must:

A. Read, sign, and date the Medicaid Provider agreement. At the top of the form, enter the same name for the provider as you entered for the Provider Name and Primary Service Location on page 1 of the application. An authorized agent must sign and date this agreement. This form is required.

B. When submitting paper claims, providers must sign every claim form or complete a Signature-on-File form. If you wish to submit claims without a handwritten signature, complete the Signature-on-File form. This form allows submission of paper claims without a handwritten signature by using a stamp or the notation, Signature-on-File. This form is optional.

- Indicate the exact notation that will be used on paper claim forms in the provider signature field. This can be the name of an individual (*e.g.*, Ima Philpot), a business (*e.g.*, Pharmacy Incorporated), or Signature-on-File. Once the Signature-on-File form is received by EDS:
- No other notation will be accepted as a valid signature on claims.
- The provider accepts responsibility for all claims submitted with the notation from the Signature-on-File form.

E. Complete the Authorization of Electronic Funds Transfer form if you wish to have your payments automatically deposited to your banking account. This form is optional.

F. Complete the Electronic Claims Submission Certification and Authorization form if you wish to bill electronically. This form is optional.

G. Complete, sign, and date the Disclosure of Ownership and Control Interest form. This form is required.

H. Complete the four page W-9 form found at the back of this packet. Follow the instructions on the W-9 form. The name on the W-9 form is the name under which you report to the IRS. The name on the W-9 form is the same name used for the Pay-to address on page 4 of the application. Date and sign the form. This form is required.

Idaho Department of Health and Welfare
Medicaid Provider Agreement

Name and address of individual or entity applying to provide these items or services:

_____

_____

_____

_____

Current or previous provider number for this provider type and specialty: _____

_____

_____

(Does not apply if this is an initial application)

As a condition of participation in Medicaid, the provider agrees as follows:

1. Compliance

To provide services in accordance with all applicable federal laws, and provisions of statutes, state rules, and federal regulations governing the reimbursement of services and items under Medicaid in Idaho, including *IDAPA 16.03.09, Medicaid Basic Plan Benefits, IDAPA 16.03.10, Medicaid Enhanced Plan Benefits, IDAPA 16.03.13, Consumer Directed Services, IDAPA 16.03.17, Medicare/Medicaid Coordinated Plan Benefits, and IDAPA 16.03.18, Medicaid Cost Sharing,* as amended; the current applicable *Medicaid Provider Handbook*; any Additional Terms attached hereto and hereby incorporated by reference; and any instructions contained in provider information releases or other program notices.

1.1. To comply with the Health Insurance Portability and Accountability Act (HIPAA), §§ 262 and 264 of Public Law 104-191, 42 USC § 1320d, and federal regulations at 45 CFR Parts 160 and 164. The provider shall comply with all amendments of HIPAA and federal regulations made during the term of the Contract. The provider specifically acknowledges its obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations.

1.2. To protect the confidentiality of identifying participant information that is collected, used, or maintained according to *IDAPA 16.05.01, Use and Disclosure of Department Records*, and 42 CFR § 431.300.

1.3. To comply with the False Claims Act (31 USC 3729-3733). Any provider who either receives or makes annual Medicaid payments of at least five million dollars ($5,000,000) shall comply with 42 USC § 1396(a)(68). The provider specifically acknowledges the responsibility regarding employee education about the False Claims Act and state laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws.

1.4. To comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.

1.5. To comply with the disclosure of ownership requirements in 42 CFR § Part 455, Subpart B, and 42 CFR § 411.361, when applicable, and to notify the Department of Health and Welfare (IDHW) 30 days prior to any change of ownership. This Provider Agreement is not transferable.

1.6. To comply with the advance directives requirements of 42 CFR Part 489, Subpart I, and 42 CFR § 417.436(d), when applicable.

2. Contact

To advise IDHW of the provider's current mailing address. If a PO Box is used, the owner's home address and phone number must be included. All correspondence sent to the mailing address on file with the state's fiscal agent shall be deemed to have been received by the provider.

3. Professionalism

To be licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with statute, rules, and professionally recognized standards by qualified staff or professionally supervised paraprofessionals where their use is authorized. The provider shall respect the Medicaid participant's right to privacy, dignity, and free choice of provider.

4. Recordkeeping

To document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of Idaho Code, § 56-209h(3), as amended, applicable rules, and this agreement. Such records shall be maintained in hard copy for at least five years after the date of services or as required by rule. In compliance with 42 CFR 1001.1301, IDHW, the Medicaid Fraud Control Unit of the Office of the Idaho Attorney General, the U.S. Department of Health and Human Services, or their agents, shall be given immediate access to, and permitted to review and copy any and all records relied on by the provider in support of services billed to Medicaid.

5. Accurate Billing

To certify by the signature of the provider or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and medically necessary, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable Department rules, and this agreement. The provider shall be solely responsible for the accuracy of claims submitted, and shall immediately repay IDHW for any items or services IDHW or the provider determines were not properly provided, documented, or claimed. The provider must assure that a duplicate claim under another program or provider type is not submitted.

