

Thank you for your interest in joining Chiropractic Management Services (CMS). One of the many benefits of becoming a CMS provider is acquiring access to multiple statewide networks under one contract with CMS. Enclosed please find documents pertaining to CMS policies and procedures.

Should you desire to pursue membership in the CMS Provider Network please forward to the CMS Office the following listed information, as well as the CMS Provider Application for each Doctor within your practice at your convenience.

- Application fee of \$200.00 per doctor
- W-9 Form
- Copies of your State Chiropractic License
- Declaration page of Malpractice Insurance
- Malpractice and Claims History
- Letter of authorization for release of information
- CPR Certification Card
- Chiropractic College Diploma
- Most recent CV
- Three sets of complete patient notes for current patients, including health history, exams, intake data, and radiology reports. (These will be shredded after the review)
- One 3 view Cervical Series x-ray and one 2 view Lumbar Series X-ray. These x-rays do not have to be from the same patients that you are sending notes on. (The x-rays will be returned to you after the review)

Upon receipt and validation of the above information, the monthly assembled CMS Credentialing Committee will review all the applicant documents. The practice will further be contacted to arrange an on-site visit subsequent to the approval of the application. The Credentialing Committee recommendation and the on-site visit assessment will also need to be evaluated by the Executive Board of CMS.

Should you have any questions, please feel free to call me at 262-513-9999.

Sincerely,



Dianna Badipour  
Executive Director

CHIROPRACTOR \_\_\_\_\_

CLINIC \_\_\_\_\_

***CHIROPRACTIC MANAGEMENT SERVICES INC  
(CMS)***

***MEMBERSHIP APPLICATION***



**NATURE OF PRACTICE**

SOLE PROPRIETORSHIP \_\_\_\_\_ PROFESSIONAL CORPORATION \_\_\_\_\_ PARTNERSHIP \_\_\_\_\_ LLC \_\_\_\_\_

OFFICE SHARING ARRANGEMENT \_\_\_\_\_ OTHER: \_\_\_\_\_

**Please list below the names of any partners or associates at your location**

NAME OF PARTNER/ASSOC. CLINIC NAME LICENSE #

CLINIC COMPLETE ADDRESS AND PHONE NUMBER

NAME OF PARTNER/ASSOC. CLINIC NAME LICENSE #

CLINIC COMPLETE ADDRESS AND PHONE NUMBER

*NOTE: Please list any additional associates/partners on a separate sheet of paper (include License #).*

**Please list below the names of any covering colleagues not at your location**

NAME OF COLLEAGUE CLINIC NAME & ADDRESS & PHONE # LICENSE #

NAME OF COLLEAGUE CLINIC NAME & ADDRESS & PHONE # LICENSE #

DO YOU ACCEPT ASSIGNMENT ON MEDICARE? YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU ACCEPT MEDICAID? YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU ACCEPT NEW MEDICARE PATIENTS? YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU ACCEPT NEW MEDICAID PATIENTS? YES \_\_\_\_\_ NO \_\_\_\_\_

MEDICARE PROVIDER #: \_\_\_\_\_

MEDICAID PROVIDER #: \_\_\_\_\_

DEA CERTIFICATE #: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER: \_\_\_\_\_ Clinic NPI Number: \_\_\_\_\_

YEARS IN PRACTICE AT CURRENT LOCATION: \_\_\_\_\_ TOTAL YEARS IN PRACTICE: \_\_\_\_\_

**NOTE: Copies of current State license, DEA Certificate (if applicable), CPR Certification & Chiropractic College Diploma must be attached to application.**

**CERTIFICATIONS**

DO YOU HOLD ANY OF THE FOLLOWING CERTIFICATIONS? IF YES, PLEASE PROVIDE EXPIRATION DATES.

