Kittitas County
Review Form
Grants & Contract Agreement

Today's Date 09/23/2014		Agenda Date
Fund/Department 116-Public Health		

Contract/Grant Information

Contract /Grant Agency: Community Health Plan of Washington Provider Agreement		
Period Begin Date: Upon Signature		Period End Date: None
Total Grant/Contract Amount: None		
Grant/Contract Number:		
Contract/Grant Summary: The Community Health Plan of Washington Provider Agreement is in place to so the Kittitas County Public Health Department can bill insurance.		

Recommendation for Board of Health and Board of Health Review on _____

Department Head Signature: _____, Administrator Date:_____

Kittitas County Prosecutor, Auditor, and Board of Health Review and Comment:
APPROVED AS TO FORM:

_____
Signature of Prosecutor's Office Date

_____
Signature of Auditor's Office Date

_____
Signature of Board of Health member Date

Financial Information

Total Amount $	State Funds $	Federal Funds $
Percentage County Funds	Matching Funds $	CFDA#
	In-Kind $ Explain	
Is Equipment being purchased?	Who owns equipment?	

New Personnel being hired?	Contact HR hiring – reporting requirements
Future impacts or liability to Kittitas County:	

Budget Information

Budget Amendment Needed?	Yes ☐ attach budget form	No ☐ Why not
New Division Created?		
Revenue Code		

Pass Through Information

Agency to Pass Through	
Amount to Pass Through	$
Sub-Contract Approved	Date:

Prosecutor Review

Has the Prosecutor reviewed this agreement?	Yes ☐ No ☐

County Departments Impacted

	Auditor		Facilities Maintenance
	Information Services		Human Resource
	Prosecutor		Treasurer

Submitted

Signature:	Date:
Department:	

Assignment of Tracking Information

Auditor's Office	
Human Resource	
Prosecutor's Office	
Who Signed the grant application	

Reviewer	Date

COMMUNITY HEALTH PLAN OF WASHINGTON PROVIDER AGREEMENT

This Agreement ("Agreement") is made by and between **Community Health Plan of Washington** ("CHPW"), a not for profit Washington Corporation and **Kittitas County Public Health Department**, a Specialty Care Provider ("Contractor") and is effective the _____day of _____, 20__ ("Effective Date").

RECITALS

A. CHPW is a 501(c)(4) tax exempt entity, accredited by the National Committee on Quality Assurance ("NCQA") and certified as a health care services contractor, organized and operating under the laws of the State of Washington to provide or arrange for provision of covered health care services to individuals enrolled in its Benefit Plans ("Members");

B. CHPW arranges for provision of covered health services to Members pursuant to its contracts with state and federal agencies, including Washington State Health Care Authority ("HCA"), and Centers for Medicare and Medicaid Services ("CMS"), that sponsor various health programs (collectively, "state and federal sponsored health programs");

C. Contractor has available duly licensed providers of health care services located in the State(s) in which it provides health care services and has met CHPW's criteria to be a provider of health care services for Members; and

D. CHPW desires to contract with Contractor to provide Covered health care services to Members pursuant to this Agreement and CHPW Benefit Plans ("Services"), and Contractor desires to contract with CHPW to provide such Services. This agreement is written in compliance with 42 CFR 434.6.

NOW, THEREFORE, in consideration of the recitals, mutual promises, covenants, and agreements set forth herein, both parties agree as follows:

AGREEMENT

I. DEFINITIONS

1.1 "Agreement" means this Provider Agreement entered into between CHPW and Contractor with all amendments, schedules and exhibits hereto.

1.2 "Benefit Plan" means a healthcare benefit product defined by the applicable plan sponsor that is offered or administered by CHPW for the payment of Covered Services provided to Members.

1.3 "Clean Claim" means a reimbursement claim for provision of Covered Services submitted by Contractor to CHPW that is (i) in the form required by CHPW, (ii) complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Administrative Simplification for Electronic Data Interface, and (iii) has no defect or impropriety that may prevent timely or accurate payment of the claim such as failure to include necessary substantiating documentation, encounter data or documentation of particular circumstances requiring special treatment.

1.4 "Contractor" means an individual, professional association, corporation, partnership or nonprofit organization that is duly licensed, certified, and/or registered by the appropriate state or other governmental board or agency entering into this Provider Agreement with CHPW.

1.5 "Contracted Participating Provider" is an individual or entity that is a duly licensed, certified or registered health care provider, is employed or subcontracted by or otherwise associated with Contractor, and who, upon credentialing by CHPW, becomes a Participating Provider.

1.6 "Copayments, Coinsurance and Deductibles" (also referred to as "Cost Sharing") are payments a Member may be required to make to Contractor in accordance with the conditions of the Member's Benefit Plan.

1.7 "Covered Services" are the Medically Necessary health care services that are reimbursable under a Member's Benefit Plan.

1.8 "Emergency Medical Condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

1.9 "Emergency Services" are the Covered Services required by a Member for the diagnosis and treatment of an Emergency Medical Condition

1.10 "Medically Necessary" means a service or supply that meets all of the following criteria:

1.10.1 is consistent with the symptoms or diagnosis and treatment of the Member's condition;

1.10.2 is the most appropriate supply or level of service that is essential to the Member's needs and meets the recognized standards of medical care;

1.10.3 when applied to a Member, cannot be safely provided to the Member in a less restrictive setting;

1.10.4 is not experimental or investigative;

1.10.5 is consistent with professionally recognized standards of care;

1.10.6 is not provided primarily for the convenience of the Member, Contracted Participating Provider or Contractor; and

1.10.7 is the most cost-effective of the alternative levels of service or supplies that are adequate and available.

1.11 "Member" is an individual enrolled in a Benefit Plan and entitled to receive Covered Services pursuant to that Benefit Plan.

1.12 "Non-Participating Provider" means a professional health care provider, facility, or legal entity that does not have a written agreement with CHPW to participate in its Provider Network and has not been credentialed by CHPW, but may provide health care services to Members upon referral and prior authorization.

1.13 "Participating Primary Care Provider" (also referred to as "PCP") means a Participating Provider who is responsible to Members for (i) providing primary health care, (ii) initiating referrals for specialist and inpatient care, and (iii) supervising, coordinating and maintaining continuity of Members' health care. Members are assigned only to Participating Primary Care Providers.

1.14 "Participating Provider" means an individual healthcare practitioner or entity that is duly licensed, certified, and/or registered by the appropriate state or other governmental board or agency, is credentialed by CHPW or its delegate, and under a written agreement with CHPW that is current at the time Covered Services are rendered is authorized to provide Covered Services to Members. Participating Providers are collectively referred to as CHPW's "Provider Network".

1.15 "*Provider Manual*" refers to applicable CHPW manuals, policies and procedures, and documents, as periodically revised, including those that refer to Program Integrity requirements, credentialing, utilization management, prior authorization requirements, claims, and encounter submission, payment, drug formulary, and Participating Provider lists. The *Provider Manual* and associated information are available to Contractor online through www.CHPW.org.

1.16 "Service Area" means those geographic areas in which CHPW is contracted to provide Covered Services to Members.

1.17 "Specialty Care Provider" is a physician or other professional health care provider who provides specialized Covered Services to Members billed under Specialty Care Provider's tax ID Number.

1.18 "Urgently Needed Services" means Covered Services, other than Emergency Services, that are provided:

1.18.1 without a written referral;

1.18.2 when a Member is temporarily absent from the CHPW Service Area or the CHPW's Provider Network is temporarily unavailable or inaccessible;

1.18.3 when it was unreasonable, under the circumstances, for the Member to obtain such services through CHPW Participating Providers;

1.18.4 for an unforeseen, acute illness, injury or medical condition that require immediate treatment to prevent deterioration of condition; and

1.18.5 outside of a hospital or emergency room.

1.19 "Women's Health Care Services" is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's Health Care Services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice and is for purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

1.20 Definitions pertinent to CHPW's state sponsored health benefit plans are available at www.chpw.org.

1.21 "CHPW Health Benefit Exchange Product" (also referred to as "the CHPW Exchange Product" or "CHPW HBE Product") means those health benefit programs offered and sold by CHPW to individuals or groups who obtain health coverage through the Washington Health Benefit Exchange.

1.22 "Health Benefit Exchange (also referred to as "the Exchange" or "HBE") means the Washington health benefit exchange established in RCW 43.71.020, et seq., the Health Benefit Exchange Act and regulated by the Washington State Office of the Insurance Commissioner ("OIC").

1.23 "CHPW Commercial Product" means a Benefit Plan that is not associated with a specific state or federal contract or with the Health Benefit Exchange Products.

1.24 "Washington Apple Health" means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

II. OBLIGATIONS OF CONTRACTOR

2.1 Engagement. CHPW hereby engages Contractor to participate in CHPW's Provider Network, and Contractor hereby accepts such engagement pursuant to the terms and conditions hereunder.

2.2 Services.

2.2.1 Contractor has service locations and Contracted Participating Providers listed on Exhibit A attached hereto. Contractor shall notify CHPW in writing within 60 days of changes in its list of locations, Contracted Participating Providers and their status as employees or subcontractors. The process for updating Exhibit A is contained in the *Provider Manual.*

2.2.2 Contractor shall provide or arrange for provision of efficient and effective Covered Services through its Contracted Participating Providers to Members of those Benefit Plans identified on Exhibit B. Covered Services shall be Medically Necessary and appropriate to each Member's clinical condition in accordance with the *Provider Manual*, industry standards, accreditation requirements, and applicable state and federal laws and regulations.

2.2 3 Contractor represents and warrants that neither it nor its Contracted Participating Providers is or has been excluded from participation in any state or federally funded health care program, including Medicare and Medicaid. Contractor shall promptly notify CHPW of any threatened, proposed, or actual exclusion of Contractor, a key employee or a Contracted Participating Provider from any state or federally funded health care program.

2.2.4 Contractor's loss or suspension of licensure or its exclusion from any federally funded health care program, including Medicare and Medicaid, shall constitute cause for immediate termination pursuant to Section 6.2 of this Agreement.

2.2.5 Contractor shall participate in and cooperate with CHPW's education and training programs for participating providers and for Members

2.2.6 Contractor shall provide all Services hereunder to Members in the same manner and timeliness as such Services are made available to non-Members, without regard to an individual's participation in private health care coverage or in a publicly funded Benefit Plan, in accordance with this Agreement and industry standards.

