



and subsidiaries

Dental Provider Practice Application

How to Join the Avesis Network....

- Complete and sign the application
- Complete and sign the W-9
- Complete and sign the Credential Verification Release
- Complete and sign the Attestation

Mail Completed form to:

Avesis
Attn: Dental Credentialing
10324 S. Dolfield Road
Owings Mills, MD 21117

Include:

- Copy of current State License
- Copy of DEA and/or CDS Certificate, if applicable
- Certificate of Professional Liability Insurance

| Practice Information | | | | | | |
|---|---------|---|---|--|---|---|
| Is Practice (Check One): <input type="checkbox"/> Solo <input type="checkbox"/> Partnership <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Other | | | | | | |
| Type of Practice: <input type="checkbox"/> General Dentist <input type="checkbox"/> Specialty: <input type="checkbox"/> Endo <input type="checkbox"/> Perio <input type="checkbox"/> Prosth <input type="checkbox"/> Pedo <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Ortho | | | | | | |
| Avesis Program(s): <input type="checkbox"/> Commercial <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Other: | | | | | | |
| Provider's Name: | | | | | | |
| Corporation's Name (if applicable): | | | | | | |
| TIN: | | | NPI-2 (if applicable): | | | |
| Practice Name: | | | | | | |
| Mailing Address: | | | | | | |
| Billing Address: | | | | | | <input type="checkbox"/> Check here if multiple billing addresses (Please list on separate page) |
| Please indicate address where to send signed Provider Agreement and Welcome packet: <input type="checkbox"/> Mailing Address <input type="checkbox"/> Billing Address <input type="checkbox"/> Primary Office Address <input type="checkbox"/> Other: | | | | | | |
| Business Contact: | | | | | Phone: () | |
| Practice Manager: | | | | | Phone: () | |
| Primary Office Location | | | | | | |
| Please provide information for only those locations to participate with Avesis. | | | | | | |
| Complete Address (Street, City, State, Zip): | | | | | | |
| Office Manager: | | | Phone: () | | Fax: () | |
| Hours of Operation | | | | | | |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Staff Information | | | | | | |
| Name of Provider(s) at this Location, INCLUDING THE APPLICANT. Please provide Medicaid numbers for each provider, as applicable: | | | | | | |
| 1. _____ | | 2. _____ | | 3. _____ | | 4. _____ |
| Please complete if different from above Practice Information | | | | | | |
| Billing Address for this Location: | | | | | | |
| TIN for this Location (if different, please submit additional W-9): | | | | | | |
| Patient Relation Services | | | | | | |
| Languages Spoken by Provider: | | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> French | <input type="checkbox"/> Other: | |
| Languages Spoken by Staff: | | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> French | <input type="checkbox"/> Other: | |
| Accepts Patients with Developmental Disabilities: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | TTY Available: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Signing Available: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Handicap Accessible Office (ADA Compliant): <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Handicap Parking Available: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Provider or Staff CPR certified: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Age of Patients: From To | | |
| Patient Procedure Services | | | | | | |
| Nitrous Oxide: <input type="checkbox"/> Yes <input type="checkbox"/> No | | IV Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Panoramic X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| General Anesthesia: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Oral Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Intraoral X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Electronic Claims Submission: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Digital Radiograph Submission: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Web Access: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Sterilization Method: <input type="checkbox"/> Autoclave <input type="checkbox"/> Chemiclave <input type="checkbox"/> Other: | | | | | | |

