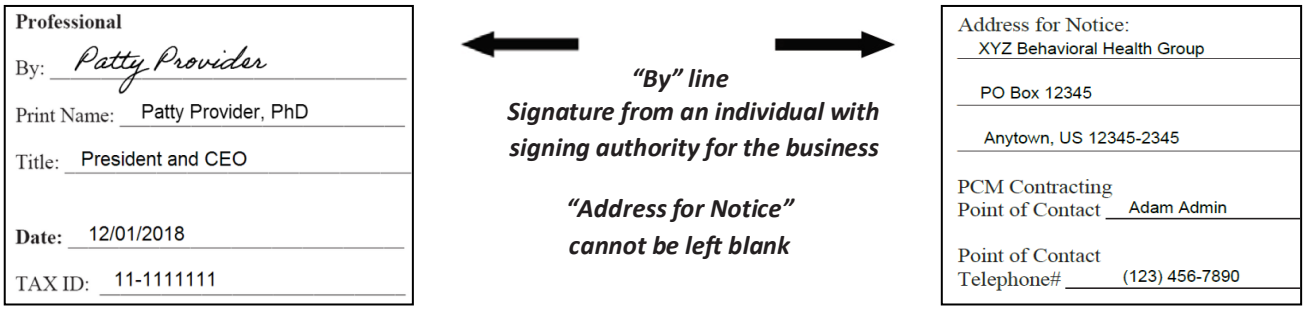
Please read all the information prior to submitting your contract packet.

***All* of the following information is required in order for this packet to be considered complete:**

- ☐ Completed Information Form
- ☐ Signed copy of IRS W-9 Form
- ☐ Signed Professional Agreement, including:
  - ☐ Complete Signature Page
  - ☐ Complete Attachment B for each Service Location
  - ☐ Attachments C & C-1
- ☐ Complete CAQH ProView Profile (https://proview.caqh.org/pr) – we will not accept paper applications and/or documents for credentialing
  - ☐ Recent attestation
  - ☐ Updated documents have been uploaded
  - ☐ Humana has been granted access to view your profile
- ☐ Group Roster in electronic format with **TRICARE-Certified Professionals ONLY** (see page 3 for detailed instructions)

***Incomplete or Incorrect packets will not be processed.**
***Please return all complete packets by email to HBHMilitaryNetwork@humana.com**

Example of a contract signed correctly:



CREDENTIALING REQUIREMENTS:

For all TRICARE-Certified Professionals, Credentialing will be initiated by accessing the Provider's information through the CAQH database. **Our Credentialing department will verify all of the following information after the complete contract packet is received**. Please ensure Humana is authorized to view your CAQH profile.

If any of the following elements are missing from your CAQH profile, Credentialing will not proceed:

- Explanation and copy of court document/dismissal papers or statement from attorney for each action, suit, or proceeding (If applicable). Provider must not have been convicted of a felony related to controlled substances, health care fraud, or a child or patient abuse.
- Current Copy of State License or State Certification showing expiration date. Providers must have a valid, unrestricted, and un-probated professional state license in the state(s) where they practice.
- Employment history: Including explanations for any gaps of 6+ months over the past 5 years

CREDENTIALING REQUIREMENTS (Continued):

- Educational history: Providers must have graduated from a school appropriate to their profession and completed postgraduate training appropriate to their practicing specialty
- Current Liability Insurance Policy Cover Page (with limits, policy number and expiration date)
  - Physicians must carry a minimum limit of $1,000,000/$3,000,000 (or as defined by State Law)
  - Non-physicians must carry a minimum limit of $1,000,000/$1,000,000 (or as defined by State Law)
  - ABA providers must carry a minimum limit of $1,000,000/$3,000,000 (as defined by TRICARE Policy)
  - Note: If the group carries the insurance, each professional's name must appear on the certificate or list of the covered providers
  - Proof of state insurance fund participation, or self-insurance, if applicable, is acceptable
- Copy of Federal Drug Enforcement Agency (DEA) Certificate: Prescribers must have a current, valid, unrestricted, and un-probated DEA registration, if applicable to their practicing specialty
- Copy of State Controlled Dangerous Substance (CDS) Certificate: Prescribers must have a current, valid, unrestricted, and un-probated CDS registration, if applicable to their practicing specialty and to the state in which they practice
- Board Certifications (Psychiatry/Addiction Medicine, if applicable) **Psychiatric Nurses must have state or national certification in psychiatry/mental health.
- Psychiatric/Addiction Medicine Residency Information (If not Board Certified)

In addition to the elements above, individuals must also:

- Be a **TRICARE-Certified Professionals**, applications are available at www.humanamilitary.com/provider
- Be eligible to participate in federal health care programs, such as Medicare or TRICARE
- Not have any physical or mental health condition that cannot be accommodated without undue hardship
- Not have untreated chemical/substance dependency
- Be licensed to practice and have a service location in the TRICARE East Region
- Complete a Background Check, even if previously credentialed by Humana, Inc.