BASIC LIFE SUPPORT (BLS) YES \_\_\_\_\_ NO \_\_\_\_\_ CERTIFICATION DATE (MM/DD/YYYY) \_\_\_\_\_

ADVANCED CARDIAC LIFE SUPPORT (ACLS) YES \_\_\_\_\_ NO \_\_\_\_\_ CERTIFICATION DATE (MM/DD/YYYY) \_\_\_\_\_

CPR-CARDIO PULMONARY RESUSCITATION YES \_\_\_\_\_ NO \_\_\_\_\_ CERTIFICATION DATE (MM/DD/YYYY) \_\_\_\_\_

**PLEASE ATTACH COPIES OF CERTIFICATION/DOCUMENTATION (CARDS/CERTIFICATES ETC...)**

**EDUCATION / TRAINING / LICENSE(APPLICANT)**

CHIROPRACTIC COLLEGE \_\_\_\_\_ ADDRESS \_\_\_\_\_ DEGREE \_\_\_\_\_ START & FINISH DATES \_\_\_\_\_  
(Month & Year)  
DID YOU COMPLETE YOUR PROFESSIONAL EDUCATION AT THIS SCHOOL? YES \_\_\_\_\_ NO \_\_\_\_\_  
LICENSE # \_\_\_\_\_ STATE: \_\_\_\_\_ YEAR OBTAINED: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_

FOREIGN LANGUAGES SPOKEN: \_\_\_\_\_

**UNDERGRADUATE EDUCATION (APPLICANT)**

COLLEGE \_\_\_\_\_ ADDRESS (REQUIRED) \_\_\_\_\_ DEGREE \_\_\_\_\_ START & FINISH DATES \_\_\_\_\_  
(Month & Year)  
DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? YES \_\_\_\_\_ NO \_\_\_\_\_  
(If no, please attach a separate listing of other institutions, dates attended and degrees obtained.)

FOREIGN LANGUAGES SPOKEN: \_\_\_\_\_

**ADDITIONAL FORMAL TRAINING, such as Preceptorships, etc.:(APPLICANT)**

INSTITUTION/CLINIC NAME \_\_\_\_\_ STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTY \_\_\_\_\_  
( ) \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_ PROGRAM DIRECTOR/SUPERVISOR \_\_\_\_\_

**SECONDARY SPECIALTY**

DO YOU HAVE A SECONDARY SPECIALTY? YES \_\_\_\_\_ NO \_\_\_\_\_

TYPE OF SECONDARY SPECIALTY? \_\_\_\_\_

WHERE DID YOU TRAIN OR BECOME CERTIFIED FOR THIS SECONDARY SPECIALTY?  
(NAME OF INSTITUTION/ADDRESS/CITY/STATE/ZIP/COUNTRY)

\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL SPECIALTY**

DO YOU HAVE ANY ADDITIONAL SPECIALTIES? YES \_\_\_\_\_ NO \_\_\_\_\_

TYPE OF ADDITIONAL SPECIALTY? \_\_\_\_\_

WHERE DID YOU TRAIN OR BECOME CERTIFIED FOR THIS ADDITIONAL SPECIALTY?  
(NAME OF INSTITUTION/ADDRESS/CITY/STATE/ZIP/COUNTRY)

\_\_\_\_\_  
\_\_\_\_\_

.....

**PROFESSIONAL REFERENCES (REQUIRED)**

PLEASE PROVIDE THREE (3) PROFESSIONAL REFERENCES THAT ARE NOT COLLEAGUES IN YOUR OWN GROUP PRACTICE AND ARE NOT RELATIVES.

|                                    |            |                  |
|------------------------------------|------------|------------------|
| NAME (LAST, FIRST, MIDDLE INITIAL) |            | PROVIDER TYPE    |
| ADDRESS                            | CITY       | STATE & ZIP CODE |
| ( )                                | ( )        |                  |
| PHONE NUMBER                       | FAX NUMBER | COUNTRY          |

|                                    |            |                  |
|------------------------------------|------------|------------------|
| NAME (LAST, FIRST, MIDDLE INITIAL) |            | PROVIDER TYPE    |
| ADDRESS                            | CITY       | STATE & ZIP CODE |
| ( )                                | ( )        |                  |
| PHONE NUMBER                       | FAX NUMBER | COUNTRY          |

|                                    |            |                  |
|------------------------------------|------------|------------------|
| NAME (LAST, FIRST, MIDDLE INITIAL) |            | PROVIDER TYPE    |
| ADDRESS                            | CITY       | STATE & ZIP CODE |
| ( )                                | ( )        |                  |
| PHONE NUMBER                       | FAX NUMBER | COUNTRY          |

**WORK HISTORY**

PLEASE LIST ALL PREVIOUS LOCATIONS WITHIN THE LAST 10 YEARS (INCLUDE DATES AT EACH LOCATION):

|                      |                 |
|----------------------|-----------------|
| PREVIOUS CLINIC NAME | DATES TO & FROM |
|----------------------|-----------------|