6. Secondary Payer

To acknowledge that Medicaid is a secondary payer and to seek payment first from other all sources as required by rule, regulation, or statute, before billing Medicaid. The provider shall not refuse to furnish services on account of a third party's potential liability for the services. (42 CFR § 447.20)

7. Payment

To accept Medicaid payment for any item or service as payment in full and to make no additional charge except that specifically allowed by Medicaid. The provider further agrees:

7.1. To submit requests for prior authorization, if required, before the item or service is provided. The provider agrees not to bill Medicaid if a required request for prior authorization is not timely submitted.

7.2. Not to bill the participant unless the item or service is not covered by Medicaid, and the participant has agreed to be responsible for payment prior to receiving the item or service.

7.3. That if a third party pays the participant, the participant may be billed for that amount, and Medicaid will not be billed.

7.4. Not to bill Medicaid or the participant if a third party payment is made to the provider unless the third party payment is less than the amount Medicaid would pay.

8. Service Providers

To be responsible for the recruiting, hiring, firing, training, supervision, scheduling, and payroll for its employees, subcontractors, or agents. The provider shall maintain general liability insurance coverage, worker's compensation, and unemployment insurance, and shall pay all FICA taxes and state and federal

tax withholding for its employees. The provider agrees to bill only for service providers who have the qualifications required for the type of service that is being delivered.

9. Officers and Employees Not Liable

No official, employee, or agent of the State of Idaho shall be in any way personally liable or responsible for any term of this agreement, whether express or implied, nor for any statement, representation, or warranty made in connection with this agreement.

10. Duration and Termination of Agreement

This agreement shall remain in effect until terminated in writing. In the event of termination, IDHWs sole obligation shall be to pay for services provided prior to the effective date of termination. The IDHW shall not be responsible for any costs or expenditures of the provider in reliance upon the terms of this agreement.

10.1. This agreement may be terminated by either party without cause by giving 30 days notice in writing to the other party.

10.2. This agreement shall be terminated if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of the agreement infeasible or impossible.

10.3. This agreement shall be terminated immediately if the provider's license or certification required by law is suspended, not renewed, or is otherwise not in effect at the time service is provided.

10.4. The IDHW may, in its discretion, terminate this agreement in writing when the provider fails to comply with any applicable rule, term, or provision of this agreement, either immediately or upon such notice as IDHW deems appropriate. The provider also understands and agrees that its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, and *IDAPA 16.05.07, The Investigation and Enforcement of Fraud, Abuse and Misconduct*, as amended. The provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this agreement. Notice of these sections shall in no way imply that they represent an exclusive or exhaustive list of available actions to deal with fraud and abuse.

11. Provider Liability

If the provider is any type of partnership, corporation or nonprofit entity, the provider agrees that the entity and the partners, directors, officers, members, or individuals with an ownership interest of 5 percent or greater, are jointly and severally liable for any breach of this provider agreement, and that action by IDHW against the provider may result in action against all such individuals in the entity.

12. Additional Terms, if any, are provided in Appendix A, attached.

I have read the foregoing provider agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this agreement constitute sufficient grounds for termination of this agreement and may be grounds for other action as provided by state rule, federal regulation, or statute.

Printed name of individual practitioner or individual authorized to sign on behalf of the provider:

_____

Position: _____

By my signature, I declare, under penalty of perjury, that I have the legal authority to enter into this agreement and hereby bind all entities and individuals that comprise the provider.

_____ _____

Signature Date

Signature-on-File

I hereby certify that I have compared the information submitted regarding materials furnished and services rendered against my records and that the foregoing information is true, accurate, and complete. I further certify that:

- The charges submitted for the material furnished and services rendered are correct charges against the state of Idaho pursuant to applicable IDHW regulations and state law.
- The claim is due.
- I am authorized to sign for the payee.
- Complete records of materials and services will be provided upon request to the Secretary of the United States Department of Health and Human Services, the Idaho Department of Health and Welfare, and the Medicaid Fraud and Program Integrity Unit.
- I accept payment as payment in full subject to adjustment in accordance with IDHW regulations.
- All materials furnished and/or services rendered have been provided without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical handicap, or mental handicap.

I understand that payment and satisfaction of all claims submitted with my signature will be from federal and state funds and that any falsification or concealment of material fact is subject to prosecution under applicable federal and state laws.

I agree and certify that, for all Medicaid claims submitted with the signature of:

_____,

the terms and conditions of the above statement have been met and will continue to be met.

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

The provider or responsible corporate official must sign this certificate statement.

Authorization for Electronic Funds Transfer

Complete all the sections below if you wish to have your payments automatically deposited to your bank. The transaction routing number can be obtained from your bank.

Important: You must include a letter from your bank verifying your transaction routing number and account number. For deposits to a checking account, you may instead include an original voided check or copy of a voided check. If you include a voided check, tape it in the space provided below. (Please, do not staple the check.)

Provider Name: _____

Bank Name: _____ **Bank Phone Number:** (_____)_____

Bank Address: _____

_____

Account Number: _____

Transaction Routing Number: (9-digit) ___ ___ ___ ___ ___ ___ ___ ___ ___

Type of Account: (circle only one) **Checking** **Savings**

I authorize the electronic transfer of Idaho Medicaid payments made to the above provider. I understand that I am responsible for the validity of the above information.