******DO NOT SUBMIT INFORMATION FOR PROFESSIONALS WHO ARE NOT TRICARE-CERTIFIED******

ADDITIONAL REQUIREMENTS FOR ABA THERAPY:

- As of July 1, 2021 all ABA professionals are required to have an National Provider Identifier (NPI), including BCBA-D, BCBA, BCaBA, and BT's
- All ABA professionals must have Basic Life Support (BLS) or a Cardiopulmonary Resuscitation (CPR)-equivalent certification, as demonstrated by completion of a live course (no web-based programs) that includes practice on a dummy
- BCBAs and BCBA-Ds who supervise assistant behavior analysts (BCaBA's) and/or Behavior Technicians (BTs) must complete the eight-hour online supervisory training/competency course offered by the Behavior Analyst Certification Board®, Inc. (BACB®)
- TRICARE requires that Behavior Technicians (BTs) complete a 40-hour training program, satisfied by obtaining any of the following:
  - Registered Behavior Technician™ (RBT®) from The Behavior Analyst Certification Board®, Inc. (BACB®)
  - ABA Technician (ABAT) through The Qualified Applied Behavior Analysis (QABA) Credentialing Board
  - Board Certified Autism Technician (BCAT) from The Behavioral Intervention Certification Council (BICC)
- All Behavior Technicians, must possess RBT, ABAT, or BCAT certification, or certification from a body approved by the Director of the DHA, ***prior to*** applying for TRICARE-Certified provider status

GROUP ROSTER INSTRUCTIONS

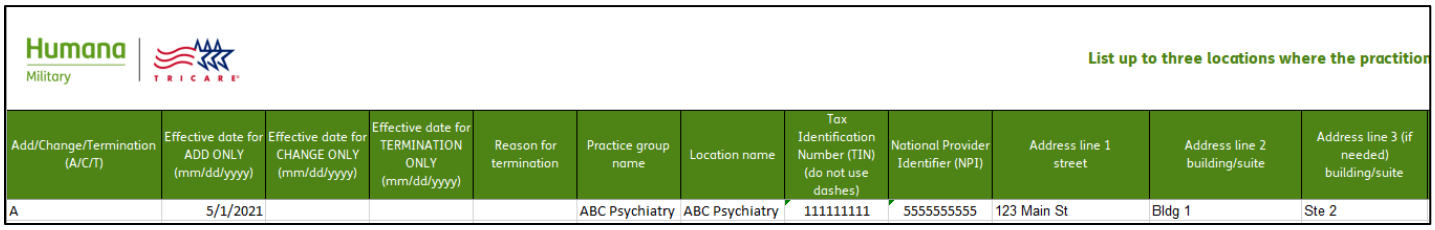
Please read and follow these instructions very carefully

General Instructions

- All groups using a Type 2 NPI number are required to complete a group roster
- Your contract will NOT be processed if the group roster is missing or incomplete
- Rosters must be submitted using the Humana Military provided template/excel spreadsheet
- Group rosters must be returned in electronic format - No faxes or printed versions will be accepted
- DO NOT use any special characters when completing the roster (i.e. hyphens, dashes, parentheses)
- Both tabs, located at the bottom of the workbook must be completed along with *ALL* required fields (all fields are required unless noted otherwise below)
- **All Professionals need to be TRICARE-Certified PRIOR to submission**
    - **DO NOT list any professionals on your Group Roster that are not currently TRICARE-certified**
    - **If no professionals are certified, STOP and DO NOT return this packet until at least 1 professional has completed TRICARE-Certification**
    - **Applications are available at www.humanamilitary.com/provider**

Tab 1 – TINs-Billing Info

- ☐ Provide only the group/business's practice information on this tab
- ☐ Mark A for Add in Column A, and today's date as the effective date in column B
- ☐ Provide the group's legal name, DBA name, Tax I.D. number, and Group NPI in columns F-I
- ☐ If you have more than one service location please complete one line per location (columns J-O)
    - Address line 1 (column J) = Street number and name
    - Address line 2 (column K) = Building number OR Suite Number
    - Address line 3 (column L) = Suite or Floor Number IF you also have a building number
- ☐ Phone and Fax numbers are required for every location to appear in the directory
- ☐ In the Specialty fields (columns S-U) please list the NPI registered taxonomy, examples include:
    - Multi-Specialty Group
    - Single Specialty Group
    - Clinic/Center – Mental Health
    - Clinic/Center – Developmental Disabilities
    - Community/Behavioral Health
- ☐ List Pay to address as it appears on your W9 (columns V-AA), and follow the address instructions listed above



Humana Military | TRICARE

List up to three locations where the practition

Add/Change/Termination (A/C/T)	Effective date for ADD ONLY (mm/dd/yyyy)	Effective date for CHANGE ONLY (mm/dd/yyyy)	Effective date for TERMINATION ONLY (mm/dd/yyyy)	Reason for termination	Practice group name	Location name	Tax Identification Number (TIN) (do not use dashes)	National Provider Identifier (NPI)	Address line 1 street	Address line 2 building/suite	Address line 3 (if needed) building/suite
A	5/1/2021				ABC Psychiatry	ABC Psychiatry	111111111	5555555555	123 Main St	Bldg 1	Ste 2

Tab 2 – Professional Info

- ☐ Provide the individual professional/practitioner's information
- ☐ **All Professionals need to be TRICARE-Certified PRIOR to submission**
- ☐ Mark A for Add in Column A, and today's date as the effective date in column B
- ☐ Provide each practitioners SSN, DOB, Gender, and Individual/Type 1 NPI number in columns F-I
- ☐ Complete *ALL* State License fields (columns J-N), if your specialty does not require a license leave *ALL* license fields blank
- ☐ As a Behavioral Health and/or Autism professionals you are NOT a PCM, columns T-W do not apply
- ☐ List Patient Age Restrictions (column x) as a number range only by years (i.e. 2-99, 18-65), do not use words (i.e. ages 2 and up, 18 and under)
- ☐ In the Specialty fields (columns Y-AA) please list the NPI registered taxonomy, examples include:
  - Psychiatry & Neurology Psychiatry
  - Psychologist Clinical
  - Social Worker Clinical
  - Marriage & Family Therapist
  - Behavior Analyst
  - Behavior Technician
- ☐ At least 1 professional is required for each location listed on the TINs-Billing Info tab
- ☐ If the practitioner works at more than 1 location, please complete 1 row per location (columns AB-AJ)
  - Address line 1 (column AE) = Street number and name
  - Address line 2 (column AF) = Building number OR Suite Number
  - Address line 3 (column AG) = Suite or Floor Number IF you also have a building number
- ☐ Phone and Fax numbers are required for every location to appear in the directory
- ☐ CAQH Number is required for all professionals with a Master's degree or above (column AQ)

