

Instructions for Completing the Central Billing Office Application

These directions are not meant to take the place of the reference pages enclosed with the Central Billing Office application. The intention is to provide supplemental information to assist you in completing the applications forms correctly. Please note that the reverse sides of all original forms print out as a second page. Provider Connections is not responsible for the accuracy of your CBO application if you fail to follow these instructions.

The Payee Agreement:

The Payee Agreement replaces the former Individual and Agency Service Provider Agreements. Only one copy of the Payee Agreement needs to be completed by an agency. All subsequent agency applicants should disregard the Payee Agreement portion of the CBO application.

- Your name must match the name on your state license on all application forms.
- Enclose a copy of your marriage license or other court document if your name is different.
- “Payee name” refers to the individual provider’s name or the agency name.
- The “Payee Representative Name” is the individual provider or person acting as the Agency Representative.
- “Title” refers to the title of the Agency Representative signing the agreement. Individual providers should write “Individual” on this line.
- The individual provider or agency representative must sign and date this page.
- Be sure to return all six of the pages. This is an agreement between you and the Illinois Department of Human Services so all six pages of the Payee Agreement are required.
- Only Interpreters and Deaf Mentors need to complete the Addendum to the Payee Agreement. Other applicants should disregard this page as it does not apply.

The EI Service Matrix:

This page is sent to the Central Billing Office along with the W-9 Form. Enclosed with the application is a list of county codes—be sure to use the codes and not the county names. File the county code sheet for future reference. “How to contact you for referrals” should be used as a site of service address for agency providers. Individual providers should list their contact address in this space. Refer to the Matrix Instructions to complete this page.

Important to note: as of May 1, 2007, all applicants must have their own personal NPI (National Provider Identification) number. **Applications missing the NPI number cannot be processed.** You can obtain one by going to <http://nppes.cms.hhs.gov>.

Initial Interpreter applicants must document completion of Systems Overview Training, Interpreter Training, and successful score on the Interpreter/Translator proficiency exam. A Transportation applicant must include a photocopy of his/her driver’s license, proof of insurance, and vehicle registration with the enrollment application. Applications cannot be processed without such documentation.

Indicate the insurance companies you are enrolled for as a provider. If you are not enrolled with any, leave this part blank.

The Provider Enrollment Application (HFS 2243):

EI providers need to complete only Sections A, B, and F on this form. Do not complete any other sections. Please note that highlighting is forbidden on any HFS documents (new policy).

Section A: Only #1-15 need to be completed. All else does not apply.

- If you are an agency provider you must list both your full social security number and the agency FEIN number.
- Refer to Attachment A to get the code for #2 Provider Type.
- Even though it asks for an “Office Address” HFS prefers you use a home address where you can be reached for re-enrollment mailings every three years. Be sure to use a street address—Post Office box numbers are not acceptable on this page.

Section B: Refer to Attachment A to get the code for #22 Category of Service. This is the only blank you need to complete for Section B.

Section F: Sign, date and print your name in this section.

The Agreement for Participation in the Illinois Medical Assistance Program (HFS 1413):

On the front side of the form, list your name, and if you are a sole proprietor, you should list your d.b.a name. Do not list your corporate agency name as a d.b.a. unless you own the company. If you are already enrolled with the HFS and have an HFS provider number, list it on the line below your name. Do not list your agency’s HFS or FEIN number on this line.

On the reverse side of the form, complete #14 only if you are an owner or a stockholder in the agency. If you are an independent provider, you must write “NONE” on the Print Name line. Sign, date, and print your name. Leave the agreement effective date blank. Do not highlight any portion of this form.

The W-9 Request for Taxpayer Identification Number and Certification:

IMPORTANT: This page must be completed correctly or the entire application will be returned to you. Only the applicant or applicant’s agency is authorized to make corrections to this page.

If you are an agency provider, your personal name does not go on this form. Print the agency name in the “Name” blank. If the agency is using a d.b.a., that name should be listed using the prefix d.b.a. on the “Business name” blank. Check the appropriate tax status box. Enter only the agency FEIN number for the tax identification number in Part I. Do not list your social security number. A signature and date is required on Part III—either an agency representative or a provider signature is acceptable.

