McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

PROVIDER INFORMATION FORM

Please complete this form to ensure accurate provider directory and payment information.
If needed, copy this form for additional sites.

Group Name (or Name of Practice): _____ **Fed Tax:** _____

Hospital Affiliation(s): _____

Contact Name: _____

Email Address: _____ **How many physicians within practice?** _____

Service Location(s):

PRIMARY ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

SECONDARY ADDRESS (if applicable)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

Please list additional service locations submitted on a separate sheet.

Billing Location:

ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

Is Payment Location the same as Billing ☐ **Yes** ☐ **No** **If No, Please list Payment Address:**

ADDRESS	SUITE	CITY	STATE	ZIP- 9 DIGIT
				-

E-Prescribing: ☐ **Yes** ☐ **No**
Patient Portal: ☐ **Yes** ☐ **No**
Certified Patient Centered Medical Home (PCMH): ☐ **Yes** ☐ **No**

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Please complete one form for each provider within the practice. INDIVIDUAL AND GROUP NPI IS REQUIRED FOR ALL PROVIDERS. IF THE PROVIDER DOES NOT USE A GROUP NPI, PLEASE SIGNIFY WITH N/A.

Provider Information:

Last Name			
First Name			
Title		**Type - Circle One**	Primary Care ☐ Specialist ☐
CAQH #		**Specialty**	
Individual NPI #		**Group NPI #**	
Alt. Language(s)		**State License #**	
American Sign Language	☐ Yes ☐ No		
Race - Circle One	American Indian or Alaskan Native ☐ Asian ☐ White ☐ Other ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐		
Ethnicity - Circle One	Hispanic or Latino ☐ Not Hispanic or Latino ☐	**Champs Enrolled?**	☐ **Yes** ☐ **No**

Meaningful Use Participation

Please check the appropriate box if you have received incentive payments from Medicare or Medicaid.

Medicare	Stage 1 ☐	Stage 2 ☐	Stage 3 ☐
Medicaid	Stage 1 ☐	Stage 2 ☐	Stage 3 ☐

Completed Cultural Competency? (CLAS) Attestation Required	☐ Yes ☐ No
Children's Special Health Provider? Attestation Required	☐ Yes ☐ No
Does Provider practice at each location?	

PHO PHYSICIAN AFFILIATION ACKNOWLEDGMENT
BETWEEN
MCLAREN HEALTH PLAN, INC., MCLAREN HEALTH PLAN COMMUNITY, INC. AND HEALTH ADVANTAGE, INC.
AND
OAKWOOD ACCOUNTABLE CARE ORGANIZATION, LLC

PHYSICIAN AFFILIATION ACKNOWLEDGEMENT

This PHO Physician Affiliation Acknowledgment ("**Acknowledgement**") is effective _____ (date assigned by Plan), by and among McLaren Health Plan, Inc., a non-profit health maintenance organization (**"HMO"**), for and on behalf of itself and its subsidiaries, Health Advantage, Inc., a Michigan for-profit corporation and third party administrator and McLaren Health Plan Community, a non-profit corporation and HMO, (each a **"Plan"** and collectively the **"Plans"**) and **OAKWOOD ACCOUNTABLE CARE ORGANIZATION, LLC**, a Physician Hospital Organization (**"PHO")** and _____ (**"Provider"**), who is a member of the PHO.

Recitals

A. The Plans and PHO entered into a Physician Hospital Agreement (**"Agreement"**); and

B. Provider desires to participate in the Agreement and be bound by the terms of the Agreement and this Acknowledgment.

The parties agree as follows:

1. GENERAL PROVISIONS

1.1 Agreement. Provider acknowledges that Provider has received a copy of the Agreement and Provider agrees to be bound by the terms of it. As a condition to Provider's Participating Provider status, Provider agrees that PHO has authority to execute participation agreements and other participation-related contracts, amendments and other documents with the Plans on Provider's behalf. Provider agrees to be bound by any such agreement, amendment or other document.