State medical license information

Social Security Number (SSN) (do not use dashes)	Date of Birth (DOB) (mm/dd/yyyy)	Gender (M/F)	Individual National Provider Identifier (NPI)	State license number	State of license issue	State license date issued	State license expiration date	License status (Active / Inactive)	First name	MI	Last name
999999999	1/1/1999	F	1234567891	123456	AL	1/1/2018	12/31/2019	Active	Patty	A	Provider

Primary Care Manager (PCM) - Current panel status

Title (MD, DO, NP, PhD etc)	PCM Y/N	Accepting new patients	Not accepting new patients	Existing patients ONLY	Patient age restriction - Min/Max (required for A	Primary specialty	Secondary specialty	Tertiary specialty	Tax Identification Number (TIN) affiliation (do not use dashes)	Practice group name	Lo
MD	N	Y	N	N	2-99	Psychiatry & Neurology Psychiatry			111111111	ABC Psychiatry	ABC Psychiatry

Address line 1 street	Address line 2 building/suite	Address line 3 (if needed) building/suite	City	State	ZIP Code	Practice phone - with area code (do not use dashes) REQUIRED	Practice fax - with area code (do not use dashes) REQUIRED	Referral fax - with area code (do not use dashes)	Is this their primary address? (Y/N)	Is this a solo provider? (Y/N)	Do they offer telemedicine? (Y/N/blank)	Council for Affordable Qual Healthcare Identification (CAQHID)
123 Main St	Bldg 1	Ste 2	Austin	TX	12345	(123) 456-7891	(123) 456-7891	(123) 456-7891	Y	N	Y	88888888

If you have any questions or concerns about this contract or group roster, please reach out to us at Email: HBHMilitaryNetwork@humana.com

East Behavioral Health Network – Group Information Form

Date:	State:
Legal Name:	DBA Name:
Group NPI Number:	Tax ID Number (TIN):
Telephone Number:	Fax Number:
Contracting Contact Person:	Contracting Email Address:
Credentialing Contact Person:	Credentialing Email Address:

Specialties: (*Please select all that apply for your group)*

- ☐ Physician (MD/DO)
- ☐ Psychiatric Nurse with Rx authority
- ☐ ABA Supervisor (BCBA/BCBA-D)
- ☐ Assistant Behavior Analyst (BCaBA/QSAP)
- ☐ Behavior Technician (RBT/ABAT)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker
- ☐ Licensed Pastoral Counselor
- ☐ Licensed Marriage & Family Therapist
- ☐ Licensed Drug and Alcohol Counselor/Therapist
- ☐ Other Licensed Counselor/Therapist (Masters-level): _____

Are you considered a physician group for a specific Facility or Hospital? ☐ Yes ☐ No

Facility/Hospital Name:_____ Facility/Hospital TIN:_____

Are you affiliated with an Independent Practice Association (IPA), Physician-Hospital Organization (PHO), or Management Services Organization (MSO)? ☐ Yes ☐ No

IPA/PHO/MSO Name:_____ Contact/Email:_____

Do you provide Telehealth (TMH) Services? ☐ Yes ☐ No *If Yes*, are you the ☐ Originating Site ☐ Distant Site

For ABA/Autism Providers Only. Please confirm that all of your participating providers hold a Basic Life Support (BLS) and/or a Cardiopulmonary Resuscitation (CPR) equivalent certification: ☐ Yes ☐ No

Area(s) of Practice Focus: To assist with making appropriate referrals, please check your focus area(s) below:

- ☐ ADD/ ADHD
- ☐ Anger Management
- ☐ Anxiety/Phobia
- ☐ Autism
- ☐ Bipolar Disorder(s)
- ☐ Chemical Dependency
- ☐ Child Abuse/Neglect
- ☐ Child/ Adolescent Substance Use
- ☐ Child/Adolescent BH Disorders
- ☐ Critical Incident Stress Debriefing
- ☐ Dialectical Behavioral Therapy (DBT)
- ☐ Dissociative Identity Disorder
- ☐ Eating Disorders
- ☐ EMDR
- ☐ Faith Based Therapy
- ☐ Family and Marital Therapy
- ☐ Gender Dysphoria
- ☐ Grief Therapy
- ☐ LGBTQ+ Concerns
- ☐ Med Assisted SUD Treatment
- ☐ Men's Concerns
- ☐ Mood or Depression
- ☐ Neuropsychological Testing
- ☐ Nursing Home BH Consults
- ☐ Obsessive Compulsive Disorder
- ☐ Personality Disorders
- ☐ Play Therapy
- ☐ PTSD/PTSS
- ☐ Postpartum Depression
- ☐ Psychiatric Disability Evaluation
- ☐ Psychoanalysis
- ☐ Psychological Testing
- ☐ Serious Mental Illness (SMI)
- ☐ Sexuality/Gender Identity
- ☐ Stress Management
- ☐ STRONG STAR
- ☐ Substance Abuse
- ☐ TMS/rTMS
- ☐ Traumatic Brain Injury (TBI)
- ☐ Violence/Trauma (rape, all abuse)
- ☐ Women's Concerns

Humana Military Behavioral Health Network Contracting

HBHMilitaryNetwork@humana.com

Requesting, obtaining or submitting this form does not guarantee or imply that you will be accepted to participate in the East Behavioral Health network, nor does it entitle you to payment of services rendered to a TRICARE beneficiary prior to receiving written confirmation of an effective date and meeting any and all applicable certification requirements. All providers are subject to TRICARE authorization requirements, as well as applicable state and federal guidelines as set forth in the program manual(s).