If you are an owner of sole proprietorship or a disregarded entity LLC, place your personal name on the “Name” blank and “d.b.a. Your Business Name” on the Business name blank. Check the appropriate box. Enter the address information. If you have a FEIN number, list both your social security number and your FEIN number in Part I. Your signature and date is required in the specified blanks in Part III. Your name and signature must match the name on your state license.

If you are an individual, enter your name on the “Name” blank. Skip the business blank or write in parentheses “Private.” Enter your address information, check the individual/owner of sole proprietorship box, and enter your social security number in Part I. Sign and date the specified blanks in Part III. Your name and signature must match exactly, and they must match the name on your state license.

Any W9 Form with a date more than two years old is invalid and cannot be processed.

Attach a copy of your current state license to this application. The only exceptions are professions, which are not required to have a state license [e.g., Developmental Therapists].

Parent Liaisons, Deaf Mentors, and Interpreters are not enrolled with the Department of Healthcare and Family Services and should not complete HFS 2243 or HFS 1413. These providers should send only the Payee Agreement (if applicable), the EI Service Matrix, and the W-9 form.

VERY IMPORTANT: ALL SIGNATURES ON THE CENTRAL BILLING OFFICE APPLICATION PAGES MUST BE ORIGINAL. REPRODUCED SIGNATURES OF ANY KIND ARE INVALID AND WILL CAUSE THE APPLICATION TO BE RETURNED.

Name/Address Changes

To change your name in the credentialing and/or enrollment system, download and complete the Name Change file (the Service Matrix and W-9 form) on the Provider Connections website and include the court documentation changing your name (i.e. marriage certificate, divorce decree, etc.).

To change your address for CBO enrollment purposes, download and complete the Address Change file (the Service Matrix and W-9 form) on the Provider Connections website. It is beneficial to include a cover letter or Post-It Note indicating that you are seeking to change your address.

Important to Note

Provider Connections recommends using the most recent applications. It is best to download applications directly from the Provider Connections website and avoid maintaining a stockpile of file copies. Forms change and become obsolete, and obsolete forms are invalid.

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

Illinois Medical Assistance Program

PROVIDER ENROLLMENT APPLICATION

(Must be Typed or Printed Legible and Do Not Use Highlighter On Any Documents)

All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type NONE.

