PHYSICIAN REVIEWER APPLICATION

Name	Credentials (MD, DO, MBA, MPH, etc)	SSN#

OFFICE	HOME
Address	Address
Phone	Phone
Fax	Fax
Date available to begin review:	Please give both an office and a home address, but indicate which you prefer as your mailing address for review documents. ☐ **Office** ☐ **Home**
Pager	Assistant's Name
Cell Phone	Assistant's Phone
Email	
IL License #	

Board Certified? ☐ **Yes** List certified specialty(ies) and **sub**specialty(ies):

Board Eligible? (Residency completed) ☐ **Yes** Residency specialty(ies):

Number of hours per week in active clinical practice:	**Do you treat Mediciad recpients?** ☐ **Yes** ☐ **No**

Are you willing to discuss cases with attending physicians? ☐ **Yes** ☐ **No**	Are you willing to participate in criteria development and/or specialty committees? ☐ **Yes** ☐ **No**	Are you willing to participate in quality review panels? ☐ **Yes** ☐ **No**

PLEASE READ THE FOLLOWING CAREFULLY: A physician may not review health care services or make initial denial determinations and determinations regarding the quality of care if he/she is subject to any license restrictions, current sanctions and/or fraud and abuse issues from the Illinois Department of Healthcare and Family Services, Illinois Department of Professional Regulation, Office of the Inspector General, and/or the Center for Medicare and Medicaid Services.

Do any of the above circumstances apply to you? ☐ **Yes** ☐ **No**

If yes, please explain:

I hereby certify that all information provided is accurate and true. I have read and understand the above information and give my permission to eQHealth Solutions to contact any of the above facilities/organizations to verify this information.

Signature: **Date:**

Please INCLUDE COPIES of the following documents to support information given on this application:	**Please also sign, date and attach the following forms included in this packet:**
☐ CV ☐ Illinois Medical License ☐ Board Certifications or residency completions ☐ Hospital Admitting Privileges from at least one facility (form letter included)	☐ Licensure Attestation ☐ Active Practice Attestation ☐ Conflict of Interest ☐ Conflict of Interest Addendum ☐ Contract ☐ Physician Reviewer Job Description ☐ Physician Reviewer Attestation Sheet ☐ Sub-Business Associated Agreement ☐ W-9

Please return this completed form with ALL REQUIRED DOCUMENTATION (refer to checklists directly above). Until all necessary documentation is received, your application cannot be processed.

Mark the envelope "CONFIDENTIAL" and return your information to: eQHealth Solutions NFP
ATTN: Physician Credentialing
2050-10 Finley Road
Lombard, IL 60148

HOSPITAL ADMITTING PRIVILEGE VERIFICATION

Date:	
Physician Name:	
Hospital Name:	
Address:	
Fax:	

Dear Sir or Madam:

eQHealth Solutions conducts utilization review and peer review services for the Illinois Department of Healthcare and Family Services. As part of our credentialing and recredentialing procedure, eQHealth Solutions requires verification of admitting privileges for contract physicians. We are requesting your assistance at this time in this verification process. Please check below to indicate whether the following physician(s) have admitting privileges at the above named facility.

Please complete and fax back to **(630) 317-5202**, Attn: Angela Perry, Medical Director. Your prompt assistance is appreciated.

Admitting Privileges ☐ **YES** ☐ **NO** **Comments:**_____

Facility Representative

Name_____

Title_____

Signature_____

Date_____

Sincerely,
Tobia Barbato, MD
Medical Director
eQHealth Solutions NFP

CONFLICT OF INTEREST ATTESTATION STATEMENT

No physician and/or Consultant shall review any case in which he or she has a conflict of interest. A conflict of interest is defined as:

1. Any case in which the Physician Reviewer and/or Consultant rendered medical care, either directly or indirectly.
2. Any case from a facility, physician, and/or patient with whom the Physician Reviewer and/or Consultant has a financial interest.
3. Any case in which the Physician Reviewer and/or Consultant requests refusal of review because objectivity may be at risk for personal or professional reasons.