Professional Agreement

This Professional & Urgent Care Agreement ("**Agreement**") is entered into by and between the undersigned Provider ("**Provider**") and Humana Government Business Inc., d\b\a, Humana Military ("**HM**").

RECITALS

WHEREAS, Humana Military is the health services and support contractor for the United States Department of Defense (the "Government") Defense Health Agency ("DHA") and is responsible for the management and delivery of health care services to TRICARE beneficiaries who receive health care benefits covered by the TRICARE program and;

WHEREAS, PROVIDER is a TRICARE program participating provider and authorized to provide services to TRICARE beneficiaries and desires to provide healthcare services for such beneficiaries;

NOW, THEREFORE, the parties hereto agree as follows:

1. **Scope of Agreement**:

   This Agreement applies to all health services provided by Provider to all persons covered under the TRICARE program ("**Beneficiaries**"), including active duty military personnel and those who are eligible to receive benefits under the program as administered by HM pursuant to an agreement between HM and DHA.

2. **Services to be Provided**:

   Provider agrees to participate in the HM provider network under the terms and conditions of this Agreement and agrees to provide health care services for Beneficiaries in accordance with the TRICARE program regulations, policies and procedures (hereinafter referred to as "**Covered Services**"). Covered Services shall be provided (a) without discrimination on the basis of health care benefit plans, source of payment, sex, age, race, color, religion, origin, health status or handicap and in the same manner as provided to any other patient, and (b) in accordance with the prevailing practices and standards applicable to Provider.

3. **Relationship of the Parties**:

   In performance of the duties and obligations of each of the parties to this Agreement and in regard to any services rendered or performed for Beneficiaries by either party, it is mutually understood and agreed that HM and Provider and their respective employees and agents are at all times acting and performing as independent contractors and that neither party, nor their respective employees and agents, shall be considered the agent, servant, employee of or joint venture with the other party. With the exception of Paragraph 18, below, this Agreement is not intended for the benefit of any third parties.

   A. Unless otherwise agreed to herein, the parties acknowledge and agree that neither Provider nor HM will be liable for the activities of the other nor the agents and employees of the other, including but not limited to, any liabilities, losses, damages, injunctions, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (I) any failure to perform any of the agreements, terms, covenants or conditions of the Agreement; (II) any negligent act or omission or other misconduct; (III) the failure to

comply with any applicable laws, rules or regulations; or (IV) any accident, injury or damage to third parties.

B. Provider acknowledges that all patient care and related decisions are the sole responsibility of the treating physician and that HM does not dictate or control the treating physician's clinical decisions with respect to the medical care or treatment of Beneficiaries. Provider further agrees to and hereby does indemnify, defend and hold harmless HM, DHA and the Government from any and all claims, judgments, costs, liabilities, damages and expenses, including reasonable attorneys' fees, whatsoever, arising from any acts or omissions in the provision of medical services by Provider to Beneficiaries under this Agreement.

C. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between physicians and Beneficiaries regarding patient treatment, and Provider acknowledges that all patient care and related medical decisions are the responsibility of the Provider.

4. **Policies and Procedures**:

Provider agrees to abide by all quality assurance, utilization management, grievance, appeals, rules, regulations and other policies and procedures including claims submission policies and TRICARE program payment methodologies applicable to the TRICARE program. Such policies and procedures of HM are outlined in the Provider Handbook, a copy of which is attached hereto as **Attachment A.** Additional copies are available from HM upon request. The Provider Handbook, the TRICARE program policies, rules, regulations and manuals, as amended from time to time, are hereby incorporated by reference and made a part of this Agreement.

5. **Accreditation/Licensure**:

Provider shall procure and maintain for the term of the Agreement: appropriate licensure and/or certification for Provider and all employees of Provider required to be so licensed and/or certified, under applicable state and federal laws. Provider shall notify HM immediately of any changes in its federal health programs participation, licensure, certification or accreditation status, and/or of any material action to suspend, revoke or restrict such participation, certification, license and/or accreditation, or authority to conduct its business, which may adversely affect Provider's performance or ability to fulfill its obligations under this Agreement.

6. **Credentialing:**

Provider and Provider's employees and subcontractors, as applicable, must be credentialed by HM for delivery of health care services to Beneficiaries. Participation under this Agreement by Provider, and any of Provider's employees or subcontractors required to be credentialed, is subject to the satisfaction and maintenance, in HM sole judgment, of all credentialing standards adopted under the HM policies and procedures. In the event HM determines that Provider or Provider's employees and subcontractors, as applicable, at any time do not meet the credentialing standards adopted by HM, then HM may immediately terminate this Agreement.