2.2.7 Before providing Covered Services, other than screening and treatment for emergency medical conditions, Contractor shall verify each Member's eligibility either electronically at www.CHPW.org as set forth in the *Provider Manual* or by calling CHPW's Customer Service Department at the telephone number printed on the back of Member's CHPW identification card.

2.2.8 Contractor shall not delegate the provision of Covered Services without CHPW's prior written approval. To the extent Contractor subcontracts provision of any Covered Services, such subcontracts shall be in writing and include compliance with all provisions of this Agreement, including the credentialing, insurance and hold harmless sections.

2.2.9 Contractor providing primary care Services shall assure that each Member is assigned to a Contracted Participating PCP.

2.2.9.1 Contracted Participating PCPs shall comply with PCP requirements set forth in the CHPW-HCA Agreement which is available upon request.

2.2.9.2 In consultation with other appropriate health care professionals such as care managers, community health workers or community-based care managers, PCPs shall provide, coordinate, and supervise health care to meet the needs of each Member, including initiation and coordination of referrals for medically necessary specialty care.

2.2.9.3 In consultation with other appropriate health care professionals, PCPs shall assess and develop individualized treatment plans for Members with special health care needs that ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.

2.2.10 Each Contracted Participating Provider shall exercise independent medical judgment and control over his/her professional services. Nothing herein shall give CHPW authority over Contracted Participating Provider's medical judgment or direct the means by which s/he practices within the scope of his/her licensed, certified, and/or registered practice.

2.2.11 Each Participating Provider is responsible for his/her relationship with each Member he/she treats and for the quality of health care services provided to Members. Contractor shall be solely responsible to each Member for medical care provided.

2.2.12 Contractor shall assist CHPW with the transfer of any Member who has selected a Contracted Participating Provider and is receiving Emergency or other authorized care from a non-

participating facility to a participating facility at which the Contracted Participating Provider or another suitable Participating Provider has admitting privileges in accordance with the CHPW Medical Director's determination of the medical acceptability of such transfer.

2.2.13 To the extent that Contractor's PCPs have capacity, Contractor's PCPs shall accept enrollment of any Member at CHPW's request.

2.3 Contracted Participating Providers, Licenses and Credentialing.

2.3.1 Contractor shall select each individual Contracted Participating Provider using its written procedures with consideration of the individual's professional qualifications, experience, and ability to deliver efficient, effective health care Services to Members. Each Contracted Participating Provider who provides Covered Services to Medicare Advantage Members must be a Certified Medicare Provider.

2.3.2 Contractor shall cooperate and comply with CHPW credentialing criteria and verification procedures for Contracted Participating Providers. Contractor represents and warrants that each of its Contracted Participating Providers is fully qualified and duly licensed and/or certified by the appropriate state or other governmental board or agency to provide healthcare services within the scope of his/her license. Contractor and Contracted Participating Providers shall maintain such license(s) and/or certification(s) in good standing. Contractor will provide prompt written notice to CHPW of any changes in the license or certification of any of its Contracted Participating Providers, any legal or governmental action, or any other situation which may adversely impair the Contracted Participating Provider's ability to provide Covered Services to Members pursuant to this Agreement.

2.3.3 Contractor represents and warrants that each of its Contracted Participating Providers is fully qualified and duly licensed certified and/or registered by the appropriate state or other governmental board or agency to provide health care services within his/her scope of practice or specialty. Contractor shall maintain applicable license(s) and/or certification(s) for each of its Contracted Participating Providers in good standing for the duration of this Agreement. Contractor will provide immediate written notice to CHPW of any changes in the license or certification of any of its Contracted Participating Providers, any legal or governmental action, or any other problem or situation which may adversely impair the Contracted Participating Provider's ability to provide Covered Services to Members hereunder.

2.3.4 Contractor shall provide an accurate list of Contracted Participating Providers with status designations as "employed by Contractor" or "subcontracted with Contractor" in Exhibit A. Contractor shall promptly notify CHPW in writing of changes in its list of Contracted Participating Providers and/or their status designations. Contractor shall provide an accurate list of Contracted Participating Providers with status designations as "employed by Contractor" or "subcontracted

with Contractor" in Exhibit A. Contractor shall promptly notify CHPW in writing of changes in its list of Contracted Participating Providers and/or their status designations.

2.3.5 Contractor shall orient Contracted Participating Providers, employees and subcontractors to the applicable terms of this Agreement, the *Provider Manual*, and to other areas specifically designated by CHPW, including Member rights, marketing, enrollment and disenrollment procedures, risk management, customer service, claims preparation and authorizations, hospital admission notification and certification, transfer and discharge procedures.

2.3.6 In performing its duties hereunder, Contractor shall require its Contracted Participating Providers to comply with all applicable terms of this Agreement, the Benefit Plans listed on Exhibit B and applicable requirements of the *Provider Manual* that CHPW may amend from time to time at its sole discretion.

2.3.7 Contractor shall assure that Contracted Participating Providers participate in continuing education programs required by law. Contractor shall participate in and cooperate with CHPW's education and training programs for Contracted Participating Providers and for Members.

2.3.8 CHPW may terminate a Contracted Participating Provider's participation upon thirty (30) days notice to Contractor for his/her violation of the terms of this Agreement and immediately upon his/her failure to maintain compliance with CHPW's credentialing requirements. Contracted Participating Provider's exercise of any right to appeal such termination that he/she may have shall not change the effective date of such termination.

2.4 Member Access to Services.

2.4.1 Contractor shall provide access to Members on the same basis as such services are made available to individuals who are not Members.

2.4.2 Participating Primary Care Provider must make available to Members access by phone to a health care professional, licensed to practice independently or Physician's Assistant, on a 24-hour-a-day, seven-day-a-week basis for the purpose of rendering medical advice concerning emergent, urgent or routine medical conditions, and for authorizing emergency medical services or out of area urgent care services.

2.4.3 Participating Specialty Care Provider must make available to Members access by phone to a health care professional, licensed to practice independently or Physician's Assistant, on a 24-hour-a-day, seven-day-a-week basis for the purpose of rendering medical advice concerning emergent, urgent or routine medical conditions.

2.4.4 Contractor shall maintain an appointment system for Members' prompt access to health care in compliance with the following appointment wait time standards set forth in 42 CFR 438.206 (c)(1)(i):

- To the extent applicable, transitional healthcare by a PCP available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.
- To the extent applicable, transitional health care by a home care nurse or home care registered counselor within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan.
- Non-symptomatic – 30 calendar days;
- Non-urgent – 10 calendar days;
- Urgent – 48 hours;
- Emergency care access – 24/7 provided at area Hospital Emergency Departments.

2.4.5 At least annually and upon CHPW request, Contractor shall provide a report on its capacity for additional primary care enrollment or capacity to provide specialty Services.

2.4.6. Contractor shall provide CHPW at least one hundred twenty (120) calendar days written notice before Contractor, any Clinic or Contracted Participating Provider ceases providing Covered Services to Members.

2.4.7 If a Contracted Participating Provider's participation with CHPW is discontinued by either party, Members undergoing an active course of treatment (including treatment for second or third trimester pregnancy and postpartum care) with a terminated Contracted Participating Provider, shall be given the option to continue such treatment with the terminated Contracted Participating Provider for ninety (90) days following the effective date of the Contracted Participating Provider's termination or completion of the active course of treatment, whichever occurs first. A Member who is receiving inpatient care on the effective date of Contracted Participating Provider's termination shall continue receiving Services from the terminated Contracted Participating Provider until the Member has been discharged from inpatient treatment or transferred to another Participating Provider. CHPW shall reimburse Contractor in accordance with the reimbursement rate provided herein for any Covered Services rendered after the effective termination date. Contractor shall work with the terminating Contracted Participating Provider and affected Member to develop a reasonable transition plan. This Section 2.4.7 shall not apply to Contracted Participating Providers terminated for incompetence, unprofessional conduct, loss of license or exclusion from Medicare or Medicaid.

2.4.8 Termination of Contracted Primary Care Provider(s). CHPW shall provide written notice to each Member affected by the termination or cessation of practice of the Member's Contracted PCP at least thirty (30) calendar days prior to the effective date of such termination or cessation. Such notice shall include the PCP's name, effective date of termination, the procedure for selecting another PCP and an offer to assist the Member to select a new PCP.

2.4.9 Termination of Contracted Specialty Care Provider or Specialty Group. Contracted specialty groups and individual specialists shall provide timely written notice to Members of pending termination or cessation of their practice. Notwithstanding the foregoing, CHPW shall be responsible to notify in writing each Member affected by termination or cessation of a specialty group's or individual specialist's practice. CHPW shall provide such notice to affected Members prior to the effective date of such termination or cessation of practice.

2.4.10 Contractor shall give CHPW at least ninety (90) calendar days written notice before opening any additional sites or satellite facilities that are not currently listed on Exhibit A. Within sixty (60) calendar days of receiving the notice, CHPW shall approve or disapprove in writing the use of such locations for providing Covered Services to Members.

2.4.11 CHPW will monitor Member access to and availability of Contracted Participating Providers and inform Contractor of significant concerns and Member complaints about access to or availability of Covered Services. If a CHPW access study shows excessive Member wait times for appointments, CHPW may suspend further enrollment or referrals of Members with Contractor until capacity improves and another access study shows acceptable wait times.

2.4.12 Contractor providing primary care Services may close enrollment of new Members to its Clinic(s) due to lack of capacity, after providing forty-five (45) days written notice to CHPW and with written approval from CHPW, which shall not be unreasonably withheld. Contractor's enrollment of Members shall not be closed if enrollment remains open to other plans or lines of business.

2.4.13 Contractor providing covered services to Medicare Advantage Members must promptly notify CHPW in writing if the Contractor terminates its core agreement with CMS.

2.5 Member Rights.

2.5.1 Contractor and Contracted Participating Providers shall obtain informed consent prior to treatment. Without regard to Benefit Plan limitations or cost, Contractor and Contracted Participating Providers shall communicate freely and openly with Members (i) about their health status, and treatment alternatives (including medication treatment options); (ii) about their rights to participate in treatment decisions (including refusing treatment); and (iii) providing them with relevant information to assist them in making informed decisions about their health care.