Federal C.F.R. § 476.98- Persons excluded from review:

1. A person may not review health care services if he or she, or is perceived to have, a conflict of interest such as:

    - Participation in developing or executing the beneficiary's treatment plan;
    - Is a member of the beneficiary family; or
    - Is a governing body member, office, partner, five percent or more owner, or managing employee in the health care facility where the services were/are to be furnished,

    or

    - Any license restrictions, current sanctions and/or fraud and abuse issues form the Illinois Department of Department of Healthcare and Family Services, Office of the Inspector General, Illinois Department of Professional Regulations, or the Center for Medicare and Medicaid Services.

I understand and will abide by the above protections against a conflict of interest affecting the peer review process.

SIGNATURE_____

PRINT NAME_____

DATE_____

NOTE: PLEASE COMPLETE THE ATTACHED ADDENDUM

CONFLICT OF INTEREST ATTESTATION ADDENDUM

Please provide the following information regarding potential conflicts of interest related to your responsibilities and job duties with eQHealth Solutions- Illinois Division.

Please list below the entities with which you have the following types of relationships:

- A health care business association
- Employment with a healthcare facility or provider, claims payment organization or health plan (full or part time)
- Admitting privileges at additional hospitals or health care facilities
- A business partner relationship
- A monetary (financial) interest in a business
- Any associations or relationship which could be perceived as a potential conflict of interest

Name	**Address** **City, State, Zip**

☐ I affirm that the above is current and accurate and I will notify my supervisor and Human Resources when any changes occur.

_____ _____

Physician Reviewer Date

☐ **N/A:** I have no employment, associations or relationships that might be perceived as a potential conflict of interest. I understand that should that change it is my responsibility to immediately notify eQHealth Solutions.

_____ _____

Physician Reviewer Date

CHANGE IN PROFESSIONAL LICENSURE STATUS ATTESTATION

As a licensed physician conducting utilization review activities for eQHealth Solutions $_{NFP}$, I understand it is my obligation to immediately report to eQHealth Solution Medical Director any change in the status of my professional licensure. I understand that changes in licensure status may be grounds for disciplinary action.

SIGNATURE _____

PRINTED NAME_____

DATE_____

ACTIVE PRACTICE ATTESTATION

As a licensed physician conducting utilization review activities for eQHealth Solutions $_{NFP}$, I understand that it is my obligation to report immediately to eQHealth Solutions Medical Director any change in active practice status. Active practice means a minimum of 20 hours per week. I understand that active practice status of less than 20 hours will make me ineligible to conduct reviews on behalf of eQHealth Solutions.

SIGNATURE _____

PRINTED NAME_____

DATE_____

PHYSICIAN REVIEWER ATTESTATION

In order for eQHealth Solutions NFP to adhere to company standards for Physician Reviewer credentialing, I hereby give permission to eQHealth Solutions to verify required information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by eQHealth Solutions including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a photocopy of this document with my signature may be accepted by any entity from which such information is sought, with the same authority as the original, and I specifically waive written notice from any such entities or individuals which may provide information based upon this authorized request.

I represent that information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by eQHealth Solutions. I agree to inform eQHealth Solutions immediately if there is any change in the information provided on the application as a result of developments subsequent to my signing this application.

SIGNATURE _____

PRINTED NAME_____

DATE_____

PHYSICIAN REVIEWER CONTRACT

This Contractor Agreement (Agreement) is entered into this _____, 20___, by and between eQHealth Solutions, Inc. (eQHealth), 2050-10 S. Finley Rd. Lombard, Illinois 60148, and _____, Physician Reviewer, in consideration of the mutual promises made herein, as follows:

Services to be Rendered by Contractor

Contractor agrees to perform all tasks and jobs assigned by eQHealth. The Physician Reviewer agrees to review the medical data submitted to them by eQHealth Solutions and to prepare and/or provide eQHealth Solutions, in legible written or electronic form, the details qualifying the conclusion and results of all review determination. The Physician Reviewer shall, where possible, make a determination of medical necessity, quality of care, appropriateness of treatment, and/or appropriate level of care as defined by the Illinois Department of Healthcare and Family Services (HFS), using his/her best medical judgment.