7. **Use of Network Providers and Facilities**:

Except in the case of medical emergency, or unless otherwise approved by HM, Provider shall admit, refer and cooperate with the transfer of Beneficiaries for Covered Services only to providers and/or facilities designated or specifically approved by HM ("**Network Provider**")

8. **Provider's Location**:

Provider is, or will be providing health care services at the office site(s) listed in **Attachment B** of this Agreement. Provider agrees not to change the location of Provider's office site(s), or to add any new location that serves Beneficiaries, or close an existing office site without prior notice to HM. Provider will establish regular business hours for the provision of services to Beneficiaries. In establishing business hours, Provider should take into consideration the number and type of Beneficiaries assigned to the office site. The business hours established by Provider are noted in **Attachment B** of this Agreement. No time limitations set forth in **Attachment B** shall serve to relieve Provider of its obligation to provide medical coverage for Beneficiaries twenty-four (24) hours a day, seven (7) days a week.

9. **Equal Access**:

Provider agrees to accept and admit Beneficiaries as patients in accordance with Provider's medical practice. In the event Provider ceases to accept new patients, such cessation will apply to all prospective patients without discrimination. Should Provider subsequently accept new patients, Provider agrees to accept Beneficiaries in the same manner as all other patients seeking Provider's services.

10. **Insurance:**

Provider agrees to maintain, at no expense to HM, such policies of comprehensive and general liability, professional liability, and worker's compensation coverage as required by law, and with such carriers and in such amounts as HM may reasonably approve, insuring Provider, its partners, shareholders or members and employees (as applicable), against any claim or claims for damages arising as a result of injury to property or person, including death, occasioned directly or indirectly in connection with the performance of medical services contemplated by this Agreement and/or the maintenance of Provider's facilities and equipment. Upon request, Provider shall provide HM with evidence of professional liability coverage, as required by the state and acceptable to HM, and if Provider is a physician group, shall apply to each partner, shareholder, member or employee of the physician group. Provider shall require the carrier(s) to provide HM with at least ten (10) days prior notice of any cancellations and/or modifications. This clause shall survive for a period of time following the termination of this Agreement not less than the Statute of Limitations applicable to personal injury in this State.

11. **Medical Records**:

Provider shall prepare and maintain medical records on all Beneficiaries receiving medical services in a form and for time periods required by applicable state and federal laws, and licensing, certification and reimbursement entities. HM, or any state or federal regulatory agency, as permitted or required by law, may obtain, copy, and have access, upon request, to any medical, administrative or financial record of Provider related to medical services provided by Provider to any Beneficiary. Provider shall maintain the confidentiality of information contained in the medical records of Beneficiaries in accordance with applicable state and federal laws and regulations.

A. Upon the request of HM or the Beneficiary, Provider agrees to transfer to another provider, the complete original or a complete acceptable copy of the medical records of such Beneficiary transferred to such other provider. Except as may otherwise be provided for in TRICARE regulations, such transfer of medical records shall be at no additional cost to either HM or the Beneficiary and shall be made within a reasonable time, but in no event in less than seven (7) days except in cases of emergency. Provider shall pay court costs and/or legal fees necessary for HM to enforce the terms of this **Paragraph 11.A**.

B. Provider agrees to provide to HM and/or DHA, upon request, with copies of medical records of Beneficiaries for the purpose of conducting quality assurance, utilization management and Beneficiary grievance procedures, or for any other reasonable purpose. Failure of the Provider to provide such records in a timely manner may result in the denial, delay or recoupment of payments related to the claims associated with the requested medical records.

C. This **Paragraph 11** shall survive the termination and/or expiration of this Agreement.

12. **Malpractice Claims**:

Provider shall within seventy-two (72) hours, or such lesser period of time as required by the applicable law of the state in which Provider is located, notify HM in writing of notice of any Beneficiary claim alleging malpractice or the occurrence of any incident which is required to be reported under such statute.

13. **Grievance and Appeals Procedure**:

Provider agrees to cooperate and participate with HM and DHA in their grievance and appeals procedures to resolve disputes, which may arise between HM and Provider, and/or HM and Beneficiaries. Provider will comply with all final determinations made through the grievance and appeals procedures.

14. **Use of Provider's Name**:

HM shall have the right to include the Provider's name, telephone number, address, in any and all marketing and administrative materials it distributes. Provider will not advertise or utilize marketing materials, logos, trade names, service marks, or other materials created or owned by HM, or make reference to HM without written consent from HM. Provider shall not acquire any right or title in or to the marketing materials, logos, trade names, service marks, or other materials of HM, and the same shall remain at all times the exclusive property of HM.

15. **Payments to Provider**:

Provider agrees to accept as payment for the services provided hereunder the amounts set forth in **Attachment C,** and in accordance with the terms and limitations set forth herein. Such payment plus the amounts owed by Beneficiaries pursuant to the terms of their coverage, including but not limited to copayments, coinsurance, deductibles and/or cost-share amounts ("**Copayments**"), shall be accepted by Provider as payment in full for all Covered Services. Provider shall collect any Co-payments applicable to the Covered Services provided. Provider understands that no payment may be made to Provider for services rendered to Beneficiaries which are, in the opinion of HM or DHA, not Medically Necessary, or not otherwise a covered benefit under the TRICARE program. Provider has the right to dispute the amount of reimbursement of a claim for a period of twelve (12) months following the date of service.

16. **Billing/Encounter Procedures:**

Provider agrees to submit claims electronically for payment and make their best effort to conform to paperless transactions including electronic remittances and electronic funds transfers. Provider will ensure response to HM regarding the provision of Covered Services for Beneficiaries in a format as HM and the TRICARE program may require and/or approve. Provider shall use the most current and applicable billing codes on all forms submitted with respect to its claims for payment for services provided to Beneficiaries. Provider will abide by all TRICARE program and HM rules and guidelines for coding that are applicable (including inclusive procedure codes) to the services provided hereunder.