| | | | | | | |
|--|---------|---|--|---|---|----------|
| Office Location Number 2 Please provide information for only those locations to participate with Avesis. | | | | | | |
| Complete Address (Street, City, State, Zip): | | | | | | |
| Office Manager: | | | Phone: () | | Fax: () | |
| Hours of Operation | | | | | | |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Staff Information | | | | | | |
| Name of Provider(s) at this Location, INCLUDING THE APPLICANT. Please provide Medicaid numbers for each provider, as applicable: | | | | | | |
| 1. _____ | | 2. _____ | | 3. _____ | | 4. _____ |
| Please complete if different from above Practice Information | | | | | | |
| Billing Address for this Location: | | | | | | |
| TIN for this Location (if different, please submit additional W-9): | | | | | | |
| Patient Relation Services | | | | | | |
| Languages Spoken by Provider: | | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> French | <input type="checkbox"/> Other: | |
| Languages Spoken by Staff: | | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> French | <input type="checkbox"/> Other: | |
| Accepts Patients with Developmental Disabilities: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | TTY Available: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Signing Available: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Handicap Accessible Office (ADA Compliant): <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Handicap Parking Available: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Provider or Staff CPR certified: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Age of Patients: From _____ To _____ | | | |
| Patient Procedure Services | | | | | | |
| Nitrous Oxide: <input type="checkbox"/> Yes <input type="checkbox"/> No | | IV Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Panoramic X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| General Anesthesia: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Oral Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Intraoral X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Electronic Claims Submission: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Digital Radiograph Submission: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Web Access: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Sterilization Method: <input type="checkbox"/> Autoclave <input type="checkbox"/> Chemiclave <input type="checkbox"/> Other: | | | | | | |

| | | | | | | |
|--|---------|--|-------------------------------------|---------------------------------|--|--------------------|
| Office Location Number 3 Please provide information for only those locations to participate with Avesis. | | | | | | |
| Complete Address (Street, City, State, Zip): | | | | | | |
| Office Manager: | | | Phone: () | | Fax: () | |
| Hours of Operation | | | | | | |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Staff Information | | | | | | |
| Name of Provider(s) at this Location, INCLUDING THE APPLICANT. Please provide Medicaid numbers for each provider, as applicable: | | | | | | |
| 1. _____ | | 2. _____ | | 3. _____ | | 4. _____ |
| Please complete if different from above Practice Information | | | | | | |
| Billing Address for this Location: | | | | | | |
| TIN for this Location (if different, please submit additional W-9): | | | | | | |
| Patient Relation Services | | | | | | |
| Languages Spoken by Provider: | | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> French | <input type="checkbox"/> Other: | |
| Languages Spoken by Staff: | | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> French | <input type="checkbox"/> Other: | |
| Accepts Patients with Developmental Disabilities: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | TTY Available: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Signing Available: |
| Handicap Accessible Office (ADA Compliant): | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicap Parking Available: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Provider or Staff CPR certified: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Age of Patients: | | From | To |
| Patient Procedure Services | | | | | | |
| Nitrous Oxide: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | IV Sedation: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Panoramic X-Ray: |
| General Anesthesia: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Oral Sedation: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Intraoral X-Ray: |
| Electronic Claims Submission: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Digital Radiograph Submission: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Web Access: |
| Sterilization Method: | | <input type="checkbox"/> Autoclave | <input type="checkbox"/> Chemiclave | <input type="checkbox"/> Other: | | |

Please complete and attach all documents. Missing information will delay processing.

| Provider Information | | | |
|---|---------------------|--------------------------------|---|
| Provider's Name: | | | Suffix (Jr., Sr., etc.): |
| Maiden/Other Name(s) (if applicable): | | <input type="checkbox"/> Owner | <input type="checkbox"/> Assoc. <input type="checkbox"/> Employee |
| SSN: - - | TIN (if different): | DOB (MM/DD/YY): / / | <input type="checkbox"/> Male |
| Medicaid Number (if applicable): | | NPI-1: | <input type="checkbox"/> Female |
| Medicare Number (if applicable): | | E-mail: | |
| Do you submit claims under your TIN or the Practice: <input type="checkbox"/> TIN <input type="checkbox"/> Practice <input type="checkbox"/> NA | | | |

| Professional Training | | |
|---|--|--------------------|
| Professional School: | | |
| Degree: | Year Graduated: | Years in Practice: |
| If trained outside of the United States, check here and attach copy of ECFMG <input type="checkbox"/> | | |
| Residency Program (if applicable): | From: | To: |
| Advanced Training (if applicable): | From: | To: |
| Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable | Board Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable | |
| Name and Address of Board: | | |