Eligibility Requirements

The Physician Reviewer certifies that he/she meets the requirements as outlined below:

1. Must be licensed in Illinois.
2. Must be a doctor of medicine, osteopathy, dentistry, or another individual who is authorized under Federal and State law to practice medicine, surgery, osteopathy, or dentistry.
3. In active practice in the Illinois. Active practice is defined as usually practices a minimum of 20 hours per week.
4. Board certified or board eligible in their specialty
5. Staff privileges in at least one (1) health care facility (e.g., hospital) in Illinois. Active staff privileges means that a physician is authorized on a regular basis to order an admission, perform diagnostic services or care for and treat patients in a facility.

Compensation

In consideration of the services to be performed by the Contractor, eQHealth agrees to pay the Contractor at the rate of $85.00 per hour, payable in monthly installments and based upon an invoice submitted by the Contractor. These invoices will be submitted for approval to the Project Director.

Obligations of eQHealth Solutions

eQHealth agrees to meet the terms of all reasonable requests of the Contractor necessary to the performance of the Contractor's duties under this Agreement.

eQHealth agrees to furnish space on its premises for use by the Contractor while performing the above-described services as necessary.

Termination of Agreement

Notwithstanding any other provisions of this Agreement, either party hereto may terminate this Agreement at any time.

Confidentiality

The Contractor shall use the same means as he uses to protect his own confidential proprietary information, but in no event less than reasonable means, to keep any Confidential information confidential and shall not, without the prior written consent of eQHealth, disclose or permit disclosure of any Confidential information in any manner whatsoever, in whole or part. The Contractor shall not use Confidential information for any purpose other than assisting eQHealth. The Contractor further agrees not to make any copies of written or electronic documentation or storage of Confidential information except as may be necessary to assist eQHealth in the execution of this Agreement.

As used in this Agreement, "Confidential Information" means all the information regarding the business and affairs of eQHealth furnished to the Contractor, or his representatives, by eQHealth or generated by the Contractor as a result of services provided under this Agreement, for the purpose of assisting eQHealth for all purposes. Confidential information shall exclude any information which rightfully and lawfully (i) becomes available to the Contractor from a source, other than eQHealth, that

is not under a confidentiality obligation to eQHealth, (ii) was known to the Contractor prior to its disclosure to the Contractor by eQHealth, through no breach of a confidentiality obligation to the Contractor, (iii) is required to be disclosed by the Contractor or eQHealth under operation of law, provided that the Contractor shall immediately notify eQHealth of the requirement for such disclosure, (iv) is a "work product" which is generated or developed independently by the Contractor separate from this project, or (v) is or becomes generally available to the public other than as a result of a disclosure by the
Contractor or his representatives in violation of this Agreement. As used in this Agreement, "representatives" shall mean any and all directors, officers, employees, agents or representatives, including without limitation, attorneys, accountants, consultants and financial advisors.

The Contractor agrees, in the event that he is not involved in the pursuit of a transaction or at any time at the request of eQHealth, the Contractor will immediately destroy, or at eQHealth's request return to eQHealth, the Confidential information and all copies thereof that may be in his possession or under his control.

eQHealth and the Contractor agree that any disclosure or use of Confidential information in violation of this Agreement would result in irreparable damage to eQHealth for which no adequate remedy would be available in law. Therefore, eQHealth and the Contractor agree that eQHealth shall be entitled to equitable relief, including injunctive relief and specific performance, in the event of any breach of the provisions of this Agreement. However, the Contractor does not waive any defenses he may have regarding whether or not the terms of this Agreement have been violated and both parties will have an opportunity to present their respective claims and defenses to an appropriate court of law.

Notices

Any notices to be given hereunder by either party to the other may be effected either by personal delivery or by mail, registered or certified, postage prepaid with return receipt requested. Mailed notices shall be addressed to the parties at the addresses appearing in the introductory paragraph of this Agreement, but each party may change that address by written notice in accordance with this paragraph. Notices delivered personally shall be deemed communicated as of the date of actual receipt; mailed noticed shall be deemed communicated as of three (3) days after the date of mailing.