Authorized Signature: _____ Date: _____

Name typed or printed: _____

For checking account deposit only, tape a voided check here.

Electronic Claims Submission Certification and Authorization

_____, hereinafter referred to as 'provider', hereby certifies as follows:

(Provider name)

The provider certifies that all services and items for which reimbursement will be claimed shall be furnished by, or under the supervision of, the provider.

The provider understands that the use of electronic claims submission does in no way relieve the provider of responsibilities for (a) Maintaining such medical and fiscal records as are necessary to disclose fully the nature and extent of services or items provided by the provider to Medicaid recipients, and making such records available upon request to the Idaho Department of Health and Welfare (IDHW) and the United States Department of Health and Human Services; and (b) Promptly returning to IDHW, or its fiscal agent, the amount of any erroneous or excess payments received for services or items provided to any Medicaid recipients.

The provider certifies that the claim is due, that the provider is authorized to sign for the payee, that complete records of these services are being kept in hardcopy form for five years, and will be provided upon request. The provider accepts payment in full for the claims submitted subject to adjustment as authorized by IDHW regulations and certifies that these services have been rendered without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical or mental handicap. The provider certifies that if prescription services are provided, a legal prescription is on file for each medication issued.

The provider certifies that all services and items from which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the Idaho Medicaid Program, and that all charges submitted for services and items provided shall not exceed provider's usual and customary charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

The provider understands that any payments made in satisfaction of claims submitted will be derived from federal and state funds and that any false claims, statements, documents, or concealment of material fact may be subject to prosecution under applicable federal and state law.

If the provider uses a billing service, the provider agrees to report completely and accurately to the billing service all information necessary to ensure compliance with federal and state laws pertaining to the Idaho Medicaid Program, as amended.

The provider understands that IDHW reserves the right to revoke its approval for electronic claims submission, at any time, for failure on the part of the provider or billing service to comply fully with any or all guidelines governing the submission of electronic claims.

The provider holds EDS harmless and indemnifies EDS against any liability to the provider, the state of Idaho, or to any Medicaid provider arising out of the entering into this agreement or subsequent receiving and processing of Medicaid claims by tape or other electronic media.

SECTION I

Idaho Department of Health and Welfare shall allow providers to enter Medicaid claims through the claims entry system developed by IDHWs fiscal agent and designated Electronic Claims Submission (ECS), through the use of entry screens developed by authorized computer vendors, by magnetic tape, or cartridge.

Both EDS and the state of Idaho must approve of any provider prior to the submission of electronic claims.

The provider shall allow IDHW access to claims data and assure that submission of claims data is restricted to authorized personnel so as to preclude erroneous payments resulting from carelessness or fraud.

Provider Name: _____

Provider Address: _____

City: _____ State: _____ Zip+4: _____

Phone Number: (_____) _____

Authorized Signature: _____ Date: _____

Name printed or typed: _____

National Provider Identifier (NPI) to be linked to this Idaho Medicaid number: _____

SECTION II

(To be completed by providers using a billing service)

The provider agrees to abide by the policies affecting electronic submissions as published in the electronic specification manual for Medicaid claims.

The provider hereby certifies that _____ is authorized to

(Billing Service)

submit electronic claims on provider's behalf.

The provider agrees that if the billing arrangement with the aforementioned billing service is terminated, the provider will immediately report the termination in writing to IDHW or its fiscal agent.

Authorized Signature: _____ Date: _____

Name printed or typed: _____

Mail to:
EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Fax to:
EDS
Attn: Provider Enrollment
(208) 395-2198

Information:
(800) 685-3757
Ask for *Provider Enrollment*

Attachments

Providers are required to include copies of the following documentation unless otherwise noted. It is the provider's responsibility to have valid documentation for all dates of service. Do not send original documents.

The dates of all documentation must cover the dates for billed services. All licensing and certification must be kept current for continued enrollment in the Idaho Medicaid Program.

Effective Date

If Field 8, Part 1 is circled YES (back date requested for effective date), a written request to justify the effective date is required. Also, all applicable licenses or certifications submitted with this application must cover the requested dates of service. This may require including licenses or certifications for more than one year.

Pharmacy License

Pharmacists are required to include a copy of the state pharmacy license issued by the Board of Pharmacy

Drug Enforcement Agency (DEA) Certification

A copy of DEA certification is required.

Out-of-State Pharmacists

Out-of-state pharmacists mailing medications into Idaho must include a copy of the mail order license issued by the Idaho Board of Pharmacy.

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. 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.

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

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 on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the 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 withholding on your share of partnership income.

The person who gives 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 is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

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

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the 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 not subject to backup withholding, give the requester the appropriate completed Form W-8.

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

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

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

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. 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 the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

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 possession of the United States, or any of their political subdivisions or instrumentalities,

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

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 7[2]

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

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

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

If you are asked to complete Form W-9 but do not have a TIN, 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 domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

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

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 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 to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

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

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. 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

[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 second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

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, social security number (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.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

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

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

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

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

Visit the IRS website at *www.irs.gov* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax 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. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.