2.5.2 Contractor and Contracted Participating Provider shall inform each Member of his/her right to a second opinion and the right to self refer for certain Covered Services including Women's Health Care, family planning, immunizations, TB and sexually-transmitted disease testing in accordance with the applicable Benefit Plan and with the *Provider Manual*. Contractor shall also assist such Member in arranging for the receipt of desired, appropriate non-covered health care services and in obtaining important related information including (i) the estimated cost and possible sources of payment for the non-covered services to the extent Contracted Participating

Provider is aware of such information and sources and (ii) Member's responsibility for payment for non-covered services.

2.5.3 Contractor shall provide notice to Members of their personal financial obligations for non-covered services. Contractor may bill a Member for non-covered services only if Contractor has, prior to the provision of non-covered services, obtained a written acknowledgement and acceptance of financial responsibility from the Member after full written disclosure of (i) Contractor's intent to bill Member for non-covered services, and (ii) the non-liability of CHPW for such non-covered services.

2.5.4 Contractor shall comply with state and federal laws and regulations that pertain to member rights when furnishing Services hereunder.

2.5.4.1 Contractor shall comply with the Natural Death Act, HCA, CMS and other applicable rules concerning advance directives and, when appropriate, inform Members or their representatives of their right to make anatomical gifts. Contractor shall document the existence of an Advanced Directive in each Member's record in compliance with the Patient Self-Determination Act of 1990.

2.5.4.2 Contractor shall assure that all sterilizations and hysterectomies performed for Members are in compliance with 42 CFR 441 Subpart F, and that the HCA Sterilization consent Form HCA13-364 or its equivalent is used. No payment shall be made under state sponsored Benefit Plans for sterilization procedures and hysterectomies that do not comply with the requirements of this paragraph.

2.5.4.3 Contractor shall make reasonable accommodation for Members with disabilities, in accord with the Americans with Disabilities Act, and shall assure that physical and communication barriers do not inhibit disabled Members from obtaining Services.

2.5.5 Contractor shall cooperate and comply with CHPW's Member complaint and appeals procedures as set forth in the *Provider Manual*, for resolution of a Member's complaints or appeals that may arise from Contractor's provision of Services or CHPW's denial of coverage. Contractor shall notify CHPW of Member complaints and appeals that it receives and the subsequent resolutions. Contractor shall cooperate with CHPW in the investigation and resolution of Member complaints or appeals received by CHPW regarding Contractor or Contracted Participating Providers' performance.

2.5.6 Contractor shall provide care in a culturally competent manner and shall provide or arrange for interpretive services for each Member who is hearing impaired, or whose oral or written language creates a barrier to access, for all contacts between Contractor and Member including appointments for provision of Covered Services, emergent and urgent services, telephone contacts, and assistance with all steps necessary to file Member complaints and appeals. Contractor

shall assure that all generally available written materials provided to Members are developed at the 6th grade reading level, translated into the Member's primary reading language, or audibly in the Member's primary language or provided in an alternative medium or format acceptable to the Member and approved by CHPW.

2. 6 Member Copayments, Coinsurance, Deductibles.

2.6.1 Contractor shall collect and may retain Member Cost Sharing amounts authorized under the applicable CHPW Member's Benefit Plan for Covered Services.

2.6.2 Copayments that Contractor charges a Member hereunder shall not exceed the actual cost of providing the associated Covered Services.

2.6.3 Members enrolled in a CHPW Medicare Advantage Special Needs Plan and for whom a state provides coverage ("Dual Eligible Enrollees") will not be required to pay any cost sharing amounts for Services covered by Medicare Parts A and B when the State Medicaid Program is required to pay.

2.6.3.1 In lieu of collecting such cost sharing under the Medicare Advantage Benefit Plan, Contractor may either (i) bill such cost sharing amounts to the appropriate state Medicaid source or (ii) forego collecting cost sharing amounts and accept the Medicare Advantage Benefit plan reimbursement as payment in full.

2.6.3.2 Contractor may determine that a Member is a Dual Eligible Enrollee by reviewing plan information on the Member's ID card and through the CHPW internet provider portals.

2.7 Hold Harmless and Insolvency.

2.7.1 In no event, including, but not limited to non-payment by CHPW, CHPW insolvency, or breach of this Agreement, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, a person acting on a Member's behalf or HCA for Services provided hereunder. This provision shall not prohibit collection of copayments, coinsurance and deductibles and/or fees for non-covered services which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Member in accordance with the terms of Member's Benefit Plan.

2.7.2 In the event of CHPW's insolvency, Contractor shall continue to provide the Services promised in this Agreement to Members for the duration of the period for which premiums on behalf of Members were paid to CHPW or until Member is discharged from inpatient facilities, whichever time is greater.

2.7.3 Notwithstanding any other provision herein, nothing in this Agreement shall be construed to modify the rights and benefits contained in a Member's Benefit Plan.

2.7.4 Contractor may not bill Members for Covered Services (except for copayments, coinsurance and deductibles) when CHPW denies payment because Contractor failed to comply with the terms of this Agreement.

2.7.5 Contractor further agrees that this Section 2.7 shall survive termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of CHPW Members and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contractor and Members or persons acting on their behalf.

2.7.6 If Contractor contracts with other care providers who are not Participating Providers and who agree to provide Covered Services to CHPW Members with the expectation of receiving payment directly or indirectly from CHPW, such providers must agree to abide by the provisions of this Section 2.7.

2.7.7 If Contractor contracts with Participating Providers (other than Contracted Participating Providers) who are in a risk contract with CHPW, Contractor will look solely to those Participating Providers for payment during the period in which the Member is assigned to such Participating Providers.

2.7.8 Solvency. If Contractor is at financial risk, CHPW will provide oversight to assure that Contractor maintains CHPW's solvency requirements throughout the term of this Agreement,

2.7.9 If Contractor willfully collects or attempts to collect an amount from Member under any of the provisions outlined above, the act will constitute a class C felony under RCW 48.80.030(5).

2.8 Referrals and Authorizations.

2.8.1 Contractor shall not refer Members to any Non-Participating Providers without prior written authorization from CHPW except as necessary in the case of Emergency or Urgently Needed Services. Contractor must notify CHPW of referrals for Emergency or Urgently Needed Services by the next business day.

2.8.2 Contractor shall cooperate and comply with prior authorization, hospital admission and certification procedures required by the then current *Provider Manual*.

2.8.3 Except as described in Section 2.8.4 below, Contractor shall make best efforts to refer Members to other Participating Providers for Covered Services as Medically Necessary and appropriate when such Covered Services are not available from Contractor.

2.8.4 Certain Covered Services including Women's Health Care Services, are legally exempt from prior authorization and Contractor referral requirements. Members may self refer to any Participating Provider in CHPW's Network for such services, and Contractor shall not restrict Members' self referrals to Contracted Participating Providers.

2.9 Utilization Review and Quality Assurance.

2.9.1 Contractor shall maintain a quality improvement system tailored to the nature and type of Services rendered hereunder that affords quality control for the health care provided

2.9.2 Contractor shall comply with, cooperate and participate in utilization review, quality improvement, quality assurance programs, necessity of care evaluations, coordination of benefit activities, health care coding reviews and cost containment activities, as set forth in the *Provider Manual* and as CHPW deems necessary, including concurrent and retrospective reviews, audits and/or reviews by independent quality improvement organizations and accreditation agencies.

2.9.2.1 Contractor shall cooperate with CHPW's collection, production and distribution of comparative data for quality assurance and utilization review. CHPW may use such data regarding Contractor and its Contracted Participating Providers' performance in activities such as quality improvement, public reporting to consumers, preferred status designations and other activities that promote transparency to consumers and Members.

2.9.2.2 Contractor shall cooperate and communicate freely with CHPW regarding quality issues and notify CHPW of any Member's medical situation or special health care needs that may benefit from case management in accordance with the conditions of the Members' Benefit Plans and the *Provider Manual.*

2.10 Insurance Requirements.

2.10.1 Contractor shall maintain the following insurance coverage limits to cover all of Contractor's Services in the minimum amounts specified except as otherwise agreed.

2.10.1.1 Professional liability coverage with minimum limits of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate for professional liability, negligence, errors and omissions. These limits must apply per Contracted Participating Provider and not be shared among Contractor's Contracted Participating Providers.

2.10.1.2 One Million Dollars ($1,000,000) per occurrence and One Million Dollars ($1,000,000) annual aggregate for commercial and comprehensive general liability;

2.10.1.3 Applicable state statutory limits for workers compensation; and

2.10.1.4 Any other usual and customary policies of insurance or an equivalent program of self-insurance applicable to the work being performed and acceptable to CHPW.

2.10.1.5 To the extent applicable, coverage for Federally Qualified Health Centers under the Federal Torts Claims Act will be deemed to meet these requirements.]

2.10.2 By requiring insurance herein, CHPW does not represent that coverage and limits will necessarily be adequate to protect Contractor. Such coverage and limits shall not be deemed as a limitation on Contractor's liability under the indemnities granted to CHPW herein.

2.10.3 Contractor will promptly notify CHPW of any cancellation, reduction, or other material change in the amount or scope of such coverage. Upon CHPW's request, Contractor will furnish a certificate of insurance to CHPW evidencing all of the policies of insurance and limits required hereunder.

2.10.4 All policies maintained by Contractor shall be primary with respect to any insurance maintained by CHPW. Failure to maintain the required insurance constitutes cause for termination of the Agreement.

2.10.5 The requirements of this Section 2.10 shall survive termination or expiration of this Agreement.

2.11 Record Keeping and Access.

2.11.1 Contractor shall prepare, maintain, and retain accurate Member health records including appropriate medical, administrative and financial records related to this Agreement and to Services provided hereunder in accordance with the *Provider Manual*, industry standards, applicable state and federal sponsored health programs, and applicable federal and state statutes and regulations. Such records shall be maintained for the maximum period required by federal or state law as set forth in Section 5.5, below. CHPW shall have continued access to Contractor's records necessary for CHPW to perform its obligations hereunder, to administer its Benefit Plans, and to comply with federal and state laws and regulations and applicable accreditation requirements.

2.11.2 Contractor shall completely and accurately report encounter data to CHPW and assure that it and all its Contracted Participating Providers that are required to report encounter data have the capacity to submit all required data including HCA required data to enable the CHPW to meet the reporting requirements in the Encounter Data Transaction Guide published by HCA.