| Licensing Information | | | | |
|---|---------|-----------------|------------------|---|
| State Licenses: Please attach copies of current license(s) and certificate(s) | State: | License Number: | Effective Date: | Expiration Date: |
| | State: | License Number: | Effective Date: | Expiration Date: |
| | State: | License Number: | Effective Date: | Expiration Date: |
| DEA Certificate | Number: | Effective Date: | Expiration Date: | <input type="checkbox"/> Not Applicable |
| Controlled Substance Certificate (CDS) | Number: | Effective Date: | Expiration Date: | <input type="checkbox"/> Not Applicable |
| General Anesthesia Permit | Number: | Effective Date: | Expiration Date: | <input type="checkbox"/> Not Applicable |
| CPR Certificate | Number: | Effective Date: | Expiration Date: | <input type="checkbox"/> Not Applicable |

| | | | |
|---|--------|---------------------|--|
| Hospital Privileges If not applicable, check here <input type="checkbox"/> | | | |
| Hospital Name: | | Address: | |
| City: | State: | Zip: | |
| Phone Number: | | Contact Name: | |
| Date Privileges Granted: | | Type of Privileges: | |

For additional hospitals, please copy, complete and submit with this application.

| | |
|---|--|
| Professional Liability Insurance Information Please attach a copy of your Insurance Declaration page or Certificate of Insurance. | |
| Professional Liability Insurance Carrier: | Policy #: |
| Limits of Coverage: Individual: | Aggregate: |
| Effective Date (MM/DD/YY): | Expiration Date (MM/DD/YY): |
| American Dental Association Member: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you accept patients with AIDS, HIV+, Hepatitis B carrier, etc. in accordance with requirements of the American Dental Association and professionally recognized standards? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| Work History In lieu of completing the section below, you may attach a resume or Curriculum Vitae. | | | | |
|---|----------|---------|-------|--|
| Has your work history changed in the past five years? If yes, provide information below. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Please include CURRENT EMPLOYMENT. Explain any gaps of six (6) months or more on a separate piece of paper. | | | | |
| Dates (Month/Year) | Employer | Address | Phone | Can Employer be Contacted? |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| Professional Questions and Attestation | |
|--|--|
| 1. In the last five (5) years, have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES," please explain the reason(s) for any gap(s) on a separate page. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, ever been denied, limited, suspended, revoked, not renewed; or have you ever been placed under probation, subjected to disciplinary action or have you voluntarily relinquished any license in anticipation of any actions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have any of your DEA or State Drug Certificate registrations ever been denied, suspended, canceled or subjected to any disciplinary action? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Has your status as a provider, or membership with any professional organization, ever been denied, suspended, disciplined, canceled, sanctioned; or are you currently under investigation by any municipal, state, federal or any other governmental agency, HMO, PPO or other prepaid health plan? (e.g. Medicare, Medicaid). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Are your privileges or memberships at any hospital or institution (Military service) currently under investigation or have they ever been denied, suspended, reduced, disciplined, or not renewed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you currently, or did you in the last two years, engage in the unlawful use of drugs, including the improper use of prescription drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you have any felony or misdemeanor charges pending against you, other than traffic violations, or have you ever been convicted or pleaded "nolo contendere" to a felony? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have you been involved, within the last ten (10) years, or are you currently involved in ANY claims/lawsuits, settlements, or judgments (other than divorce or custody)? If yes, please provide detailed information on a separate sheet of paper including: docket number of the case, location of the court, the names of the plaintiff(s) and defendant(s), description and date(s) of the incident(s), your involvement, current disposition, and the amount of settlement, if any. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Are you currently practicing WITHOUT, or with an EXPIRED, Professional Liability/Malpractice Insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Do you monitor your Dental Hygienist's license to verify it is current? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered "yes" to any of the above questions, please explain, in detail, on an additional page. | |
| <p>I understand that acceptance of my application for participation in the Avesis Dental Network may require Avesis or its designee to review information listed above. I hereby authorize the release of such information to Avesis and its authorized designee. I further understand that all information provided in this document will be held in confidence by Avesis, to the extent permitted by law. I agree that Avesis and its agents shall not be liable for any action or omission related to the evaluation or verification of information provided in this document. I further agree to notify Avesis within thirty (30) days of any change to the information requested herein. I understand that submission of this application does not constitute approval or acceptance as an Avesis participating dentist.</p> <p>I hereby acknowledge that I have read, and understood each of the questions contained herein and that I certify that the responses I have provided herein are accurate, complete and the truth, to the best of my knowledge and belief.</p> | |
| Dentist's Name (Print): | |
| Signature: | Date: |