1.2 Member Hold-Harmless. Provider shall only look to a Plan for compensation for services rendered to a Member when the services are covered by the Plan. Provider shall not bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member (other than the Plan), except if the applicable Certificate of Coverage specifies a Copayment, Coinsurance or Deductible must be collected by Provider or as permitted under the coordination of benefits section of this Agreement. Provider shall not maintain any action at law or in equity against a Member to collect sums that are owed to Provider under the terms of this Agreement, even if the Plan fails to pay, under the terms of the Agreement, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This section will survive termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. The Parties do not intend this section to apply to the collection of sums that are owed to Provider for services provided after this Agreement has terminated,

except as otherwise provided in this Agreement, or to services that are not Covered Services or to Copayments, Deductibles or Coinsurance. Provider further agrees that this provision supersedes any oral or written agreement entered into between Provider and any Member or person acting on a Member's behalf, if the agreement relates to payment for services provided under the terms and conditions of this Agreement.

1.3 Compliance with Laws, Regulations and Instructions. Provider agrees that he/she will comply with all applicable laws, regulations and instructions including, without limitation, Medicare laws and CMS instructions. [42 CFR Sections 422.504(i)(4)(v)]

1.4 Obligations of Recipients of Federal Funds. Provider acknowledges that payments to Provider pursuant to this Acknowledgment are made, in whole or in part, from federal funds and that this Acknowledgment is subject to all laws applicable to entities and individuals receiving federal funds. Provider shall comply with all requirements of laws applicable to recipients of federal funds, including the False Claims Act (32 USC 3729, et. seq.), the Anti-Kickback Statue (section 1128B(b)) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

1.5 Adverse Actions.

A. No Adverse Actions or Investigations. Provider asserts that, to the best of his/her knowledge, information and belief, there are no pending investigations, legal actions, or matters subject to arbitration involving Provider, employees, contractors, board members, or any major shareholders (5% or more) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.

B. No Criminal Convictions or Civil Judgments. Provider asserts that, to the best of his/her knowledge, information and belief, neither Provider nor any of its employees, contractors, board members, or any major shareholder (5% or more) has been criminally convicted or had a civil judgment entered against it for fraudulent activities, nor has Provider been sanctioned under any Federal program involving the provision of health care or prescription drug services.

C. No Excluded Or Debarred Individuals. Provider asserts that, to the best of his/her knowledge, information and belief, neither Provider nor any employees, contractors, board members, or any major shareholders (5% or more) appears on the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General, nor on the List of Debarred Contractors as published by the General Services Administration. The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be accessed online at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp. The System for Award Management can be found at http://sam.gov/.

D. Notice of Change of Circumstances. Provider is obligated to notify the Plans promptly of any change in circumstances occurring after the effective date of this Acknowledgment which would require a modified response to paragraphs A – C above.

E. Audit Compliance. The Plans reserve the right to audit Provider for compliance and/or to request verification that employees, contractors, board members, and major shareholders

have been checked against the List of Excluded Individual/Entities and the List of Debarred Contractors on at least an annual basis.

1.6 Certification of Accuracy of Data. If Provider generates data to determine payment on behalf of the Plans, then Provider must certify (based on best knowledge, information and belief) as to the accuracy, completeness, and truthfulness of the data.

1.7 Automatic Incorporation of MDHHS or CMS Requirements. Provider agrees to incorporate into this Acknowledgment such other terms and conditions as MDHHS or CMS may find necessary and appropriate, including amendments to MDHHS or CMS rules, regulations and guidance. Provider also agrees to incorporate into its downstream contracts all terms and conditions contained in this Acknowledgment and the Agreement.

1.8 Notification Requirements. Provider shall promptly provide written notice to the Plans of any changes in address, telephone number, and hours of operation.

1.9 Amendments. This Acknowledgment may be amended by the Plans in accordance with the terms of the Agreement.

1.10 Product Specific Requirements. If Provider participates in a Product, Provider shall comply with the requirements attached to the Agreement that are specific to the Product. Specifically, for Exchange products, Provider shall comply with the Exchange Regulatory Requirements Addendum. For Medicaid products (including Healthy Michigan), Provider shall comply with the Medicaid Regulatory Requirements in the Medicaid Requirements Addendum. For Medicare Advantage products, Provider shall comply with the Medicare Regulatory Requirements in the Medicare Requirements Addendum.

OAKWOOD ACCOUNTABLE CARE ORGANIZATION, LLC
Provider

_____
Provider Signature

_____ _____
Provider Name (Print or Type)

_____ _____
Date Provider Address

Provider agrees to participate in the following Plan Products:
[X] 1. Commercial and self-funded products.
[X] 2. Medicaid/MIChild (including Healthy Michigan) products.
[X] 3. Medicare Advantage products.

Execution of the PHO Physician Affiliation Acknowledgement by use of facsimile or electronically scanned signature will have the same force and effect as original signatures.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*