2.11.3 Upon CHPW request or as required by the *Provider Manual*, by CHPW's state and federal sponsored health programs and associated contracts, Contractor shall provide direct access and/or copies of information, encounter data, statistical data, and treatment records pertaining to Members who receive Services hereunder or in conjunction with claims reviews, quality improvement programs, grievances and appeals, peer review, Health Effectiveness Data and Information Set (HEDIS) reviews, Consumer Assessment of Health Plans (CAHPS) or claims payment at no cost to CHPW.

2.12 Marketing and Solicitation.

2.12.1 Contractor shall permit CHPW to use the names of Contractor, its Clinics and Contracted Participating Providers for publication in its directory of Participating Providers, for promotional purposes, and to otherwise carry out the terms of this Agreement. At its discretion, Contractor shall display CHPW approved signs and material related to provision of Services provided, participate in marketing programs approved by CHPW for its products and perform other marketing duties CHPW may request.

2.12.2 Contractor shall display CHPW approved signs and material that relate to Covered Services provided hereunder upon CHPW's request.

2.12.3 Contractor shall obtain prior written approval for any publication or distribution of promotional materials using the CHPW name or logo. Unless such material requires review and approval by HCA or CMS, CHPW shall decide whether to approve the materials within fifteen (15) working days of the submission of material to CHPW.

2.12.4 Contractor shall not undertake any marketing activities to the Medicare or Medicaid population, including but not limited to distribution of publications or promotional materials, without the prior written consent of CHPW. Contractor shall not engage in direct and/or indirect door-to-door, telephonic, or other cold-call marketing of enrollment with Members or potential Members.

2.13 Administrative Matters.

2.13.1 Contractor shall comply with applicable Program Integrity requirements, including the HCA approved fraud and abuse policies and procedures, in compliance with 42 CFR 438.608(a) and section1902(a)(68) of the Social Security Act as set forth in CHPW's contracts for state and federal sponsored healthcare programs and in the *Provider Manual.*

2.13.1.1 Contractor shall comply with RCW 48.135 concerning Insurance Fraud Reporting and notify CHPW's Director of Compliance of all incidents or occasions of suspected fraud, waste or abuse involving Services provided to any Member. Contractor shall report a suspected incident of fraud, waste or abuse within ten (10) business days of the date Contractor first becomes aware of, or is on notice of, such activity. The obligation to report suspected fraud, waste or abuse shall apply whether the suspected conduct was perpetrated by Contractor, Contractor's employee, agent, or subcontractor, or Member. Contractor shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against suspected fraud, waste or abuse. Upon request by CHPW or the State, Contractor shall confer with the appropriate State agency prior to or during any investigation into suspected Fraud,

waste or abuse. For purposes of this section, the terms fraud and abuse shall have the same meaning as provided for in 42 CFR §455.2.

2.13.1.2 CHPW shall not penalize Contractor because Contractor, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare or that may violate state or federal law.

2.13.1.3 Contractor will maintain policies and procedures that require its managers, officers and directors involved in work that relates to Members to sign a Conflict of Interest Statement upon hiring or appoint and annually thereafter and to report potential conflicts of interest that may arise.[1]

2.13.2 Contractor shall provide at least sixty days prior written notice to CHPW of any change significantly affecting the delivery of or payment for Services hereunder, including, changes in its tax identification number, billing address or practice location.

2.13.3 CHPW retains sole and ultimate authority to terminate a Member's coverage. Contractor may request termination of a Member by CHPW in compliance with the termination procedure set forth in CHPW's *Provider Manual* for Member's fraud, disruption of medical services, or repeated failure to make required co-payments. Contractor shall not request termination of a Member due to the Member's need for or utilization of medically required Services.

2.13.4 Contractor shall allow CHPW to conduct office visits during reasonable business hours, to perform structured audits and on-site review of operations, including access to medical records (to the extent necessary to conduct the audit), to ensure compliance with this Agreement and the *Provider Manual.*

III. OBLIGATIONS OF CHPW

3.1 Reimbursement. CHPW shall reimburse Contractor for Covered Services it has provided to Members in accordance with this Agreement, the *Provider Manual,* and state and federal laws, regulations and instructions.

3.2 Eligibility. CHPW or its designee shall confirm a Member's eligibility for Covered Services upon Contractor's request.

3.3 Identification Cards. CHPW shall provide an identification card to each Member. The card will display status of membership with CHPW, Member's name, Benefit Plan identification number, name of Primary Care Clinic, copayment amounts, claims address, telephone number and website address for Contractor to request or confirm the Member's eligibility, benefits, prior authorizations and to provide CHPW with required notifications.

[1] A conflict of interest may arise if a person or a member of his/her family has an existing or potential interest or relationship that impairs or appears to impair the person's independent judgment.

3.4 Data Requirements. CHPW shall provide Contractor with claim, encounter and referral format requirements.

3.5 CHPW Insurance Coverage. CHPW shall maintain general comprehensive liability insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in the aggregate and will provide Contractor evidence of such coverage upon request.

3.6 *Provider Manual.*

3.6.1 The *Provider Manual* and associated links containing information critical to Contractor's proper performance of its duties hereunder and is accessible at www.CHPW.org. It covers topics such as utilization review, general benefits information, quality assessment and improvement programs, credentialing, grievance procedures, billing and data reporting requirements, reimbursement terms and other relevant information.

3.6.2 CHPW may revise and update the *Provider Manual* from time to time, and shall use its best efforts to provide prior notice of at least sixty (60) days for changes to the *Provider Manual* that substantially affect Contractor's obligations or reimbursement, unless changes to federal or state law or regulations or other circumstances make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to the termination and continuity of care requirements hereunder, Contractor may terminate this Agreement as set forth in Section 6.3, below, if the change is unacceptable to Contractor. If there are any conflicts between the *Provider Manual* and this Agreement, this Agreement shall prevail.

3.7 Non-Discouragement.

3.7.1 CHPW shall not in any way preclude or discourage Contractor from informing Members about healthcare they require, including various treatment options and whether, in Contractor's view, such care is consistent with medical necessity, medical appropriateness or coverage under the Member's Benefit Plan. CHPW shall not prohibit, discourage or penalize Contractor from legally advocating on behalf of a Member with CHPW. Nothing in this Section 3.7, however, shall be construed to authorize Contractor to bind CHPW to pay for any service.

3.7.2 CHPW shall not preclude or discourage Contractor, Members, or those paying for their coverage, from discussing the comparative merits of different health carriers, even if such discussion is critical of CHPW.

3.7.3 Notwithstanding any other provision herein, CHPW shall not prohibit directly or indirectly any Member from freely contracting at any time to obtain any health care services outside a CHPW Benefit Plan on any terms or conditions a Member chooses. Nothing herein,

however, shall be construed to bind CHPW to pay for services delivered outside a CHPW Benefit Plan.

3.8 Reviews. CHPW shall provide ongoing monitoring and periodic formal review of Contractor's performance hereunder that is consistent with industry standards, accreditation requirements, CHPW's state and federal contracts and state and federal laws and regulations including regulations of the Washington State Office of Insurance Commissioner ("OIC"). Pursuant to 42 CFR 438.230, CHPW shall conduct a formal review at least every three years to identify deficiencies and areas for improvement.

3.9 This agreement does not terminate CHPW's legal responsibility to HCA to carry out the obligations of the Agreements between CHPW and HCA.

IV. BILLING AND REIMBURSEMENT

4.1 Requirements.

4.1.1 For all billing and reimbursement activities, the parties shall comply with applicable billing instructions, practices and policy guidelines herein and as published and periodically updated in the *Provider Manual* and, as applicable, by HCA and CMS instructions and coverage/non-coverage determinations. If there is a conflict between the substance or interpretation of the HCA Billing Instructions and the *Provider Manual*, the *Provider Manual* shall control. If there is a conflict between the substance or interpretation of CMS instructions or determinations on coverage and the *Provider Manual*, the CMS instructions or determinations shall control.

4.1.2 Risk sharing arrangements, if any, are subject to review and approval by HCA, and Contractor must have appropriate stop-loss protection if Contractor is at substantial financial risk hereunder,

4.2 Claims Submission.

4.2.1 Contractor shall comply with the claims, payment, and billing procedures set forth in the *Provider Manual* and submit Clean Claims for Covered Services rendered to the address set forth on the Member's identification card in nationally approved standard formats and through a CHPW approved clearinghouse. Contractor shall use best efforts to submit claims/encounters electronically. Contractor shall submit all required data to enable CHPW to meet the applicable reporting requirements in the Encounter Data Reporting Guide published by HCA as applicable.

4.2.2 Upon request, Contractor shall furnish all information reasonably required by CHPW to substantiate the provision of and charges for Covered Services, at no charge to CHPW. Claim approval and payment for claims or encounters are contingent upon CHPW's receipt of complete and accurate information from Contractor.

4.2.2.1 CHPW's prior authorization through prospective and/or concurrent review does not guarantee payment.

4.2.2.2 CHPW reserves the right to assure, through audit and retrospective evaluation of a Member's documented medical care that, based on the information available to the attending physician or ordering provider at the time services were provided, those services were medically necessary and claims were accurately coded. Such review or audit may result in denial of claims for services on the basis of Medical Necessity or errors in claims submission and may adversely impact payment.

4.2.2.3 If it is determined that all or part of the payment of a claim for Services other than Emergency Services, was based on information that in the opinion of CHPW is significantly different from the information that was available at the time of original certification that the Member was eligible for the Covered Services authorized or provided, CHPW may request a refund.

4.2.3 CHPW shall not pay a claim received (i) more than three hundred and sixty five (365) calendar days after the date a Covered Service was rendered or (ii) more than sixty (60) calendar days after Contractor first receives notice that CHPW is a secondary payer under applicable coordination of benefit procedures.

4.3 Reimbursement.

4.3.1 CHPW shall reimburse Contractor for timely submitted Clean Claims for Covered Services it provides to Members in accordance with this Section IV and Exhibit C. Contractor shall accept such reimbursement plus applicable Cost Sharing amounts as payment in full for such Covered Services.

4.3.2 CHPW reserves the right to change the reimbursement rates set forth on Exhibit C, attached hereto and incorporated herein, in accordance with changes in rates paid by applicable federal, state or other third party payers. Such reimbursement shall be accepted by Contractor as payment in full

4.3.2.1 CHPW will provide the Contractor at least sixty (60) days notice of changes that affect the reimbursement rates pursuant to Section 7.6.1 below unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Contractor may terminate the contract pursuant to Section 6.3 if it does not agree with the changes.