FULL CLINIC ADDRESS AND PHONE NUMBER

|                      |                 |
|----------------------|-----------------|
| PREVIOUS CLINIC NAME | DATES TO & FROM |
|----------------------|-----------------|

FULL CLINIC ADDRESS AND PHONE NUMBER

|                      |                 |
|----------------------|-----------------|
| PREVIOUS CLINIC NAME | DATES TO & FROM |
|----------------------|-----------------|

FULL CLINIC ADDRESS AND PHONE NUMBER

*NOTE: Use a separate sheet of paper for any additional locations.*

PLEASE EXPLAIN ANY GAPS IN WORK HISTORY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**GENERAL DESCRIPTION OF CLINIC / OFFICE OPERATIONS (PRIMARY PRACTICE)**

OFFICE MANAGER(full name) \_\_\_\_\_

CLAIMS PROCESSING/INSURANCE SUPERVISOR (full name) \_\_\_\_\_

EMPLOYEE / TITLE \_\_\_\_\_

EMPLOYEE / TITLE \_\_\_\_\_

DESIGNATED PHONE NUMBER FOR BILLING/INSURANCE DEPT. (IF AVAILABLE): \_\_\_\_\_

OFFICE HOURS: MONDAY \_\_\_\_\_ to \_\_\_\_\_ TUESDAY \_\_\_\_\_ to \_\_\_\_\_

WEDNESDAY \_\_\_\_\_ to \_\_\_\_\_ THURSDAY \_\_\_\_\_ to \_\_\_\_\_

FRIDAY \_\_\_\_\_ to \_\_\_\_\_ SATURDAY \_\_\_\_\_ to \_\_\_\_\_

PLEASE DESCRIBE EMERGENCY/AFTER HOURS PROCEDURES, LIMITATIONS & PHONE: \_\_\_\_\_

OFFICE STRUCTURE: OWN: \_\_\_\_\_ LEASE: \_\_\_\_\_ SIZE IN SQ FT: \_\_\_\_\_

# OF EXAM ROOMS: \_\_\_\_\_ # OF TREATMENT ROOMS: \_\_\_\_\_ # OF CHAIRS IN WAITING ROOM: \_\_\_\_\_

AVERAGE PATIENT WAITING TIME FOR TREATMENT FROM TIME OF REQUEST: DAYS: \_\_\_\_\_ HOURS: \_\_\_\_\_

NUMBER OF PATIENTS SEEN PER DAY: ESTABLISHED \_\_\_\_\_ NEW \_\_\_\_\_ AVERAGE PATIENT WAITING TIME IN LOBBY: \_\_\_\_\_

HOW MANY PATIENTS ARE TREATED PER CHIROPRACTIC HOUR?: WHAT RATIO BEST DESCRIBES YOUR PRACTICE?

1-2 \_\_\_\_\_ 3-5 \_\_\_\_\_ 6-8 \_\_\_\_\_ 9-12 \_\_\_\_\_ 12+ \_\_\_\_\_

APPROXIMATELY WHAT PERCENT OF YOUR PATIENTS COMPLETE THEIR TREATMENT IN:

1-5 VISITS \_\_\_\_\_% 6-10 VISITS \_\_\_\_\_% 11-18 VISITS \_\_\_\_\_% 18+ VISITS: \_\_\_\_\_%

IS YOUR OFFICE LOCATION HANDICAP ACCESSIBLE? YES NO

**DOES YOUR OFFICE HAVE ANY OF THE FOLLOWING COMMUNICATIONS AVAILABLE?**

TELETYPEWRITER (TTY) FOR THE HEARING IMPAIRED: YES NO SIGN LANGUAGE: YES NO

DO YOU DISPLAY HIPAA POLICIES AND PROCEDURES IN YOUR WAITING ROOM AND TREATMENT ROOMS? YES NO

DO YOU CONSIDER YOUR OFFICE TO BE HIPAA COMPLIANT OVERALL? YES NO

**INDICATE ALL TECHNIQUES USED IN YOUR PRACTICE:**

MANUAL MANIPULATION: \_\_\_\_\_ ACTIVATOR: \_\_\_\_\_ GONSTEAD: \_\_\_\_\_ TOFTNESS: \_\_\_\_\_

SACRO OCCIPITAL TECHNIQUE: \_\_\_\_\_ ACTIVATOR/MANUAL MANIPULATION: \_\_\_\_\_

NON-FORCE DIRECTIONAL MANIPULATION: \_\_\_\_\_ SIDE-POSTURE UPPER CERVICAL: \_\_\_\_\_

OTHER: \_\_\_\_\_

**GENERAL DESCRIPTION OF CLINIC / OFFICE OPERATIONS - ADDITIONAL PRACTICE/LOCATION**  
**(IF APPLICABLE)**

OFFICE MANAGER(full name) \_\_\_\_\_ CLAIMS PROCESSING/INSURANCE SUPERVISOR (full name) \_\_\_\_\_

EMPLOYEE / TITLE \_\_\_\_\_ EMPLOYEE / TITLE \_\_\_\_\_

DESIGNATED PHONE NUMBER FOR BILLING/INSURANCE DEPT. (IF AVAILABLE): \_\_\_\_\_

OFFICE HOURS: MONDAY \_\_\_\_\_ to \_\_\_\_\_ TUESDAY \_\_\_\_\_ to \_\_\_\_\_  
WEDNESDAY \_\_\_\_\_ to \_\_\_\_\_ THURSDAY \_\_\_\_\_ to \_\_\_\_\_  
FRIDAY \_\_\_\_\_ to \_\_\_\_\_ SATURDAY \_\_\_\_\_ to \_\_\_\_\_

PLEASE DESCRIBE EMERGENCY/AFTER HOURS PROCEDURES, LIMITATIONS & PHONE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OFFICE STRUCTURE: OWN: \_\_\_\_\_ LEASE: \_\_\_\_\_ SIZE IN SQ FT: \_\_\_\_\_  
# OF EXAM ROOMS: \_\_\_\_\_ # OF TREATMENT ROOMS: \_\_\_\_\_ # OF CHAIRS IN WAITING ROOM: \_\_\_\_\_

AVERAGE PATIENT WAITING TIME FOR TREATMENT FROM TIME OF REQUEST: DAYS: \_\_\_\_\_ HOURS: \_\_\_\_\_

NUMBER OF PATIENTS SEEN PER DAY: ESTABLISHED \_\_\_\_\_ NEW \_\_\_\_\_ AVERAGE PATIENT WAITING TIME IN LOBBY: \_\_\_\_\_

HOW MANY PATIENTS ARE TREATED PER CHIROPRACTIC HOUR?: WHAT RATIO BEST DESCRIBES YOUR PRACTICE?

1-2 \_\_\_\_\_ 3-5 \_\_\_\_\_ 6-8 \_\_\_\_\_ 9-12 \_\_\_\_\_ 12+ \_\_\_\_\_

APPROXIMATELY WHAT PERCENT OF YOUR PATIENTS COMPLETE THEIR TREATMENT IN:

1-5 VISITS \_\_\_\_\_% 6-10 VISITS \_\_\_\_\_% 11-18 VISITS \_\_\_\_\_% 18+ VISITS: \_\_\_\_\_%

IS YOUR OFFICE LOCATION HANDICAP ACCESSIBLE? YES NO

**DOES YOUR OFFICE HAVE ANY OF THE FOLLOWING COMMUNICATIONS AVAILABLE?**

TELETYPEWRITER (TTY) FOR THE HEARING IMPAIRED: YES NO SIGN LANGUAGE: YES NO

DO YOU DISPLAY HIPAA POLICIES AND PROCEDURES IN YOUR WAITING ROOM AND TREATMENT ROOMS? YES NO

DO YOU CONSIDER YOUR OFFICE TO BE HIPAA COMPLIANT OVERALL? YES NO

**INDICATE ALL TECHNIQUES USED IN YOUR PRACTICE:**

MANUAL MANIPULATION: \_\_\_\_\_ ACTIVATOR: \_\_\_\_\_ GONSTEAD: \_\_\_\_\_ TOFTNESS: \_\_\_\_\_

SACRO OCCIPITAL TECHNIQUE: \_\_\_\_\_ ACTIVATOR/MANUAL MANIPULATION: \_\_\_\_\_

NON-FORCE DIRECTIONAL MANIPULATION: \_\_\_\_\_ SIDE-POSTURE UPPER CERVICAL: \_\_\_\_\_

OTHER: \_\_\_\_\_



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PLEASE DESCRIBE ALL THERAPY EQUIPMENT USED IN YOUR OFFICE

PLEASE LIST ALL TREATMENT TABLES USED IN YOUR OFFICE

|              |     |
|--------------|-----|
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |

|              |     |
|--------------|-----|
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |
| TYPE / BRAND | AGE |

