Kettering Health Medical Group
Central Credentialing Office
1 Prestige Place
Miamisburg, OH
O (937) 762-1300
F (9370)522-9990
ketteringhealth.org

WELCOME TO OUR TEAM!

To ensure a smooth integration, we need to begin the credentialing process with all our payors. Please provide all the information and documentation requested on the accompanying page.

Access the appropriate signature pages for your designation. Please do not date these signatures. Signatures will be dated once your application is completed and sent to the carriers as some carrier applications are time sensitive.

Once all forms are signed, please mail to: Provider Enrollment Team
Kettering Health
1 Prestige Place, Suite 550
Miamisburg, OH 45342-6115

If you need staff privileges at one of the Kettering Health hospitals, please complete the application on this website. Be sure to also complete the Delineation of Privileges (DOP), read the bylaws, etc. Signatures on the hospital privilege applications MUST be dated.

Please don't hesitate to contact us if there is anything we can do to assist with this process.

We are looking forward to beginning our work together!

Sincerely,

The Provider Enrollment Team

Kettering Health

Before you mail these documents, have you remembered to enclose:

- ☐ Required Documents
- ☐ CAQH and NPPES login
- ☐ Signature Pages

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DOCUMENTS NEEDED FOR CREDENTIALING

- ☐ Copy of OHIO DEA certificate *(please change to your new practice address)* Website is: http://www.deadiversion.usdoj.gov/drugreg/index.html
- ☐ Copy of all Board certificates
- ☐ Copy of Medical School, Internship, Residency and Fellowship certificates including ECFMG (if applicable)
- ☐ Copy of Current Driver's License
- ☐ Copy of CV accounting for all time since completion of Medical School (or Masters) ***(month and year must be included for work history and training)***
- ☐ Explanation for any gaps in work history greater than 30 days
- ☐ Explanation Documentation of any Malpractice Claims.
- ☐ PA-C: Copy of Supervison Agreement
- ☐ CNP or NS: Copy of Standard Care Agreement

MUST HAVE THE CAQH AND NPI ACCESS INFORMATION:

CAQH number, user ID and password
Number:_____ User Name:_____ Password:_____
(If you do not know this, please call CAQH Help Desk at 888-599-1771 and they can tell you (the provider only) this information.)

NPI number, user ID and password
Number:_____ User Name:_____ Password:_____

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Surrogacy Request for CMS

First off, we would like to Welcome you to KHMG/KPN. We hope this is a smooth transition for you.

We just wanted to inform you, that during the On Boarding process, the Central Credentialing Office, will be requesting a Surrogacy through CMS for PECOS, NPPES and the EHR Incentive Program.
This must be completed so that we are able to start the payor credentialing process.

What to expect:

Once a credentialing specialist has been assigned to you, we will send you an email from the Central Credentialing Office that will have all the details regarding the Surrogacy. Please keep in mind that when we request the surrogacy, it is ONLY for us here at KPN/KHMG.
If you are affiliated with any other group or Tax ID #, it will NOT interfere with them at all.

In the email that we provide, it will give a detailed explanation for the Surrogacy request.
Around the same time that you receive our email, you will receive an email from CMS. If you don't see this email in your Inbox, you might want to look in your spam folder. This email will provide you the link to click on to get to the login screen.

At any time during this process, feel free to reach out to us with any questions that might come up.

We look forward to working with you to make this process as seamless as possible.

Sincerely,

The Provider Enrollment Team

Kettering Health

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.*

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE *(Continued)*

6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***	**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.

C. DELEGATED OR AUTHORIZED OFFICIAL OF INDIVIDUAL/ORGANIZATION/GROUP CERTIFICATION STATEMENT AND SIGNATURE

Only complete this section if you are a Delegated/Authorized Official of an organization/group or an individual practitioner receiving reassigned benefits and are accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information in Section 4F, between yourself and the individual practitioner listed in Section 2A.

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature ***(First, Middle, Last Name, Jr., Sr., M.D., etc.)***	**Date Signed** ***(mm/dd/yyyy)***

In order to process this application it MUST be signed and dated.

SECTION 6: CERTIFICATION STATEMENTS AND SIGNATURES

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 C.F.R. section 424.73 and 42 C.F.R. section 424.80. All individual practitioners who allow another individual or organization/ group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group or individual identified in Section 2 to receive Medicare payments on your behalf.
The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 3 and the organization/group or individual shown in Section 2. The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 C.F.R. section 424.80. These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits.

A. Individual Practitioner Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

In order to process this application it MUST be signed and dated.

B. Delegated or Authorized Official of Organization/Group Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

In order to process this application it MUST be signed and dated.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1179 (Expires: 01/2023). The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

******CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please visit http://www.cms.gov/MedicareProviderSupEnroll.**

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

CAQH ID:_____

3094

DOB: _____ ST License: _____