Entire Agreement

This Agreement supersedes any and all other agreements, either oral or in writing, between the parties hereto with respect to the performance of services by the Contractor for eQHealth, and contains all of the covenants and agreements between the parties with respect to the rendering of such services in any manner whatsoever. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any parties, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Any modification of this Agreement will be effective only if it is in writing signed by the party to the charged.

Partial Invalidity

If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois.

Ava L. Muckerheide, Project Director eQHealth Solutions, Inc.	Physician Reviewer
Date	Date

JOB DESCRIPTION

Position: Physician Reviewer (PR)
Reports to: Project Director

Qualifications and Requirements:

- Must have a current Illinois unrestricted license to practice medicine in all its branches.
- Must be board certified or board eligible by a specialty board approved by the American Board of Medical Specialties (MD's); or the Advisory Board of Osteopathic Medicine.
- Must be in active practice (minimum of 20 hours per week), and have admitting privileges to one or more Illinois healthcare facility.
- Must be in good standing with the Department of Healthcare and Family Services (HFS) and with the Office of the Inspector General (OIG).
- Must have strong verbal and written communication skills.
- Required to maintain professional behavior in dealing with colleagues and nurse staff.
- Maintain CME credits for proper credentialing process of license.
- Actively participate in quality improvement activities.
- Assure availability during scheduled time.
- Be able to apply sound medical judgment during the review process.

I have read and understand the above job description.

SIGNATURE _____

PRINTED NAME_____

DATE_____

SUB BUSINESS ASSOCIATE AGREEMENT

This Sub Business Associate Agreement is made and entered into on this _____ day of _____, 20__ by and between eQHealth Solutions (hereinafter referred to as "Business Associate") and _____ (hereinafter referred to as "Sub Business Associate").

BACKGROUND

WHEREAS, the Business Associate has been engaged by the Illinois Department of Health care and Family Services (the "Program") to provide certain services as described herein on behalf of the Program;

WHEREAS, the Program may disclose or require health care providers to disclose Protected Health Information as defined by the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Rule") for the performance of these services on behalf of the Program;

WHEREAS, the Business Associate has entered into a business agreement with the Program whereby the Business Associate has agreed to require any agent, such as Sub Business Associate, to whom it provides Protected Health Information received from or on behalf of the Program, to agree to the same restrictions and conditions that apply to the Business Associate through a business associate agreement between the Business Associate and the Program;

WHEREAS, the Business Associate and Sub Business Associate desire to enter into an agreement that defines the obligations of the two parties with respect to the Protected Health Information provided to the Sub Business Associate to provide the services described herein;

THEREFORE, in consideration of the foregoing, the Parties agree to the following:

1. Definitions. The following terms shall have the meanings noted below for purposes of this Business Associate Agreement:

(a) Individual. "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

(b) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, and is limited to the information created or received by the Sub Business Associate from or on behalf of the Business Associate.

(c) Required By Law. "Required By Law" means a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court

of law. Examples of "required by law" includes, but is not limited to, court orders and court-ordered warranties; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information.

(d) Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

2. Obligations of the Sub Business Associate. The Sub Business Associate agrees to the following:

(a) Sub Business Associate agrees to not use or disclose Protected Health Information received from, or on behalf of, the Business Associate other than to perform the services described in this Agreement or as Required By Law.

(b) Sub Business Associate agrees to use appropriate safeguards to prevent any use or disclosure of Protected Health Information received from or on behalf of Business Associate other than to perform the services described in this Agreement.

(c) Sub Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Sub Business Associate of a use or disclosure of Protected Health Information by Sub Business Associate in violation of the requirements of this Agreement or the HIPAA Privacy Rule.

(d) Sub Business Associate agrees to report to the Business Associate any use or disclosure of Protected Health Information not provided for by this Agreement of which the Sub Business Associate becomes aware.

(e) Sub Business Associate agrees to provide the Business Associate access at any time to Protected Health Information to enable the Business Associate to comply with the requirements of the HIPAA Privacy Rule that provide an individual with the right to access their Protected Health Information provided in 45 C.F.R. § 164.524.