17. **Recoupment**:

Provider authorizes HM to deduct from payments that may otherwise be due and payable to Provider any amounts that Provider may, for any reason, owe to HM or the Government.

18. **Coordination of Benefits; Recovery Rights**:

Payment for Covered Services provided to each Member is subject to coordination with other benefits payable or paid to or on behalf of the Member, and to subrogation or recovery rights in other party liability situations.

A. In cases where a Beneficiary has coverage for health care services in addition to coverage under the TRICARE program, and which requires or permits coordination of benefits from the third party payor providing such other coverage, HM will coordinate TRICARE program benefits with such other payor(s). HM will, in all cases, coordinate benefit payments in accordance with applicable statutes, laws and regulations.

B. Provider shall use its best efforts to determine the availability of other benefits, including other party liability, and to obtain any information or documentation required by HM to facilitate HM coordination of such other benefits.

19. **No Liability to Beneficiaries for Charges**:

Provider hereby agrees that in no event, including, but not limited to nonpayment by HM or the Government, HM insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Beneficiaries, or persons other than HM acting on their behalf, for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of fees for any non-covered service and/or Copayments in accordance with the terms of the Beneficiary's coverage and this Agreement. Provider further agrees that (I) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Beneficiary, (II) this provision supersedes any oral or written contrary Agreement now existing or hereafter entered into between Provider and Beneficiary or persons acting on their behalf, and (III) this provision shall apply to all employees and subcontractors of Provider.

20. **Access to Information:**

Provider agrees HM, or its designee, shall have access and an opportunity to examine facilities, books, records and operations of Provider, or any related organization or entity at any reasonable time agreed to by the parties, or during normal business hours, upon request that relate to Beneficiaries. Related organization or entity shall be defined as (I) having influence or ownership or control and (II) either a financial relationship or a relationship for rendering of services. The purpose of such requirement is to permit HM the right to assure compliance with all financial, operational, quality assurance, as well as, any and all other obligations required of Provider under this Agreement. Provider and/or its related organization, shall comply with any requests for such access within ten (10) business days of receipt of a request.

21. **Assignment and Delegation**:

Any assignment by Provider of its interest under this Agreement shall require the prior written consent of HM, which consent may be granted or denied in HM's sole and complete discretion.

22. **Term of Agreement:**

This Agreement shall be effective on the first day of the month after HM notifies Provider that Provider has been duly credentialed by HM. The term of this Agreement and provisions for termination are set forth in **Attachment D**.

23. **Compliance with Laws and Regulatory Requirements**:

Provider agrees to be bound by and comply with the provisions of all applicable state and federal laws and regulations. If Provider violates any of the provisions of applicable state and federal laws or commits any act or engages in conduct for which its license is revoked or suspended by the State in which the Provider is licensed, or is otherwise disciplined by any regulatory or accrediting organization, or in the event Provider fails to maintain participation in the Medicare or TRICARE program, HM may terminate this Agreement as specified in **Attachment D**. Provider further agrees to comply with all TRICARE managed care support policies and procedures and to become TRICARE certified. Such TRICARE policies and procedures are set forth in **Attachment A.**

24. **Severability:**

If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law or professional ethics, that part shall be reformed, if possible, to conform to law and ethics, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

25. **Right to Injunction**:

In the event of an actual or threatened breach of this Agreement, HM shall be entitled to an injunction enforcing this Agreement in addition to all other remedies available at law.

26. **Binding Arbitration**.

In the event of a dispute between PROVIDER and HM which the parties cannot settle by mutual agreement, including, without limitation, a dispute involving the interpretation of any provision of this Agreement, or otherwise arising out of the parties' business relationship, the performance by PROVIDER or HM hereunder, allegations or claims involving interpretations or violations of federal laws or regulations, such dispute shall be resolved by binding arbitration, conducted by a single arbitrator selected by the parties from a panel of arbitrators proposed by the American Arbitration Association (AAA). In the event the parties cannot agree on the arbitrator, then the arbitrator shall be appointed by the AAA. The arbitration shall be conducted in Louisville, KY, in accordance with and subject to the Commercial Arbitration Rules of the American Arbitration Association then in effect, or under such other mutually agreed upon guidelines. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction sitting in Louisville, KY, or application may be made to such court for judicial acceptance and enforcement of the award, as applicable law may require or allow. The submission of any dispute to arbitration shall not adversely affect either party's right to seek preliminary injunctive relief with respect to an actual or threatened termination, repudiation or rescission of the Agreement. The costs of any arbitration proceeding(s) hereunder shall be borne equally by the parties and each party shall be responsible for its own attorneys' fee and such other costs and expenses incurred related to the proceedings. Notwithstanding the foregoing, the parties agree that claims arising out of (1) alleged violations of title VII of the Civil Rights act of 1964, or (2) any tortious conduct related to or arising out of alleged sexual assault or harassment, including assault and battery, intentional infliction of emotional distress, false imprisonment, negligent hiring, supervision or retention, shall not be subject to resolution by the foregoing mandatory binding arbitration provision.

27. **Waiver**:

Waiver, whether expressed or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any other provision or a waiver of any subsequent breach of the same provision. In addition, waiver of one of the remedies available to HM in the event of Provider default shall not at any time be deemed a waiver of HM's right to elect such remedy at any subsequent time if a condition of Provider default continues or recurs.

28. **Notice**:

Any notices, requests, demands or other communications, except notices of changes in policies and procedures pursuant to Paragraph 4, required or permitted to be given under this Agreement shall be in writing and shall be given to the other party at the address set forth below their respective signatures to this Agreement, or to such other person or entity as either party shall designate by written notice to the other in accordance herewith.