Patients often express preferences for providers of a particular ethnic background or gender. Your completion of the information below will allow us to meet these patients' needs when a referral is requested. If you VOLUNTEER to provide this information it will be used only when a patient indicates that such information is important in selecting a provider and it will be held in the strictest confidence.

- Ethnic Background:
- | | |
|---|---|
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> American Indian/Alaska Native American |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Other |

Credentials Verification Release



| |
|---------------|
| Provider Name |
|---------------|

I, the undersigned provider, acknowledge and agree that Avesis Incorporated and its subsidiaries have a valid interest in obtaining and verifying information concerning my professional competence for the sole purpose of evaluating my credentials and qualifications as a provider. Avesis agrees to keep this information confidential and may use such confidential information only in the furtherance of the purposes and obligations of the Provider Agreement. Accordingly,

1. I represent and warrant to Avesis that the information contained herein is true and complete, to the best of my knowledge and belief.
2. I authorize Avesis or its authorized agents to consult with previous employers, members of medical or other professional staffs, malpractice carriers, hospital administrators and other persons to obtain and verify my credentials and qualifications as a provider. I release Avesis and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and evaluating my application.
3. I consent to the release by any person to Avesis or its authorized agents all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical stature. This information is to include any information relating to any disciplinary action; suspension or curtailment of surgical/medical privileges; and/or any malpractice actions. I hereby release any such person providing such information from any and all liability for doing so.
4. I agree to immediately notify Avesis upon any investigation, revocation, reduction, termination, denial, limitation or suspension of my professional license, professional liability insurance, participation in Medicare or Medicaid Programs or other certification programs, DEA certification or other credentialing programs authorizing me to practice dentistry. I also agree to notify Avesis upon termination, suspension or revocation of my staff privileges at any hospital or health care facility. I understand that the NPDB will be reviewed.
5. I agree to inform Avesis promptly if any material change in the information submitted herein occurs whether before or after entering into an Agreement with Avesis for the provision of professional services.

| | |
|--------------|------|
| Signature | Date |
| Printed Name | |
| Address | |
| Phone | |

A photocopy of this consent shall be as effective as the original when so presented.

Request for Taxpayer Identification Number and Certification

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

Print or type
 See Specific Instructions on page 2.

| | |
|--|---|
| Name (as shown on your income tax return) | |
| Business name, if different from above | |
| Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶ | |
| Address (number, street, and apt. or suite no.) | Requester's name and address (optional) |
| City, state, and ZIP code | |
| List account number(s) here (optional) | |

Part I Taxpayer Identification Number (TIN)

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

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

| |
|--------------------------------|
| Social security number |
| or |
| Employer identification number |

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here

Signature of
 U.S. person ▶

Date ▶

General Instructions

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

Purpose of Form

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

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

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

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

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

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

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

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

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

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

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

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

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

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

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

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

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

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

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

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

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

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

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

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

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

Other entities. Enter your business name as shown on required federal tax documents on the “Name” line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the “Business name” line.

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

Exempt Payee

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

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

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

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

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

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

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

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

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

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

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

What Name and Number To Give the Requester

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

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

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

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

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

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

Protect yourself from suspicious emails or phishing schemes.

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

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

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

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

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.