SECTION A: PROVIDER

1. New Enrollment Re-Enrollment Name Change Reinstatement Request 2. Provider Type

3. Provider Name

4. Primary Office Address Street

5. City 6. County

7. State 8. Zip 9. Telephone 10. Fax

11. Email Address (3)

12. National Provider Identification # - NPI *Report Additional NPI's In Section D* 13. FEIN

14. SSN 15. License/ Certification 16. DEA

17. Medicare Part A# 18. Organization Type 19. Control of Facility 20. Fiscal Year

21. CLIA #

SECTION B: SERVICE/SPECIALTY

22. Category Of Service

23. Provider Specialty: Primary Specialty Secondary Specialties

24. Physician UPIN No. 25. OBRA Qualification (Physicians Only)

26. Hospital Admitting Privilege: (Physicians Only)

Hospital Name Address

Hospital Name Address

27. Pharmacy Location 28. Pharmacy License # 29. Pharmacist In Charge License #

30. Electronic Billing? Yes No 31. If Yes, Pharmacy Software Vendor Name 32. Pharmacy NCPDP#

33. Transportation: Taxi Base/ Meter/Flag Rate 34. Taxi Mileage Rate 35. Medigar: Hydraulic Manual Lift or Ramp Yes No

36. Long Term Care Medical Bed Capacity 37. Long Term Care Medicare Fiscal Intermediary

38. Long Term Care Building ID Code

SECTION C: FORMER PARTICIPATION

39. Change of Ownership Yes No Effective Date

40. Former Provider Number Former Provider Name

SECTION D: ADDITIONAL NPI – National Provider Identification #

41. NPI NPI NPI

NPI NPI NPI

SECTION E: PAYEE INFORMATION

42. Name 43. Telephone

44. DBA

45. Street Address

46. City 47. State 48. Zip 49. TIN Type Code

50. SSN/FEIN 51. Billing Provider/Pay To NPI #

52. Medicare Part B # 53. PIN 54. DMERC#

Name Telephone

DBA

Street Address

City State Zip TIN Type Code

SSN/FEIN Billing Provider/Pay To NPI #

Medicare Part B # PIN DMERC#

SECTION F: CERTIFICATION/SIGNATURE

I understand that knowingly falsifying or willfully withholding information may be cause for termination of participation in the Medical Assistance Program.

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider’s employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services to verify the information provided on this application with other state and federal agencies.

Illinois HFS website address: <http://www.hfs.illinois.gov/>
Illinois HFS Handbook updates are available: <http://www.hfs.illinois.gov/handbooks>
Illinois HFS Laws and Rule Regulations: <http://www.hfs.illinois.gov/lawsrules/index.html>

Check this box if you want a provider handbook mailed

Signature: Date:

Printed name of person signing above

INSTRUCTIONS
ILLINOIS MEDICAL ASSISTANCE PROGRAM
PROVIDER ENROLLMENT APPLICATION

Enrollment in the Illinois Medical Assistance Program requires the completion of an application with an original signature of an individual or if a business entity, an authorized person. All providers are required to complete, sign and date a Provider Agreement. Enclose additional pages when more information is available than space allows.

Providers are required by the U.S. Postal Service to use a 9-digit zip code for all address. Mail without the 9 digits may be returned by the U.S. Postal Service

NOTE: When a Change of Name occurs, a new enrollment application, agreement and attachments must be completed and submitted to the Department.

NOTE: Transportation requires copy of Vehicle Identification Card for all vehicles approved to transport medical clients.

SECTION A: PROVIDER

1. Check appropriate box for type of enrollment.
2. **PROVIDER TYPE:** Enter allocable three (3) digit code from Attachment A.
3. **PROVIDER NAME:** Individual Practitioners must enter name in last name, first name format. All other applicants must enter the complete business name.
4. **PRIMARY OFFICE ADDRESS STREET:** Provider must give a physical location, not a PO Box.
6. **COUNTY:** For Transportation providers this must reflect the county where vehicle (s) are located.
11. **EMAIL ADDRESS:** Enter up to three (3) e-mail addresses.
12. **NATIONAL PROVIDER IDENTIFICATION # - NPI:** Enter ten (10) digit NPI number assigned by Federal Government to eligible health care providers and provide a copy of NPI approval letter.
15. **LICENSE/CERTIFICATION/ENROLLMENT REQUIREMENTS:** See Attachment B for specific provider requirements.
16. **DRUG ENFORCEMENT ACT NUMBER:** Enter the DEA number issued to the above identified address and any additional DEA numbers issued.
17. **MEDICARE PART A NUMBER:** Enclose documentation of Medicare Certification.
18. **ORGANIZATION TYPE:** Enter the one (1) digit number to indicate the type of ownership: (1) SOLE PROPRIETARY (2) PARTNERSHIP (3) CORPORATION.
19. **CONTROL OF FACILITY:** Enter the one (1) digit number to indicate the type of facility control: (1) STATE/COUNTY/CITY (2) PARTNERSHIP (3) CORPORATION.
20. **FISCAL YEAR:** Enter the end date of your Business Fiscal Year (MM/DD/YYYY).
21. **CLINICAL LABORATORY IMPROVEMENT ACT NUMBER:** Enter appropriate CLIA number documenting the approval to provide laboratory services.