4.3.2.2 The parties acknowledge that configuring new rates into CHPW's reimbursement system to begin paying claims at a new rate requires up to 30 days. Therefore, in situations

where federal or state rate changes do not allow CHPW to provide 60 days advance notice to Contractor, the new rates will be implemented on the later of the date CHPW has completed configuring its system or on the published effective date of the new rates. Where a change allows for 60 days notice, the new rates will be implemented on the published effective date of the rate change.

4.3.2.3 CHPW will apply new rates only to claims received on and after the implementation date defined in the preceding Section 4.3.2.2. If such action results in a substantial negative impact to either party, the impacted party may request that the parties negotiate a settlement payment in lieu of retroactive adjustment of individual claims.

4.3.3 As set forth in its *Provider Manual* and HCA instructions, CHPW shall not reimburse Contractor for services rendered in conjunction with commonly recognized grossly negligent acts including, those referred to as Serious Reportable Adverse Events and Never Events.

4.3.4 CHPW shall pay or deny not less than ninety-five percent (95%) of all Clean Claims received from Contractor within thirty (30) days of service; ninety-five percent (95%) of all claims received from Contractor within sixty (60) days of service; and ninety-nine percent (99%) of all Clean Claims received from Contractor within 90 days, except as agreed to by the parties on a claim-by-claim basis. A Clean Claim is "received" on the date CHPW receives either written or electronic notice of the claim. For state sponsored Benefit Plans, if CHPW fails to meet its obligations in this paragraph, CHPW shall pay Contractor interest at the rate of one percent (1%) per month of the contract amount of all unpaid Clean Claims that have not been denied which have aged sixty one (61) or more days until such time as CHPW is again in compliance with these requirements.

4.4 Coordination of Benefits and Third Party Payment.

4.4.1 Contractor will cooperate with CHPW's coordination of benefits, subrogation and third party payment policies as set forth herein and in the *Provider Manual*.

4.4.2 Contractor shall promptly notify CHPW if it becomes aware that a Member has a subrogation claim or right to reimbursement from a third party and assist CHPW in arranging for assignment of such right to CHPW for collection. Contractor shall also notify CHPW of Members that may approach stop-loss deductibles, have other insurance coverage available, or be eligible for Social Security coverage.

4.4.3 Except as otherwise required by Chapter 284-51 WAC, under no circumstances shall CHPW reimburse Contractor any amount greater than that provided for hereunder. If Contractor has received payment from another coverage plan or entity that has primary payment responsibility under coordination of benefits rules, and that payment is equal to or greater than the rates set forth herein, Contractor may not seek additional reimbursement from CHPW. In addition, Contractor

shall promptly refund to CHPW any amount CHPW has already paid to Contractor which, when added to amounts paid by another coverage plan or third party for the same Covered Services, are in excess of the rates set forth in this Agreement.

4.4.4 With regard to state sponsored Benefit Plans, payment for Services and benefits shall be secondary to any other medical coverage exception in accord with the applicable rules of WAC 284-51-205(1)(a). CHPW shall not refuse or reduce Services provided hereunder solely due to the existence of similar benefits under another health care contract. CHPW shall pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties.

4.5 Overpayment and Underpayment Recoveries.

4.5.1 "Refund" means the return, either directly or through offset to a future claim, of some or all of a payment already received by the Contractor.

4.5.2 CHPW may request a refund from Contractor for overpayment of a previously paid claim within 24 months after the initial payment was made. Such a request must be in writing, identify the specific claim(s) at issue, and specify why Contractor owes the refund. Contractor may contest the request in writing to CHPW within thirty (30) days of receipt in accordance with Section 5.7 Dispute Resolution. Failure by Contractor to contest a request within this thirty (30) day period shall result in the request being deemed to be accepted by Contractor as due and owing. Where a request for refund is contested by Contractor, CHPW may not request that the refund be paid any sooner than six (6) months from the date of Contractor's receipt of the request.

4.5.3 Except in the case of fraud, or as provided in Section 4.5.4 below, Contractor may not: (a) request additional payment from CHPW to satisfy a claim unless Contractor does so in writing to CHPW within twenty-four (24) months after the date that the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than six (6) months after receipt of the request. Any such request must identify the specific claim(s) at issue and specify why the Contractor believes CHPW owes the additional payment. Any dispute arising out of such a request shall be handled in accordance with Section 5.7 Dispute Resolution.

4.5.4 Where coordination of benefits is involved, a request for refund by CHPW or a request for additional payment by Contractor pursuant to this Section 4.5.4 must be made within thirty (30) months after the claim was paid or submitted. The requirements of this Section 4.5.4 are not applicable to subrogation claims.

V. MUTUAL OBLIGATIONS

5.1 Independent Contractors. CHPW and Contractor are independent entities. No provision herein is intended to create, nor shall be construed to create, any relationship other than that of independent

entities contracting with each other solely for the purpose of effecting this Agreement. Neither party nor any of its respective employees and subcontractors shall be construed to be the principal, agent, employee, or representative of the other party.

5.2 Representatives. Each party shall designate a representative who is responsible for coordination and communication between Contractor and CHPW in performance of this Agreement including review of the *Provider Manual* and subsequent updates. Each party's representative and their respective contact information are set forth on Exhibit F, attached hereto and incorporated herein. Each party shall promptly notify the other in writing pursuant to Section 7.6 of any changes to the representative's designation or contact information.

5.3 Compliance.

5.3.1 Each party shall comply in all material respects with requirements of applicable federal and state laws and regulations, the terms of this Agreement and applicable terms and conditions set forth in CHPW's contracts with state and federal agencies obligating it to administer all or some of the Benefit Plans referred to herein, including:

5.3.1.1 Applicable Medicare laws, regulations and CMS Instructions;
5.3.1.2 Title VI of the Civil rights Act of 1964 implemented by regulations at 45 CFR 84;
5.3.1.3 The Age Discrimination Act of 1975, implemented by regulations at 45 CFR 91;
5.3.1.4 The Rehabilitation Act of 1973;
5.3.1.5 The Americans with Disabilities Act;
5.3.1.6 The False Claims Act (32 U.S.C. §3729 et. seq.);
5.3.1.7 The Anti-kickback Statute (Section 1128B(b) of the Act);
5.3.1.8 Other laws applicable to recipients of federal funds; and
5.3.1.9 Applicable federal and state laws that pertain to enrollee rights.
5.3.1.10 Additional CMS requirements set forth in Exhibit F attached hereto and incorporated herein.

5.3.2 Each party agrees to require that all subcontracts related to this Agreement will be written and will specify that the subcontractor must also comply with such applicable federal and state laws, regulations and requirements and with terms of this Agreement.

5.3.3 As a condition to entering into this Agreement, and in compliance with 42 CFR 455.101-106, Contractor shall provide to CHPW a completed, accurate Disclosure of or Change in Ownership and Control Interest form. Contractor shall promptly provide updates to the Disclosure of or Change in Ownership and Control Interest form when information on the current form changes. Failure to provide a complete accurate form or updates to it shall be deemed a material breach of this Agreement.

5.4 Confidentiality and Privacy.

5.4.1 All information provided by a party in the process of negotiation and performance of this Agreement identified by either party as confidential or proprietary, including reimbursement rates,

fee schedules, Member and CHPW group information, is confidential and shall not be disclosed to any third person or entity in any format without the express prior written consent of the other party. This provision shall not preclude access to such records in order to allow billing and quality assurance review with respect to Covered Services delivered. Upon termination of this Agreement, any documents identified by either party, as proprietary shall be returned or otherwise disposed of as mutually agreed to by the parties. This section shall survive termination of the Agreement.

5.4.2 Each party is a covered entity and in performing this Agreement, each party may have access to and receive from the other party Protected Health Information ("PHI") as those terms are defined under the Health Insurance Portability and Accountability Act of 1996, Section 1171 of Public Law 104-191 ("HIPAA"), and Chapter 70.02 RCW, the Washington State Health Care Information Access and Disclosure of 1991.

5.4.2.1 Each party shall maintain the confidentiality of PHI and shall not use or disclose Member PHI except as necessary to carry out the terms and conditions of this Agreement or as permitted or required by federal or state law or regulations.

5.4.2.2 Each party shall implement a documented health information system and a privacy security program that includes administrative, technical and physical safe guards designed to prevent the accidental or unauthorized use or disclosure of Member PHI and medical records. The information system and the privacy and security program shall, at a minimum, comply with applicable HIPAA regulations regarding the privacy and security of PHI, including but not limited to 42 CFR § 438.242; 45 CFR § 164.306(a); and 45 CFR § 162.200 as well as the HIPAA privacy provisions in Title 13 of the American Recovery and Reinvestment Act of 2009 ("ARRA").

5.4.2.3 This Section 5.4 shall be interpreted as broadly as necessary to implement and comply with applicable current and future HIPAA requirements, and resolve any ambiguity in favor of a meaning that complies and is consistent with HIPAA requirements.

5.4.3 This Section 5.4 shall survive termination of the Agreement.

5.5 Record Retention, Access and Audits.

5.5.1 Each party shall cooperate and assist in providing access to records reasonably required or permitted for inspection, evaluation and audit as set forth herein.

5.5.2 Consistent with industry standards and applicable state and federal laws and regulations, including OIC regulations, each party or its representative may, during normal business hours and upon giving reasonable notice to the other party, audit, examine and inspect (to the extent necessary to perform the audit) the other party's books and records, including medical records, related to this Agreement, to transactions between CHPW and Contractor hereunder, and to

surveys for accreditation and compliance. Pursuant to 42 CFR 438.230, CHPW shall conduct a formal review at least every three years to identify deficiencies and areas for improvement.