PLEASE DESCRIBE ALL DIAGNOSTIC EQUIPMENT USED IN YOUR OFFICE:

|              |       |     |
|--------------|-------|-----|
| TYPE / BRAND | POWER | AGE |
| TYPE / BRAND | POWER | AGE |
| TYPE / BRAND | POWER | AGE |
| TYPE / BRAND | POWER | AGE |

DO YOU PERFORM X-RAYS ON SITE? Yes \_\_\_\_\_ No \_\_\_\_\_

If "NO" is checked, please indicate where you send patients for x-rays \_\_\_\_\_

NAME OTHERS QUALIFIED TO OPERATE X-RAY EQUIPMENT: \_\_\_\_\_

PLEASE LIST HMOs, PPO's, & IPA's THAT YOU CURRENTLY BELONG TO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MALPRACTICE INSURANCE**

MALPRACTICE CARRIER ADDRESS CITY STATE ZIP

\*POLICY NUMBER \*\*AMOUNT OF COVERAGE ORIGINAL START DATE OF POLICY EXP. DATE

\* Copy of declaration page of malpractice insurance policy must be attached to application.

\*\* Minimum coverage requirement of \$1,000,000/\$3,000,000.

PLEASE LIST ALL PREVIOUS MALPRACTICE CARRIERS WHO HAVE PROVIDED MALPRACTICE COVERAGE FOR YOU WITHIN THE LAST 10 YEARS (INCLUDE ADDRESS AND COVERAGE DURATION, ATTACH ADDITIONAL SHEET IF NECESSARY)

PREVIOUS MALPRACTICE CARRIER NAME & ADDRESS DATES TO AND FROM

PREVIOUS MALPRACTICE CARRIER NAME & ADDRESS DATES TO AND FROM

PREVIOUS MALPRACTICE CARRIER NAME & ADDRESS DATES TO AND FROM

PREVIOUS MALPRACTICE CARRIER NAME & ADDRESS DATES TO AND FROM

=====

PLEASE EXPLAIN ANY MALPRACTICE SUIT(S) YOU HAVE BEEN INVOLVED IN AND/OR PROVIDE ANY ATTACHMENT(S) INVOLVING THE SUIT: (IF APPLICABLE)

DATE OF OCCURRENCE (MM/DD/YYYY): \_\_\_\_\_ DATE CLAIM FILED (MM/DD/YYYY): \_\_\_\_\_

CLAIM SETTLEMENT DATE, IF APPLICABLE (MM/DD/YYYY): \_\_\_\_\_ CLAIM STATUS: (IF PENDING PUT OPEN) \_\_\_\_\_

INSURANCE CARRIER NAME, ADDRESS: \_\_\_\_\_ ( ) \_\_\_\_\_ PHONE

POLICY NUMBER: \_\_\_\_\_

SETTLEMENT AMOUNT: \_\_\_\_\_ RESOLUTION METHOD: \_\_\_\_\_

DESCRIPTION OF ALLEGATIONS: \_\_\_\_\_

WERE YOU THE PRIMARY DEFENDANT? YES NO NUMBER OF CO-DEFENDANTS: \_\_\_\_\_

YOUR INVOLVEMENT IN THE CASE: \_\_\_\_\_

DESCRIPTION OF ALLEGED INJURY TO PATIENT: \_\_\_\_\_

DID THE ALLEGED INJURY RESULT IN DEATH? YES NO

TO THE BEST OF YOUR KNOWLEDGE,  
IS THIS CASE INCLUDED IN THE FEDERATION OF THE CHIROPRACTIC LICENSING BOARD (FCLB)? YES NO

**The following questions must be completed in full. If your answer is yes to any of the following questions, please provide us with a detailed, written explanation on a separate sheet of paper.**