29. **Confidentiality**:

Provider and HM agree to maintain in strict confidence the contents of this Agreement and information regarding any dispute arising out of this Agreement, and agree not to disclose the contents of this Agreement nor information regarding any dispute arising out of this Agreement to any third party without the express written consent of Provider and HM, except pursuant to a valid court order, or when disclosure is required by governmental agency.

30. **Force Majeure**:

Neither party to this Agreement shall be deemed to breach its obligations under this Agreement if that party's failure to perform under the terms of this Agreement is due to any act of God, riot, war, or natural disaster.

31. **Incorporation of Attachments**:

Attachments A, B, C, and D are incorporated herein and made a part of this Agreement.

32. **Entire Agreement**:

This Agreement, including the Provider Handbook, the Attachments hereto and the documents incorporated herein, constitutes the entire Agreement between HM and Provider with respect to the subject matter hereof, and it supersedes any other agreement between HM and Provider concerning the subject matter contained herein.

33. **Modification or Amendment of Agreement:**

This agreement may be amended upon written agreement of the parties. In addition, HM may amend this Agreement upon sixty (60) days written notice to Provider. Failure of Provider to object to such modification or amendment during the sixty (60) day notice period shall constitute acceptance of such amendment by Provider. If Provider rejects any amendment, HM shall have the right to consider such rejection as an intent to terminate agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date(s) set forth below their respective signatures, below. Further, by signing this Agreement the Provider acknowledges that it has reviewed the Provider Handbook.

EFFECTIVE DATE: _____
(To be completed by HM only)

Humana Government Business Inc.

By: _____

Print Name: _____

Title: _____

Date: _____

Professional

By: _____

Print Name: _____

Title: _____

Date: _____

TAX ID: _____

Address for Notice:

Humana Government Business Inc.
Attn: Network Development Department
500 West Main Street
Louisville, KY 40202

cc: Law Department, Humana Inc.
500 West Main Street
Louisville, KY 40202

Address for Notice:
_____

_____

_____

Contracting
Point of Contact _____

Point of Contact
Telephone# _____

Professional Agreement

INDEX OF ATTACHMENTS

ATTACHMENT A

Humana Military
TRICARE PROVIDER HANDBOOK

Available online at www.humanamilitary.com

ATTACHMENT B

PROVIDER SERVICE LOCATIONS

Services provided under this Agreement shall be provided at the following clinical and/or service site(s) or location(s).

NOTE: If contract represents more than one (1) service location, please INSERT SPREADSHEET with relevant location information. If, during the term of this agreement, **Humana** determines that additional service locations exist, **Humana** will add additional service locations to this Agreement.

If **Provider** is a PROVIDER GROUP, please ATTACH A LIST of each participating provider under the terms of this Agreement. Include NPI, SOCIAL SECURITY NUMBER, CAQH NUMBER (if applicable), PRIMARY SERVICE ADDRESS and SPECIALTY. **Provider** agrees to provide prompt notice to **Humana** as changes occur in the attached Roster listing.

Tax Identification Number: _____

National Provider Identifier #: _____

Clinical and/or Service Site Name:

_____

Clinical and/or Service Site Address:

_____

City:_____ State:_____ Zip: _____

Phone:_____ Fax: _____

Referral FAX: _____

Contact Name and Title:_____

EMAIL: _____

Billing Contact Person/Entity Name:

_____

Billing Address:

_____

City:_____ State:_____ Zip: _____

Phone:_____ Fax: _____

Normal Business Hours:

_____

(Indicate days per week and operating/business hours per day)

Extended Business Hours:

_____

ATTACHMENT C

PAYMENT ARRANGEMENT

Subject to the limitations set out in this **Attachment C & C-1**, PROVIDER agrees to accept as payment in full from Humana Military the rates as set forth below for inpatient, outpatient or individual Covered Services provided to TRICARE Beneficiaries.

Upon written notification from Provider, HM will add newly acquired Tax IDs that are TRICARE Certified to this Agreement. If the newly acquired Tax ID is not currently contracted with HM at the time of the acquisition, HM shall add said Tax ID to this Agreement upon receipt of the written notice at the current network reimbursement rates as contained in this Agreement. If the newly acquired Tax ID is currently contracted with HM at the time of the acquisition, HM shall add said Tax ID to this Agreement; provided, however, reimbursement shall be at the rates that were in effect for said Tax ID immediately prior to the acquisition by Provider.

Provider acknowledges and agrees that 1) TRICARE authorized reimbursement amounts and methodologies are periodically adjusted by DHA and, when and as effective, supersede and replace the reimbursement methodologies and amounts set forth in **Attachment C & C-1** of this Agreement. 2) HM shall reimburse Provider the lesser percentage of the agreed TRICARE maximum allowable or the percentage of the agreed Billed Charges.

Further, Provider agrees to accept Medicare assignment, less any applicable copayments, deductibles, and/or cost-share amount due from the Beneficiary for Covered Services provided to Beneficiaries who are also Medicare dual eligible.

HM shall maintain an authorization procedure for Provider to verify coverage for Beneficiaries. Provider agrees to verify coverage of Beneficiaries and to verify pre-admission authorization prior to rendering any non-emergent Provider Services. Should Provider fail to comply with such verification/authorization requirements, any claims resulting from the admission shall be pended and may, at HM sole discretion, be subject to a fifty percent (50%) reduction in payment.