SECTION B: SERVICE/SPECIALTY

22. **CATEGORY OF SERVICE:** Enter all applicable three (3) digit codes (s) from Attachment C.
23. **PROVIDER SPECIALTY:** See Attachment D-1.
24. **PHYSICIAN UPIN NO:** Unique Physicians Identification Number.
25. **OMNIBUS BUDGET RECONCILIATION ACT (OBRA) QUALIFICATION:** (Physician only) OBRA '90 mandates that physicians being reimbursed for services to children under the age of 21 meet certain qualifications. Enter each three digit alpha code from Attachment D-2 which applies.
27. **PHARMACY LOCATION:** Enter the one (1) digit number which best describes the location of the pharmacy. (1) Hospital based (2) Long Term Care based (3) Other.
32. **PHARMACY NCPDP #:** Enter seven (7) digit National Council for Prescription Drug Program Number.
33. **TRANSPORTATION (only):** Usual and Customary rates: TAXI: Enter usual and customary base, meter, or flag and mileage rate. Enclose a copy of documentation approving your municipality rate, if applicable.
36. **LONG TERM CARE MEDICARE BED CAPACITY:** Enter Number of Medicare eligible beds in facility.
37. **LONG TERM CARE FISCAL MEDICARE FISCAL INTERMEDIARY:** Enter Name of Medicare carrier.
38. **LONG TERM CARE BUILDING ID CODE:** Enter seven (7) digit code assigned by Department of Public Health.

SECTION C: FORMER PARTICIPATION

If you are not currently participating in the Illinois Medical Assistance Program, but have participated in the past, please complete this section. If not applicable, leave blank.

SECTION D: ADDITIONAL NPI – NATIONAL PROVIDER IDENTIFICATION

If you have been issued more than one (1) National Provider Identification – NPI, please complete this section and provide a copy of all NPI approval letters. If not applicable, leave blank.

41. **NATIONAL PROVIDER IDENTIFICATION:** Enter additional ten (10) digit NPI numbers assigned by the Federal Government to eligible health care providers.

SECTION E: PAYEE INFORMATION

One or more payee section (s) must be completed.

Individual Practitioners are to complete a payee section for each address to which payments are to be sent. If payments are to be sent to more than two addresses, enclose a sheet of paper with payee information for each.

The enclosed Alternate Payee Form and Power of Attorney must be completed if the payee name is different than the provider name.

42. **PAYEE NAME:** Individual Practitioners must enter name in last name, first name format. All other applicants must enter the complete business name.
44. **DOING BUSINESS AS (D/B/A):** If a Sole Proprietorship using a d/b/a name, enter the d/b/a name.
49. **TAXPAYER IDENTIFICATION NUMBER (TIN) TYPE CODE:** Enter the one (1) digit type code below which identifies the tax structure of the SSN/FEIN entered:
- TYPE CODE**
- 1 Federal Employer Identification Number (Corporation/Partnership)
 - 2 Social Security Number (Individual)
 - 3 Governmental Unit
51. **BILLING PROVIDER/PAY TO NPI:** Enter ten (10) digit NPI number assigned by the Federal Government to eligible Billing Providers or Payees.
52. **MEDICARE PART B NUMBER:** Enter the six (6) digit number assigned by your Medicare Part B Carrier.
53. **PHYSICIAN ID NUMBER (PIN):** Enter the six (6) digit number assigned by your Medicare Part B Carrier.
54. **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC):** Enter the ten (10) digit number assigned by DME Regional Carrier.

SECTION F: ENROLLMENT DATA/CERTIFICATION/SIGNATURE/HANDBOOK

THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY.

Questions regarding completion of the Provider Enrollment Application should be directed to the Provider Participation Unit, (217) 782-0538. Please mail the completed application, signed agreement, and all other required documentation to:

**Provider Connections
Western Illinois University
1 University Circle
Macomb, Illinois 61455**

Provider Participation Unit email address
hfs.ppu@illinois.gov

Additional information regarding Illinois Healthcare and Family Services can be obtained at:
<http://www.hfs.illinois.gov/>

Illinois HFS Laws and Rule Regulations available for viewing at:
<http://www.hfs.illinois.gov/lawsrules/index.html>

Illinois HFS enrollment Forms are available at:
<http://www.hfs.illinois.gov/enrollment/>