1. Has your chiropractic license ever been limited, suspended or revoked? Yes\_\_\_ No\_\_\_
2. Have you ever been subject to disciplinary action by the Wisconsin Dept. of Regulation and Licensure or the Chiropractic Examining Board, or any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or other health professionals? Yes\_\_\_ No\_\_\_
3. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare, Medicaid or other third party payment programs? Yes\_\_\_ No\_\_\_
4. Have you ever been convicted of, or plead guilty or no contest to, a misdemeanor, or any crime or municipal violation, involving dishonesty, assault or sexual misconduct or abuse, or abuse of controlled substances or alcohol, or are charges pending against you for any such crimes by information, indictment or otherwise? Yes\_\_\_ No\_\_\_
5. Have you ever been convicted of, plead guilty to, or plead no contest to any felony? Yes\_\_\_ No\_\_\_
6. In the past ten years have you been convicted of, plead guilty to, or pled no contest to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? Yes\_\_\_ No\_\_\_
7. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined formally reprimanded, suspended or asked to resign? Yes\_\_\_ No\_\_\_
8. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? Yes\_\_\_ No\_\_\_
9. Have any of your board certifications or eligibility ever been revoked? Yes\_\_\_ No\_\_\_
10. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? Yes\_\_\_ No\_\_\_
11. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal, state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? Yes\_\_\_ No\_\_\_
12. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? Yes\_\_\_ No\_\_\_
13. Have you ever had any professional liability insurance coverage voluntarily or involuntarily canceled, declined or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused or have you voluntarily given up coverage? Yes\_\_\_ No\_\_\_
14. Have you ever been involved in a malpractice litigation? Yes\_\_\_ No\_\_\_
15. Have you ever had any judgments made against you in a professional liability case? Yes\_\_\_ No\_\_\_

16. Have you ever had any settlements made on your behalf in a professional liability case? Yes\_\_\_ No\_\_\_
17. In the past 7 years, up to and including the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? Yes\_\_\_ No\_\_\_
18. Have you ever been denied membership in any professional organization or chiropractic network, or have you ever had your membership in any such organizations revoked, suspended, or not renewed? Yes\_\_\_ No\_\_\_
19. In the past 7 years, up to and including the present, have you had a history of any physical or mental health problems that would interfere with your ability to provide high quality professional services? Yes\_\_\_ No\_\_\_
20. If you have ever been employed as a chiropractor by a military service, an HMO or any other health care organization, was your employment ever terminated by the employer? Yes\_\_\_ No\_\_\_
21. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? Yes\_\_\_ No\_\_\_
22. Have you ever been convicted of, plead guilty to, plead no contest to, sanctioned, reprimanded, restricted disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? Yes\_\_\_ No\_\_\_
23. Have you ever been the object of an administrative, civil, or criminal complaint or investigation regarding sexual harassment or other illegal misconduct? Yes\_\_\_ No\_\_\_
24. Have there ever been, or are there currently, any professional or work-related claims, settlements or judgments against you, you & your employer and/or other third party, even if not resulting in monetary damages, or have you received any notice of "Intent to File" or a "request for mediation"? Yes\_\_\_ No\_\_\_
25. Will practicing to the fullest extent of your licensure, qualifications, and privileges, with or without reasonable accommodation, in any way pose a risk of harm to your patients? Yes\_\_\_ No\_\_\_

By applying for membership to Chiropractic Management Services (CMS), I hereby give my consent for CMS to inspect all records and documents that may be material to a complete evaluation of my professional qualifications and competence, including patient records, and information requested from others regarding my professional credentials and qualifications. I also give my consent to CMS to contact professional certification boards, State Regulatory, and Licensing Departments and professional liability insurance carriers, as appropriate.

I also release from all liability the representatives of CMS for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications.

I also release from all liability all individuals and organizations who provide information to the representative of CMS in good faith and without malice concerning my professional competence, ethics, character and other qualifications in evaluating my application.

I also understand that submission of this application is in no way an acceptance as a CMS Provider and in no way implies or guarantees membership and privileges provided by CMS.

I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

**I understand and agree that the application will not be processed until the application is deemed complete by CMS. It is my responsibility to provide a "complete" application.** Once the application is considered complete I understand I will receive written notification of whether my application has been approved or denied by the credentialing committee.