Provider understands that HM shall make no payment(s) to Provider for Covered Services rendered to Beneficiaries which are determined by HM not to be medically necessary. “Medical Necessity” or “Medically Necessary” shall mean services or supplies provided by a physician, or other to identify or treat an illness or injury and which, in the opinion of HM are: (1) consistent with the symptoms, diagnosis, and treatment of the condition, disease, and ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not primarily for the convenience of the patient; and (4) the most appropriate and cost-effective supply, setting, or level of service which can safely be provided to the patient. When applied to an inpatient, it further means that the patient’s symptoms or condition required that the services, supplies, and/or treatment cannot be safely provided to the patient as an outpatient.

In the event that Provider is a party to more than one agreement with HM for the provision of Covered Services to Beneficiaries, HM will determine under which agreement reimbursement will be made to the individual Provider.

ATTACHMENT C-1

TRICARE COMPENSATION SCHEDULE

BEHAVIORAL HEALTH PROFESSIONAL AGREEMENT

Applied Behavioral Analysis (ABA) Services provided in accordance with theTRICARE Comprehensive Autism Care Demonstration (ACD): Humana Military will reimburse Provider for Covered Services 100% of the TRICARE Maximum Allowed or 100% of Billed Charges.
Transcranial Magnetic Stimulation (TMS) Services billed using CPT Codes 90867-90869: Humana Military will reimburse Provider for Covered Services the lesser of 35% of the TRICARE Maximum Allowed or 25% of Billed Charges.
All Other Professional Services: 1) Physicians - HM will reimburse Provider for Covered Services the lesser of 75% of the TRICARE Maximum Allowed or 65% of Billed Charges. 2) Psychologists - HM will reimburse Provider for Covered Services the lesser of 70% of the TRICARE Maximum Allowed or 60% of Billed Charges. 3) Nurse Practitioners - HM will reimburse Provider for Covered Services the lesser of 70% of the TRICARE Maximum Allowed or 60% of Billed Charges. 4) All Other Professionals - HM will reimburse Provider for Covered Services the lesser of 65% of the TRICARE Maximum Allowed or 55% of Billed Charges.

LIMITATIONS ON PAYMENTS APPLICABLE TO ALL SERVICES

Notwithstanding the amounts, percentages or other payment methodologies set forth on **Attachment C & C-1** with respect to services provided to TRICARE Beneficiaries by Provider, the payments made to Provider for all such services during the term of this Agreement shall not exceed 100% of TRICARE program allowable amounts,which may be based on and include, without limitation, Cost to Charge Ratio (CCR), Reasonable Cost Method, Diagnostic Related Groups (DRG) specific to the TRICARE program, CHAMPUS Maximum Allowable Charge (CMAC and other TRICARE fee schedules), Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule, State Prevailing Rates, Home Health Agency Prospective Payment System (HHA PPS),Skilled Nursing Provider PPS, DHA ASC groupers with respect to ambulatory surgery services, TRICARE Outpatient Prospective Payment System (OPPS), or Provider's billed charges (in cases in which TRICARE program rules or policies provide for such charges to constitute the maximum allowable amount).

ATTACHMENT D

TERM OF AGREEMENT

I. The initial term of this Agreement shall be for a period of one (1) year, commencing on the first of the month following the date HM notifies Provider that Provider has been duly credentialed by HM. If Provider does not successfully satisfy the HM credentialing requirements and is denied credentialed status then this Agreement shall have no effect and shall be null and void. Otherwise, the Agreement will continue in force unless terminated as provided herein.

II. After the end of the initial term of this Agreement, either party may terminate this Agreement without cause by giving the other party written notice of termination at least ninety (90) days prior to the effective termination date. In addition, this Agreement may be terminated by the mutual consent of both parties at any time. Further, if the Provider was credentialed by HM as "delegated" then the termination notice provided for in Paragraph II shall be at least one hundred fifty (150) days prior to the effective date of termination.

III. Provider may terminate this Agreement for cause if HM fails to make payments required under this Agreement, but only after written notice and providing at least sixty (60) days in which HM may avoid termination by curing the default in payment. Any dispute concerning the amount owed shall be resolved according to the procedures specified in the Handbook.

IV. HM may terminate this Agreement immediately upon written notice, stating the cause for such termination, in the event (a) Provider's continued participation under this Agreement may adversely affect the health, safety or welfare of any Beneficiary or bring HM or its health care networks into disrepute, or (b) Provider engages in or acquiesces to any act of bankruptcy, receivership or reorganization, or (c) in the event of Provider's certification, license or participation in the TRICARE or Medicare programs is suspended, terminated or revoked, or (d) as specified in the Handbook.

V. A termination of this Agreement (except immediate terminations) by either party, unless otherwise provided herein, shall become effective as of the last day of the month in which the notice period expires. Upon termination, Provider agrees to provide medical services to any Beneficiary receiving services on the date of termination until the date of discharge or until HM has made arrangements for substitute care. Provider shall accept payment for such Covered Services the amounts set forth within this Agreement.

VI. Provider understands that termination of this Agreement shall not relieve Provider from Provider's obligation to provide, or arrange and pay for Covered Services to Beneficiaries through the last day of this Agreement. HM retains the right to recover from Provider any amounts paid by HM on Provider's behalf, which are obligations of Provider and become necessary to be paid by HM to maintain the health care delivery network.

VII. HM or the Provider may terminate in part this agreement for either Medical or Behavioral services. If the Services are terminated in part, Service Provider shall continue to provide the remaining Services pursuant to the terms of this Agreement. Additionally services terminated under this agreement will be paid in accordance with TRICARE Policy surrounding Non-Network Provider services unless a separate network agreement for those services is executed with HM. Termination in part shall be subject to the same terms and procedures as a termination in whole, outlined in Attachment D.

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.