(f) Sub Business Associate agrees to include any amendment(s) to Protected Health Information provided by the Business Associate to comply with the requirements of the HIPAA Privacy Rule that provide an individual with the right to request an amendment to their Protected Health Information provided in 45 CFR § 164.526.

(g) Sub Business Associate agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by the Sub Business Associate on behalf of, the Business Associate available to the Business Associate, or to the Secretary or designated by the Secretary, for purposes of the Secretary determining the Business Associate's compliance with any business associate agreement between the Business Associate and other persons or entities.

(h) Sub Business Associate agrees to make available to Business Associate in response a request from an individual, information required for an accounting of disclosures of Protected Health

Information in accordance with 45 C.F.R. § 164.528. Sub Business Associate shall provide such information necessary to provide an accounting within thirty (30) days of the Business Associate's request.

3. Permitted Uses and Disclosures by Sub Business Associate.

(a) Except as otherwise provided in this Agreement, the Sub Business Associate may use or disclose Protected Health Information received on behalf of the Business Associate to perform health care utilization review and quality review, as well as any other consultation or project which requires the presentation of protected health information from the Business Associate to the Sub Business Associate.

(b) Except as otherwise limited in this Business Associate Agreement, Sub Business Associate may use Protected Health Information for the proper management and administration of the Sub Business Associate or to carry out the legal responsibilities of the Sub Business Associate.

4. Provisions for Business Associate to Inform the Sub Business Associate of Privacy Practices and Restrictions. The Business Associate shall make the following notifications to the Sub Business Associate, if applicable:

(a) Business Associate shall notify the Sub Business Associate of any restriction or limitation(s) that may affect the use or disclosure of Protected Health Information by the Sub Business Associate.

(b) Business Associate shall notify Sub Business Associate of any changes in, or revocation of, permission by any Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Sub Business Associate's use or disclosure of Protected Health Information.

5. Term and Termination

(a) Term. The Term of this Agreement shall be effective as of _____, and shall remain in effect until terminated in accordance with the terms of this Agreement.

(b) Termination Without Cause. The Business Associate may terminate this Agreement for any reason upon thirty (30) days written notice of such failure to the Sub Business Associate.

(c) Termination for Breach. The Business Associate, at its sole discretion, may immediately terminate this Agreement and shall have no further obligations to the Sub Business Associate hereunder if any of the following events shall have occurred:

(1) Sub Business Associate shall fail to observe or perform any material covenant or agreement contained in this Agreement for ten (10) days after written notice has been given to the Sub Business Associate by the Business Associate; or

(2) A violation by the Sub Business Associate of any provision of the HIPAA Privacy Rule or any other state or federal law.

(c) Effect of Termination.

Upon termination of this Agreement, for any reason, Sub Business Associate shall return or destroy all Protected Health Information received from the Business Associate, or created or received by Sub Business Associate on behalf of the Business Associate. The Business Associate shall not retain any copies of Protected Health Information received from the Business Associate, or created or received by Sub Business Associate on behalf of the Business Associate.

8. Miscellaneous.

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Privacy Rule means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-19 1. The Parties further agree that this Agreement may only be amended upon written consent by both Parties.

(c) Survival. The respective rights and obligations of Business Associate under this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved to permit the parties to comply with the HIPAA Privacy Rule.

(e) Indemnification. Sub Business Associate will indemnify, defend and hold Business Associate and its officers, directors, employees, agents, successors and assigns harmless, from and against any and all losses, liabilities, damages, costs and expenses (including reasonable attorney's fees) arising out of or related to any third-party claim based upon any breach of this Agreement by Sub Business Associate .

(The remainder of this page has been intentionally left blank.)

IN WITNESS WHEREOF, the parties have executed this Sub Business Associate Agreement on the date first set above.

Sub Business Associate

By: _____
Title: _____
Date: _____

Business Associate

By: _____
Title: _____
Date: _____

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/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) ▶

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on 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
__ - _____

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

Cat. No. 10231X Form **W-9** (Rev. 12-2011)