5.5.3 Each party shall provide access upon reasonable notice, during regular business hours, to state and federal agencies to periodically inspect or audit its books and records relating to a Member and to the performance of this Agreement as required to comply with state and federal laws and regulations including 42 CFR 422.310(e), 42 C.F.R. 422.502(i), 42 CFR 422.504(e)(2), and 42 CFR 1395x(v)(1)(I). Pursuant to 42 CFR 438.6(g), state and federal agencies may inspect and audit applicable financial records of the Contractor and its subcontractors. HCA or CMS staff may require immediate access for audits related to Medicaid fraud investigations. Contractor shall release to CHPW any information necessary for CHPW to perform its state and federal contractual obligations. Such access shall be limited to that necessary to perform the inspection or audit and to certify the nature and extent of the costs of the Services provided hereunder. Pursuant to 42 CFR 438.6(g), state and federal agencies may inspect and audit applicable financial records of the Contractor and its subcontractors and may require immediate access for fraud investigations. Pursuant to 42 CFR 422.504(e)(2),CMS may access Contractor's records (including medical records) that are to be used for risk-adjustment data validation (RADV) purposes to determine amounts payable under a Medicare Advantage contract.

5.5.4 Each party shall retain and protect all applicable books and records for at least ten (10) years after termination of this Agreement. Each party acknowledges that certain government agencies, including the Secretary of the Department of Health and Human Services (HHS) and the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, have the right to inspect and audit each party's books and records for ten (10) years beyond the termination of this Agreement or until the completion of any governmental audit that pertains to such books and records, whichever is later, unless: (i) HHS determines there is special need to retain a particular record or group of records for a longer period and notifies the party at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by either party, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) HHS determines that there is a reasonable possibility of fraud or similar fault, in which HHS may inspect, evaluate, and audit either party at any time. Without limiting the foregoing, following the commencement of any audit by a government agency, the party subject to the audit shall retain its relevant books and records until completion of said audit. This Section

5.5.4 shall survive termination of this Agreement for the period of time required by state and federal law. Contractor shall provide copies of such records to the auditing agency at Contractor's cost.

5.6 Responsibility for Own Acts.

5.6.1 Each party shall be responsible for its own acts and omissions and shall be liable for payment of that portion of any and all legal claims, liabilities, injuries, suits, and demands and expenses of all kinds that may result or arise out of any alleged malfeasance or neglect caused by said party, its employees, agents or subcontractors. If a claim is made against both parties, each party shall cooperate in the defense and cause its insurers to do likewise. Each party shall, however, retain the right to take any action it believes necessary to protect its own interests.

5.6.2 In regard to state sponsored Benefit Plans, Contractor agrees to indemnify and hold harmless HCA and HCA employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of Contractor, its agents, officers, employees or subcontractors.

5.7 Dispute Resolution.

5.7.1 If a dispute between CHPW and Contractor arises with regard to performance or interpretation of any of the terms of this Agreement, the parties shall first meet informally in good faith to attempt to resolve the dispute. The complaining party shall send written notice to the other party expressly referencing the provisions of this Section 5.7 and the nature of the dispute. The parties shall meet and in good faith work to resolve the dispute.

5.7.2 If the dispute is not resolved informally within thirty (30) days of receipt of such notice, either party may send written notice to the other requesting formal consideration of the disputed matter and describing its position on the disputed matter. The party receiving such request shall review the matter and send a written response that describes its position on the matter and the basis for its position to the requesting party within thirty (30) days of receipt of the request for formal consideration. Where the party receiving the request for formal consideration fails to respond within thirty (30) days of receipt, the requesting party may proceed as if the request has been rejected.

5.7.3 Where a request for informal or formal resolution fails to result in resolution of the dispute, the parties may agree to non-binding mediation conducted under mediation rules of the American Health Lawyers Association or other mutually agreed organization. The mediator's fees shall be born in equal shares by the parties. All other related costs incurred shall be the sole responsibility of the party incurring the cost.

5.7.4 If the parties cannot resolve the matter through non-binding mediation either party may institute an action in any Superior Court of competent jurisdiction in King County, Washington.

VI. TERM OF AGREEMENT AND TERMINATION

6.1 Term. This Agreement shall take effect on the date specified on page one as the Effective Date, and shall remain in force for an initial term of 12 months from the effective date. It shall automatically renew for successive one year terms unless written notice of intent not to renew is given one hundred twenty (120) days prior to the expiration date of any such annual term, or unless otherwise terminated as provided hereunder.

6.2 Termination upon Breach. Either party may terminate this Agreement if (i) it believes the other party has committed a material breach of the Agreement, (ii) it gives the breaching party written notice describing the breach and (iii) such breach is not corrected, or a corrective action plan approved by both parties is not in place, within thirty (30) days following the written notice. Further, this Agreement may be terminated immediately if a party or any of its Directors, Officers, Owners or employees is excluded from participation in a state and federal sponsored health program, is convicted of a crime, or has its license or certification revoked, or fails to accurately complete and timely return the Disclosure of or Change in Ownership and Control Interest form.

6.3 Termination without Cause. Either party may terminate this Agreement without cause upon at least one hundred twenty (120) days advance written notice to the other party given pursuant to Section 7.6 below. CHPW will inform affected Members of such notice and, subject to the requirements of Section 2.4.7 above, may require such Members to select a different Contracted Participating Provider before the effective date of termination.

6.4 Continuing Responsibilities upon Termination. Neither party shall be released from obligations hereunder prior to the effective termination date of the Agreement. Contractor shall cooperate with and assist CHPW in working with affected Members to develop a reasonable transition plan.

VII. MISCELLANEOUS

7.1 Assignment. Contractor may not assign its duties, rights, or obligations under this Agreement without prior written approval of CHPW, which shall not be unreasonably withheld, and, in regard to state sponsored Benefit Plans, the approval of HCA.

7.2 Discrimination. Neither party shall discriminate against any person because of race, color, national origin, ancestry, religion, gender, marital status, age, sexual orientation, presence of physical or mental handicaps, and any other reason(s) prohibited by law, in the provision of Services or in employment practices.

7.3 Washington State Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington irrespective of choice-of-law principles, except to the extent pre-empted by federal law. Venue for any action or proceeding related to this Agreement shall be in King County, Washington.

7.4 Amendments.

7.4.1 This Agreement may be amended by the written agreement of both parties.

7.4.2 CHPW may amend this Agreement on sixty (60) days written notice to Contractor. Contractor's failure to object in writing within sixty (60) days of receipt of such amendment shall constitute Contractor's acceptance thereof. If Contractor gives timely notice that it objects to such amendment, it may terminate the Agreement without penalty pursuant to Section 6.3

7.4.3 CHPW may immediately amend this Agreement as necessary to maintain consistency and/or compliance with any state or federal law, policy, directive or state and federal sponsored Benefit Plan.

7.5 Third Party Beneficiaries. Notwithstanding that benefits arising from this Agreement may inure to a Member or other third party, the parties hereto intend that no third party shall be a Third Party Beneficiary of the obligations assumed by either party to this Agreement and no such person shall have the right to enforce any such obligation.

7.6 Notice.

7.6.1 All notices or other communications, except notice of termination, required or permitted to be given hereunder shall be in writing and deemed to have been delivered to a party upon: (i) personal delivery to that party; (ii) electronically confirmed delivery by facsimile to the telephone number provided by the party for such purposes; (iii) electronic mail transmission to the electronic mailbox provided by the party for such purposes; (iv) upon deposit for overnight delivery with a bonded courier holding itself out to the public as providing such services, with charges prepaid; or (v) four (4) business days following deposit with the United States Postal Service, postage prepaid, and in any case addressed to the party as set forth below, or to another address that the party provides by notice to the other party.

7.6.2 Notice of termination shall be in writing and deemed to have been delivered to a party upon deposit for overnight delivery with a bonded courier holding itself out to the public as providing such services, with charges prepaid and signature receipt required; or deposit with the United States Postal Service, postage prepaid and certified mail or return receipt requested, and in any case addressed to the person set forth below, or to another address that the party provides by notice to the other party.

Community Health Plan of Washington	Kittitas County Public Health Department
Attn: Director, Provider Relations and Contracting 720 Olive Way, Suite 300 Seattle, WA 98101-1830 FAX: (206)613-5018 Email: Llyn.Kawasaki@chpw.org	Attn: Address: FAX: Email:

7.7 Force Majeure. Neither party shall be considered to be in breach hereof if its failure to comply is occasioned by an act of God, local or national emergency, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout or other labor dispute.

7.8. Payment of Federal Funds.

7.8.1 Neither party shall make any specific payment, directly or indirectly, to a physician or physician group as an incentive to reduce or limit Medically Necessary Services furnished to any particular Member. Indirect payments may include offerings of monetary value (*e.g.* stock options or waivers of debt) measured in the present or future.

7.8.2 Each party shall remain in good standing with applicable regulatory agencies and shall comply with applicable federal and state laws and regulations. Each party, in fulfilling its obligations hereunder, acknowledges that it is subject to certain laws that are applicable to individuals and entities receiving federal funds. Each party agrees to inform all related entities, contractors, and subcontractors that payments that they receive are, in whole or in part, from federal funds.

7.9. Construction.

7.9.1 Entire Agreement. This Agreement, with attached exhibits, constitutes the entire agreement between the parties with respect to its subject matter and supersedes any and all previous or contemporaneous agreements and understandings regarding such subject matter.

7.9.2 Construction and Applicability of certain laws and regulations.

7.9.2.1 Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's CHPW benefit plan. In the event of a conflict between this Agreement and

the benefits, terms, and conditions of the Member's benefit plan, the benefits, terms or conditions contained in the Member's CHPW benefit plan shall govern.

7.9.2.2 In addition to the applicable terms of this Agreement, as to the state sponsored products offered by CHPW through its contracts with HCA and listed in Exhibit B, the contract between the HCA and CHPW as well as applicable laws and regulations shall govern construction.

7.9.2.3 In addition to the applicable terms of this Agreement, as to Medicare Advantage Plans listed on Exhibit B, applicable laws and regulations as well as the CMS-CHPW Contract, CMS guidance and instructions shall govern construction.

7.9.2.4 In addition to the applicable terms of this Agreement, as to the Health Benefit Exchange Products listed on Exhibit B, applicable laws and regulations including those from the Washington Health Benefit Exchange, the Health Benefit Exchange Act including the 2012 regular session laws, chapter 87, Affordable Care Act Implementation and regulations adopted pursuant to RCW 43.71and the Washington State Office of the Insurance Commissioner ("OIC") shall govern construction.