DO NOT RETURN THIS PAGE

**ATTACHMENT A
DO NOT RETURN THIS PAGE**

PROVIDER TYPE/CATEGORY OF SERVICE TABLE

PROVIDER TYPE		ALLOWABLE CATEGORY OF SERVICE	
10	Physicians	001	Physician Services
12	Optometrists	003	Optometric Services
		045	Optical Supplies
22	Physical Therapists	011	Physical Therapy Services
		041	Medical Equipment/Prosthetic Devices
		048	Medical Supplies
23	Occupational Therapists	012	Occupational Therapy Services
		041	Medical Equipment/Prosthetic Devices
		048	Medical Supplies
24	Speech Therapists	013	Speech Therapy/Pathology Services
		041	Medical Equipment/Prosthetic Devices
		048	Medical Supplies
25	Audiologists	014	Audiology Services
		041	Medical Equipment/Prosthetic Devices
		048	Medical Supplies
55	Early Intervention	007	Developmental Therapy Services
		031	Early Intervention Services
		068	Service Coordination
63	Assistive Technology	041	Medical Equipment/Prosthetic Devices
		048	Medical Supplies
72	Taxicab and Livery Companies	053	Taxicab Service
		054	Service Car
73	Other Transport Providers (Non-registered)	055	Auto Transportation (Private)
		056	Other Transportation
74	Hospital-Based Transport Providers	053	Taxicab Services
		054	Service Car

NOTE: Provider Type 55, Category of Service 031 includes:

- Board Certified Behavior Analyst
- Registered Nurses
- Clinical Psychologists
- School Psychologists
- Clinical Professional Counselors
- Professional Counselors
- Clinical Social Workers
- Social Workers
- School Social Workers
- Marriage and Family Therapists

LICENSE/CERTIFICATION/ENROLLMENT REQUIREMENTS

MEDICAL LICENSE/PUBLIC HEALTH ASSOCIATION CERTIFICATION NUMBER: Individual practitioners licensed by the Illinois Department of Financial and Professional Regulation are to enter their own professional license number. All other provider types are to enter their Public Health or applicable association certification number.

NOTE: All OUT-OF-STATE applicants must enclose a copy of a currently valid licensure/certification form including expiration date.

APPLICANTS LISTED BELOW MUST ENCLOSE THE DOCUMENTATION DESCRIBED WHEN THE APPLICATION IS SUBMITTED.

AMBULANCE: 1) Copy of certification issued by appropriate regulatory agency (I.e., for Illinois the regulatory agency is the Department of Public Health), and 2) enclose a copy of Medicare letter with approved Method of Payment. (OUT-OF-STATE Ambulance enclose ALS certification if applicable).

AMBULATORY SURGICAL TREATMENT CENTER: 1) Copy of license issued by appropriate regulatory agency (I.e., for Illinois the regulatory agency is the Department of Public Health), and 2) copy of Medicare Certification. An ASTC must submit a copy of CLIA Certification issued by HHS to enroll for laboratory services.

CERTIFIED REGISTERED NURSE ANESTHETISTS: 1) Copy of RN license, and 2) CRNA Certification.

HOME HEALTH AGENCY: 1) Copy of license, 2) copy of letter of Health and Human Services (HHS) certification with approved rate of reimbursement.

HOSPICE: 1) Copy of license and Medicare Letter of Certification with Medicare approved rate of reimbursement.

HOSPITAL: 1) Copy of license issued by State Licensing Board, 2) Copy of Medicare Letter of Certification.

IMAGING CENTERS: 1) Copy of Medicare certification as a Portable X-Ray provider.

LABORATORY: 1) Copy of Clinical Laboratory Improvement Act (CLIA) certification.

MIDWIFE: 1) Copy of RN license, 2) copy of letter of Certification by the College Nurse Midwife Association, and 3) copy of Delivery Privilege Form with delivering physician identified.