I also understand that I have the right to obtain information about the status of my credentialing application at any time by contacting the provider relations department at CMS. I further understand that I have a right to review the information that is submitted to support my credentialing application with the exclusion of references, recommendations or other peer-review protected information. This request must be made in writing to the Provider Relations department and I will receive written correspondence in response to my request within 30 days of my request. I have the right to correct any erroneous information in writing within 30 days from the date of decision by the credentialing committee.

I fully understand and certify that all information included in this application is complete, accurate, and true. I understand and agree that any misrepresentation, misstatement, or omissions may constitute grounds for exclusion or expulsion from the CMS Chiropractic Panel whether or not they are discovered before or after membership privileges or network participation has been awarded to me, may lead to suspension or termination of that membership and/or participation in the CMS network.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF CHIROPRACTOR

*I also understand that this application will not be accepted as complete unless the attachments listed below are included:*

- 1) Application Fee of \$200.00
- 2) A current copy of my Chiropractic License from the State of Wisconsin Board of Examiners.  
**(with expiration date on it)**
- 3) A current copy of my DEA Certificate (if applicable).
- 4) A current copy of the declaration page of my malpractice insurance.
- 5) A copy of my Chiropractic College Diploma.
- 6) A copy of my current CPR Certification.
- 7) A copy of my curriculum vitae
- 8) A copy of Patient Office Notes (these will be destroyed after review)
- 9) A Set of Patient X-Rays
- 10) Banking Information
- 11) W-9 Form
- 12) Any attachments as deemed necessary.

**CHIROPRACTIC MANAGEMENT SERVICES, LLC (CMS)**

**REQUEST FOR CERTIFICATE OF INSURANCE and CLAIMS HISTORY INFORMATION  
As a Certificate Holder**

**TO:**

\_\_\_\_\_  
**Name of Insurance Company**

\_\_\_\_\_  
**Address**

**City**

**State**

**Zip**

**RE:**

\_\_\_\_\_  
**Name of Insured**

**Policy Number**

\_\_\_\_\_  
**Office Address**

**City**

**State**

**Zip**

I, the above named insured, authorize and request the above named insurance company to provide to CMS, at the address below, a certificate of insurance verifying my professional liability insurance coverage and including my policy number, expiration date, and coverage limits, as well as my medical malpractice claims history report for no less than the last (5) years. With this, I authorize CMS to be listed as a certificate holder.

\_\_\_\_\_  
**Signature of insured**

\_\_\_\_\_  
**Date**

**CMS, LLC  
19435 W. Capitol Drive  
Suite 103  
Brookfield, WI 53045  
Fax: 262-547-4472**

**Note: This letter must forwarded to CMS LLC and your Insurance carrier simultaneously**

## Request for Taxpayer Identification Number and Certification

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

|   |  |   |
|---|--|---|
| Print or type<br>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:<br><input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate<br><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____<br><input type="checkbox"/> Other (see instructions) ▶ _____ |   |
|   | <input type="checkbox"/> 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.

| Social security number |  |  |  |  |  |  |  |  |
|------------------------|--|--|--|--|--|--|--|--|
|                        |  |  |  |  |  |  |  |  |

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

| 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.

|                  |                                  |              |
|------------------|----------------------------------|--------------|
| <b>Sign Here</b> | 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 a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, 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.

#### Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

#### Penalties

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

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

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

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

#### Specific Instructions

##### Name

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

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

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

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

**Disregarded entity.** Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

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

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

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

## 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/disregarded entity 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(c)(3), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(j)(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 684(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 following chart 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 5 and 7 through 13. Also, C corporations. |
| Barter exchange transactions and patronage dividends                                   | Exempt payees 1 through 5   |
| Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup> | Generally, exempt payees 1 through 7 <sup>2</sup>                 |

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

## 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](http://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](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [irs.gov](http://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 item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

**Signature requirements.** Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

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).

**6. 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.

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

**Secure Your Tax Records from Identity Theft**

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

To reduce your risk:

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

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-929-4059.

**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](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) or 1-877-IDTHEFT (1-877-438-4338).

Visit [IRS.gov](http://IRS.gov) to learn more about identity theft and how to reduce your risk.

**What Name and Number To Give the Requester**

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

<sup>1</sup> 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.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

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

<sup>4</sup> 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.

<sup>5</sup> Note. Grantor also must provide a Form W-9 to trustee of trust.

**Privacy Act Notice**

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.