7.9.2.5 With regard to this Agreement in general, contacts between CHPW and HCA or CMS shall guide and control interpretation of the terms herein. Ambiguities shall be reasonably construed in accordance with all relevant circumstances and shall not be construed against either party, irrespective of which party is deemed to have authored the ambiguous provision. The captions and headings appearing herein are for reference only and will not be considered in construing this Agreement. As used herein, "including" means "including without limitation". If any provision hereof is held invalid or unenforceable, such provision will be amended to achieve as nearly as possible the same economic and operational effect as the original provision, and the remainder of this Agreement will remain in full force and effect. Waiver by either party of the breach of any provision hereof by the other party will not operate or be construed as a waiver of any subsequent, similar or other breach by the breaching party. The rights of each party granted herein are in addition to any others that a party may be entitled to by law, shall be construed as cumulative, and no such right is exclusive of any others or of any right or priority allowed by law. Whether specifically identified or not, obligations of the parties hereunder, that, by their nature or content would continue beyond the expiration or termination of this Agreement, shall survive such expiration or termination, and the statute of limitations shall not begin to run until the time such obligations have been fulfilled. This Agreement may be executed in any number of counterparts, each of which will be an original and all of which together will constitute one and the same instrument.

Signature Page follows

The undersigned have executed this Agreement as of the date and year written below.

Community Health Plan of Washington 720 Olive Way, Suite 300 Seattle, WA 98101-1866 Phone: 206 613-8833	Kittitas County Public Health Department 507 N Nanum Street Ste 102 Ellensburg, WA 98926 Phone: (509)962-7068
By: _____	By: _____
Print Name: Abie Castillo	Print Name: _____
Title: Vice President Network Development	Title: _____
Date: _____	Date: _____
Effective Date: _____	

EXHIBIT A:
CONTRACTOR LOCATIONS AND CONTRACTED PARTICIPATING PROVIDER ROSTERS

Contractor Name _____ TIN/NPI _____

1. Pursuant to Section 2.2.1 of this Agreement, the following are Contractor locations covered under this Agreement:

Location A: TIN/NPI:
Location B: TIN/NPI:

2. Pursuant to Sections 2.2.1 and 2.3.4 of this Agreement, either complete the following or attach roster inclusive of the information requested below for Contracted Participating Providers at each Contractor Location.
Roster effective Date: _____

Location A: _____
Address: _____
Suite/Building #_____
City: _____ State: _____ Zip: _____
Main Office Phone: _____ Fax: _____

Contracted Participating Provider Name	Specialty	Employee or Subcontractor*	Subcontracted Entity Name**

**Required. For each Contracted Participating Provider listed, indicate status as Employee or Subcontractor*
***If Subcontractor, please provide the name of the entity with which Contractor is subcontracted with.*
Use additional pages to add Rosters for Contracted Participating Providers in additional locations.

3. Whenever there are changes to any information on this Exhibit A, (and if Contractor wishes to provide additional department contact information e.g. medical records, claims, etc) Contractor shall promptly update the form either in writing to CHPW pursuant to Section 7.6 or by entering the information at Provider.Changes@chpw.org.

EXHIBIT B
BENEFIT PLANS

The following are the Benefit Plans offered by Community Health Plan of Washington that may be subject to this Agreement. CHPW may add Benefit Plans or otherwise make changes to this Exhibit B (e.g. termination of a Benefit Plan) by notifying Contractor in writing of such addition(s) or change(s), and Contractor shall not unreasonably withhold its consent to participate in additional Benefit Plan(s) or accept such change(s). If Contractor fails to object in writing within sixty days of its receipt of such notice, Contractor will be deemed to have agreed to inclusion of the additional Benefit Plan(s).The following Benefit Plans are designated as either "Included" or "Not Included" for purposes of this Agreement.

A. Medicaid Plans	Included
Washington Apple Health	
B. Medicare Advantage (MA) Plans	
Community *HealthFirst™ Medicare* Advantage Plans and Community HealthFirst™ Medicare Advantage Prescription Drug Plans.	Included
Community *HealthFirst™* Medicare Advantage Special Needs Plan.	Included
C. CHPW Health Benefit Exchange Products.	Not Included
Individual Product	
Small Group Products	
D. CHPW Commercial Products	Not Included
Individual Product	
Small Group Product	

Effective Date_____

EXHIBIT C
REIMBURSEMENT RATES

1. Rates. Subject to Section 4.3, reimbursement rates for Covered Services billed under Contractor's tax ID numbers for included Benefit Plans shall be the lesser of billed charges or the following and will be less any applicable Cost Sharing Amounts:

A. Washington Apple Health:

100% of HCA's fee schedule.

B. Medicare Plans:

Community *HealthFirst* Medicare Advantage Plans and
Community *HealthFirst*™ Medicare Advantage Prescription Drug Plans;

100% of Medicare Fee Schedule

Community *HealthFirst* Medicare Advantage Special Needs Plan

100% of Medicare Fee Schedule

This Section B reflects the CMS "Medicare Advantage" rates. [1] [2]

CHPW may adjust payments to provider consistent with any adjustment that CMS applies to CHPW as a Medicare Advantage Organization.

C. CHPW Health Benefit Exchange Product:

Individual Product
Small Group Product

N/A% of the Medicare fee schedule.

This Section C reflects CMS "Medicare Advantage" rates. [1] [2]

CHPW Health Benefit Exchange Products rates and compensation described herein shall supersede any other rates or compensation Contractor is eligible to receive for CHPW Health Benefit Exchange Products under Provider Agreements Contractor holds with third parties.

D. CHPW Commercial Products:

Individual Product
Small Group Product

N/A% of the Medicare fee schedule

This Section D reflects CMS "Medicare Advantage" rates. [1] [2]

2. Default Rates. For state-sponsored plans included herein, claims for Covered Services for which there is no HCA payment rate shall be paid according to HCA conversion factors and Medicare RVU's. If no Medicare RVU is available, the payment rate shall be the HCA "By Report" percentage of billed charges.

3. Payment. All payments hereunder shall be made in accordance with the terms of this Agreement, the *Provider Manual,* applicable billing instructions and policy guidelines published and periodically updated by applicable state and federal agencies as set forth in Section 4.1 of the Agreement.

Effective Date_____

Medicare Managed Care GME, IME, and Allied Health payments are paid through the Medicare cost reporting process, and are therefore excluded from these referred payment rates.

[2] Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH) receive a supplemental payment if their inflated and case mix adjusted base-year cost, referred to as their Hospital Specific Rate (HSR) exceed the Medicare Operating MSDRG and Outlier payments under traditional Medicare Part A fee for service. SCH and MDH special payment adjustments are excluded from these referred payment rates.

EXHIBIT D
ACKNOWLEDGEMENT OF REVIEW OF PROVIDER MANUAL

Contractor hereby acknowledges review of CHPW's *Provider Manual* and acknowledges that the *Provider Manual* was made available to Contractor for review prior to Contractor's decision to enter into this Agreement. The *Provider Manual* is available at the CHPW website, www.CHPW.org.

Date of review: _____

Initials of Contractor's authorized representative: _____

Effective Date_____

EXHIBIT E
CONTRACT REPRESENTATIVES AND CONTACT INFORMATION

Kittitas County Public Health Department

Name/Title and Mailing Address:

_____

_____

_____

Attn: _____

FAX:
Email:
Phone:

Community Health Plan of Washington

Community Health Plan of Washington
720 Olive Way, Suite 300
Seattle, WA 98101-1830
Attn: Provider Contracting Department

Provider Contracting Department
FAX: (206)613-5018
Email: Contract.Administrator@chpw.org
Phone: (206)652-7144

Contract Administrator:
Name: Patricia Lorda
Email: patricia.lorda@chpw.org
Phone: (206)652-7183

Effective Date_____

EXHIBIT F

CMS REQUIREMENTS

The Centers for Medicare and Medicaid Services ("CMS") requires that specific terms and conditions be incorporated into agreements between a Medicare Advantage Organization and a First Tier Entity *and between a First Tier Entity and Downstream* Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement or other agreements between Community Health Plan of Washington ("CHPW" or "MA Organization") and Contractor not inconsistent with this Exhibit F shall remain in full force and effect. This Exhibit F shall supersede and replace any inconsistent provisions to such agreements; and, to ensure compliance with required CMS provisions, this Exhibit F shall continue concurrently with the term of such agreements.

Definitions: The following definitions apply to this Exhibit F:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program. Contractor is a First Tier Entity for purposes of this Agreement.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. CHPW is the MA organization for purposes of this Agreement.

Member or Enrollee: for purposes of this Exhibit F is a Medicare Advantage eligible individual who has enrolled in or elected coverage through CHPW.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Contractor agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with CHPW, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. Contractor will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of CHPW. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for

Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Contractor may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Contractor are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Contractor and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]. The prompt payment provision is included in Section IV of the Agreement.

7. Contractor and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. Should the MA organization delegate responsibility for any administrative services to Contractor, such services shall be provided pursuant to a separate Delegated Services Agreement (the "delegation activities"). In such instance:

   (i) The MA organization shall monitor the performance of Contractor on an ongoing basis.

   (ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that Contractor has not performed satisfactorily.

9. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis. If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between: (i) the terms and conditions of this Exhibit F and (ii) the terms of the Agreement or another agreement, the terms of this Exhibit F control.