ADVANCED PRACTICAL NURSES: 1) Copy of RN license, 2) copy of Certification from American Nurse Association or National Certification Board of Pediatrics, and 3) copy of Medical Practice Agreement between Physician and Nurse Practitioner, and 4) Copy of Clia Certification if applicable, and 5) Copy of DEA certificate if applicable.

PHARMACY: 1) Copy of Pharmacy license, 2) Copy of Pharmacist-In-Charge license, 3) Copy of DEA certificate.

PHYSICIANS: 1) Copy of Physician license, 2) Copy of DEA certificate if applicable.

RURAL HEALTH: Copy of HHS letter of certification with rate or reimbursement.

TRANSPORTATION: Copy of Vehicle Identification Card for all vehicles approved to transport medical clients.

**AGREEMENT FOR PARTICIPATION
IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM**

WHEREAS, _____

_____ (HFS Provider Number, if applicable) hereinafter referred to as ("the Provider") is enrolled with the Illinois Department of Healthcare and Family Services hereinafter referred to as ("the Department") as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Healthcare and Family Services clients;

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program policy and billing provisions as set forth in the applicable Healthcare and Family Services Medical Assistance Program rules and handbooks.
2. The Provider agrees, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations. Hospitals are further required to be certified for participation in the Medicare Program (Title XVIII) or, if not eligible for or subject to Medicare certification, must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
3. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX and XXI of the Social Security Act and with all other applicable Federal and State laws and regulations.
4. The Provider agrees that any rights, benefits and duties existing as a result of participation in the Medical Assistance Program shall not be assignable without the written consent of the Department.
5. The Provider shall receive payment based on the Department's reimbursement rate, which shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from charges sent to the Department.
6. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to the Department for payment. Provider acknowledges that it understands the laws and handbook provisions regarding services and certifies that the services will be provided in compliance with such laws and handbook provisions. Provider further acknowledges that compliance with such laws and handbook provisions is a condition of payment for all claims submitted. Any submittal of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.
7. The Provider agrees to furnish to the Department or its designee upon demand all records associated with submitted claims necessary to disclose fully the nature and extent of services provided to individuals under the Medical Assistance Program and maintain said records for not less than three (3) years from the date of service to which it relates or for the time period required by applicable Federal and State laws, whichever is longer. The latest twelve months of records must be maintained on site. If a Department audit is initiated, the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.
8. The Provider, if a medical transportation provider, agrees that vehicle operators(s) shall have an appropriate Drivers License and vehicle(s) shall be properly registered.

9. The Provider, if not a practitioner, agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.
10. The Provider agrees to exhaust all other sources of reimbursement prior to seeking reimbursement from the Department.
11. The Provider agrees to be fully liable to the Department for any overpayments, which may result from the Provider's submittal of billings to the Department. The Provider shall be responsible for promptly notifying the Department of any overpayments of which the Provider becomes aware. The Department shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the Department.
12. The Provider (if a hospital, nursing facility, hospice or provider of home health care or personal care services) agrees to comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.
13. The Provider certifies that there has not been a prohibited transfer of ownership interest to or in the provider by a person who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12-4.25.
14. The Provider certifies the following owners/stock holders own 5% or more of the stock/shares. If additional space is needed for names, please use separate page. If there is no information to disclose, write NONE on PRINT NAME line. This section MUST be completed for enrollment purposes and an entry is required.

PRINT NAME	SOCIAL SECURITY NUMBER	% OF OWNERSHIP

15. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws.
16. Requested effective date ____/____/____. The Provider certifies that all services rendered on or after such date were rendered in compliance with and subject to the terms and conditions of this agreement.

Under penalties of perjury, the undersigned declares and certifies that the information provided in this Agreement for Participation is true, correct and complete.

ILLINOIS DEPARTMENT OF
HEALTHCARE AND FAMILY SERVICES

by: _____
(Provider Signature)

by: _____
Division of Medical Programs

(Print Name of Signature above)

Date: _____ Date: _____

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: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	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.

Social security number
or
Employer identification number

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

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 ▶
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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

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.

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.

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.

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.