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- ❖ **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- ❖ Please sign and date pages 11 and 13 .
- ❖ Please document any YES responses on the Attestation Question page.
- ❖ Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.
- ❖ Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. *Please do not use abbreviations*. **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:	City:		
	State:	Zip Code:	
Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail Address:
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number:	☐ Male ☐ Female	Languages Fluently Spoken by Practitioner:	
Have you ever voluntarily opted-out of Medicare? Yes☐ No ☐			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty primarily practicing:	Sub specialties primarily practicing:		

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

Other Professional Interests in Practice, Research, etc.:

3. PRACTICE INFORMATION **CHECK ALL THAT APPLY**

Effective Date at Primary Practice location (MM/YY) _____

Practice Setting

☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile

☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		
Is the office wheelchair accessible? ☐Yes ☐No	Office Hours		
Are you accepting new patients? ☐Yes ☐No Have you limited your practice in any way (e.g. 18 years or older?) ☐Yes ☐No If yes, please explain: _____ _____ Do you currently supervise ARNP's or PA's? ☐Yes ☐No If yes, please provide the name and specialty below: _____ _____ Please list languages fluently spoken by office staff: _____ _____	Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____ Do you provide 24 hour coverage? ☐Yes ☐No If no, please explain how your patients obtain advice and care after hours: _____ _____		

A. Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

Effective Date at Secondary Practice location (MM/YY) _____ **CHECK ALL THAT APPLY**

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile
☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No
Have you limited your practice in any way (e.g. 18 years or older?)
☐Yes ☐No If yes, please explain:

_____

_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No
If yes, please provide the name and specialty below:

_____

_____

Please list languages fluently spoken by office staff:

_____

_____

Office Hours

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday: _____

Do you provide 24 hour coverage? ☐Yes ☐No
If no, please explain how your patients obtain advice and care after hours:

_____

_____

_____

A. Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS
(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

6. UNDERGRADUATE EDUCATION (*Do not abbreviate*) **Does Not Apply** ☐

College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

7. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)

Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

8. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION **Does Not Apply** ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

10. RESIDENCIES (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

11. FELLOWSHIPS (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

12. PRECEPTORSHIP (Attach Additional Sheet if Necessary)			Does Not Apply ☐	
Institution:	Address:	City:	State:	Zip Code:
Telephone Number ( )	Fax Number ( )	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Training:	Department Chairman:		

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary)				Does Not Apply ☐
Institution:	Address:	City:	State:	Zip Code:
Telephone Number ( )	Fax Number ( )	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Position:	Faculty Director:		

14. BOARD CERTIFICATION				Does Not Apply ☐
Are you board or otherwise professionally certified?				
☐ **Yes** If "Yes", please complete below:	☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? ☐ Yes ☐ No If so, list certification and date:				
If you participate in a specialty which does not have board certification, please indicate specialty:				

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, AND OTHER INSTITUTIONAL AFFILITATIONS	Does Not Apply ☐
Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) Current Hospital affiliation, (B) Previous Hospital Affiliations, (C) Current Military Affiliation, (D) Previous Military Affiliations (E) Applications in process This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.	
A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)	
Name of Primary Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐ ☐ **Primary practice admits only** ☐ **Secondary Practice admits only** ☐ **can admit to for all locations**	

Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all locations	
Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all locations	

B....PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

C. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) **Please include Military Reserves**	Division
Name of Primary Base:	City, State , Zip
Mailing Address	Fax Number:

Phone number:	Appointment Date:
Status (active, provisional, courtesy, temporary, etc.):	

D. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)	Division
Name of Primary Base:	City, State , Zip
Mailing Address	Fax Number:
Phone number:	Appointment Date:
Status (active, provisional, courtesy, temporary, etc.):	

E. APPLICATIONS IN PROCESS (*Do not abbreviate*)			
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

17. WORK HISTORY (*Do not abbreviate*)(Do not list if already listed under Hospital Affiliations)					
Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.					
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

18. GAPS IN HISTORY Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

19. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency or fellowship for a period of less then three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	

20. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ /	☐ YES ☐ NO
	/ /	☐ YES ☐ NO

21. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began:	Expiration Date:

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate) (Attach Additional Sheet if Necessary)

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
	c.	Specialty or subspecialty board certification	YES ☐	NO ☐
	d.	Membership on any hospital medical staff	YES ☐	NO ☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO ☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO ☐
	g.	Professional society membership or fellowship	YES ☐	NO ☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO, Health Plan or other entity	YES ☐	NO ☐
	i.	Academic Appointment	YES ☐	NO ☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO ☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO ☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO ☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO ☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO ☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO ☐
	b.	Are you currently under governmental investigation?	YES ☐	NO ☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO ☐
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES ☐	NO ☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO ☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO ☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES ☐	NO ☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO ☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES ☐	NO ☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO ☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature:_____ Date_____

Type or Print name here

22. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Does Not Apply ☐
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**

23. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____
(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

_____

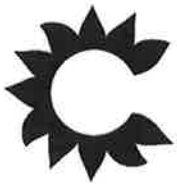
_____

_____

_____

_____

_____



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

Provider Authorization for Collection and Disclosure

In order to evaluate my application for participation with Community Health Plan (CHP), I authorize the Medical Director and/or Credentialing Staff of Community Health Plan to request information regarding my professional credentials and qualifications. This includes consent to contact the Medical Staff Office(s) and/or Chief(s) of Clinical Departments of the hospital(s) in which I have/had staff privileges, professional certification boards, State Regulatory and Licensing Departments, professional liability insurance carriers [including the amount(s) of any settlement(s) and claim(s)], nationally recognized monitoring organizations and employers.

I understand that Community Health Plan will use this information on its own behalf and I release from any liability all representatives of Community Health Plan and any entity providing information to CHP in conjunction with provider credentialing for acts performed in good faith and without malice in connection with evaluating my application and credentials.

I agree to inform CHP in writing within 30 days of any changes in the information provided on this application and during the time of the initial evaluation, as well as any changes thereafter.

I agree that submission of this application does not constitute approval or acceptance by Community Health Plan on its own behalf, and grants me no rights or privileges in any Community Health Plan programs until such time as I have received written notice of my acceptance and effective date of participation.

Provider Signature: _____

(stamped signature is not acceptable)

Provider Name: _____

(printed name)

Date: _____

(Invalid without date) (Invalid after 180 days)

PRACTITIONER NAME: _____

COMMUNITY HEALTH PLAN of Washington™

CHPW PROVIDER OWNERSHIP AND CONTROL INTEREST DISCLOSURE FORM

The federal regulations set forth in 42 CFR §455.100 - §455.106 require providers to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to Managed Care Organizations that contract with a State Medicaid Agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR §455.105 and 3) the identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity. Please attach a separate sheet, if necessary.

Completion and submission of this form is a condition of participation, and full and accurate disclosure of ownership and financial interest is required. A failure to submit the requested information will result in a refusal by Community Health Plan of Washington (CHPW) to enter into an agreement or contract with the individual and/or entity or in the termination of any existing agreements.

Please answer all questions as of the current date. If additional space is needed please use an attached sheet. Federal statutes and regulations clearly prohibit CHPW from paying for items or services furnished, ordered or prescribed by excluded persons. CHPW is required to search the exclusions database not only by the name of an entity seeking to participate in the program, but also by the name of any owner or managing employee.

This form can also be completed online at www.chpw.org/-oac/. This link will also provide you with access to FAQs and instructions.

I. Identifying Information	
OWNER TYPE (check one) *(as shown on your W-9)* ☐ Individual/sole proprietor ☐ Corporation ☐ Partnership ☐ Trust/estate	FEDERAL TAX ID/SSN *(as shown on your W-9)*
ORGANIZATION NAME *(as shown on your W-9)*	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):
BUSINESS NAME – If different from above *(as shown on your W-9)*	CHPW CONTRACT NUMBER

II. Ownership and Control Information

List each individual (e.g. members of the board of directors or officer), organization, corporation, or entity that has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. Attach additional pages as necessary. If there are no individuals or entities with 5% of more ownership/control interest, complete for managing employee(s). *All fields must be completed – please type or print legibly.*

FIRST NAME	MIDDLE NAME	LAST NAME	SSN *(personal, not business TIN)*	DOB
ADDRESS				
FIRST NAME	MIDDLE NAME	LAST NAME	SSN *(personal, not business TIN)*	DOB
ADDRESS				
FIRST NAME	MIDDLE NAME	LAST NAME	SSN *(personal, not business TIN)*	DOB
ADDRESS				

List those persons with ownership or control interest that are related to each other (spouse, parent, child, or sibling)

NAME	RELATIONSHIP	DOB

Does any owner of the disclosing entity also have an ownership or controlling interest of 5% or more in any other entity?

NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE

COMMUNITY HEALTH PLAN of Washington™

III. Subcontractor Information		
List each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Attach additional pages as necessary.		
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
IV. Criminal Offenses		
List each individual (e.g. members of the board of directors or officer) who has ownership or control interest in the disclosing entity or is an agent or managing employee of the disclosing entity, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVIII, XIX, or XX since the inception of those programs. Attach additional pages as necessary.		
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
V. Suspension or Debarment		
Have you, any of your employees, or any individual who has an ownership or controlling interest in the disclosing entity ever been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medicare, Medicaid, or Title XVIII, XIX, or XX services programs? If yes, list each person below. Attach additional pages as necessary. The current lists of excluded individuals can be found at: http://exclusions.oig.hhs.gov/search.aspx and https://www.sam.gov/.		
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or termination of an existing agreement or contract with the Plan/Network. By my signature, I certify that the information provided within is true and correct, and I acknowledge that I fully understand the consequences as explained above.		
PRINT NAME	TITLE OF INDIVIDUAL COMPLETING FORM	
SIGNATURE	DATE	

Submission Information:

Option 1: Secure Online Submission at www.chpw.org/-oac/

Option 2: Fax 206 613-5018, Attn: Provider Relations, Email to PR.Team@chpw.org or **USPS**: Community Health Plan of Washington, C/O Provider Relations, 720 Olive Way, Ste. 300, Seattle, WA 98101

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
Kittitas County Public Health Department

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)

Address (number, street, and apt. or suite no.)
507 N Nanum #102

Requester's name and address (optional)

City, state, and ZIP code
Ellensburg, WA 98926

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 the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number
			–			–				

Employer identification number
9	1	–	6	0	0	1	3	4	9

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 on page 3.

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

General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

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, payments made to you in settlement of payment card and third party network transactions, 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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

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 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, give the requester the appropriate completed Form W-8 or Form 8233.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage 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 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 *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

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

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* on page 3 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

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/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

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 Regulation section 301.7701-2(c)(2)(iii). Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must 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 the "Name" line. 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 the "Business name/disregarded entity name" line. 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.

Note. Check the appropriate box for the U.S. federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the U.S. federal tax classification in the space provided. If you are an LLC that is treated as a partnership for U.S. federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation, as appropriate. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for U.S. federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required U.S. 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/disregarded entity name" line.

Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the *Exemptions* box, any code(s) that may apply to you. See *Exempt payee code* and *Exemption from FATCA reporting code* on page 3.

Exempt payee code. 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. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

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

The following codes identify payees that 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

5—A corporation

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

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, 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—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 possession of the United States, 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 Reg. 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 Reg. 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

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 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, 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 items 1, 4, or 5 below indicate 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 the "Name" line 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), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. 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
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation 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* on page 1.

***Note.** 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, 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.

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 Publication 4535, Identity Theft Prevention and Victim Assistance.

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 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.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (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.