



**GROUP MEMBER ENROLLMENT
APPLICATION INSTRUCTIONS**

(FOR INDIVIDUAL PRACTITIONERS RENDERING SERVICES AS A MEMBER OF A GROUP)

Please Read Carefully

Dear Group Provider,

On behalf of EDS and the Office of Medicaid Policy and Planning, thank you for your interest in enrolling a practitioner as a new member of your group in the Indiana Health Coverage Programs (IHCP).

This application must be used only for enrolling a practitioner who has never previously enrolled in the IHCP. You must use the *Group Member Update* form to add a previously enrolled practitioner to your group location.

Enclosed are instructions and an application for the enrollment of a group member (also called rendering provider) as an IHCP provider. Please refer to the instructions when completing the application.

When should the Group Member Enrollment Application be used?

A *Group Member Enrollment Application* must be used when **all** of the following statements regarding the practice apply.

- The practice has two or more practitioners practicing under a single tax identification number
- The practice has an IHCP group provider number or is submitting the *Group Member Enrollment Application* along with a *Billing Provider Enrollment Application* for a group provider number
- The practitioner being enrolled as a member of your group has never previously enrolled in the IHCP

Note: Complete a separate application for each group member being enrolled.

Completing the Application

Please carefully read the instructions prior to completing the application. The instructions are numbered to correspond with the field number on the application. You must complete the **entire** application and enclose **all requested attachments** before sending the application to the IHCP Provider Enrollment. Incomplete applications will be returned to the provider and will delay enrollment.

Group Provider Information

1. Enter your group (also called “billing”) provider number. If your group has not yet been assigned a provider number, this field may be left blank and your *Group Member Enrollment Application(s)* must be sent with a *Billing Provider Enrollment Application*.

Note: If you are waiting for confirmation of a billing provider enrollment application previously sent to Provider Enrollment, do not submit the Group Member Enrollment Application until you have received your confirmation letter and group billing provider number.

2. Enter the federal Taxpayer Identification Number (TIN) of the group in the Group Tax ID field.
3. Enter the Doing Business As (DBA) name of your group in the Provider Name field. (Note that if a business uses a name other than its legal name, the DBA name must be on file with the Secretary of State.)
4. Enter a contact name for questions regarding this application.
5. Enter the telephone number for the contact listed in item 4.
6. Enter a return address for the group where the application should be sent if additional information is required for enrollment in the IHCP.

Group Member Information

7. Enter the Social Security Number of the group member (practitioner).
8. Enter the first name of the group member.

9. Enter the middle initial of the group member.
10. Enter the last name of the group member.
11. Enter the Universal Provider Identification Number (UPIN) for the group member, if applicable. If not applicable, please write N/A in this field.
12. Enter the Federal Drug Enforcement Agency Certificate number for the group member. A copy of the certificate must be attached to the application.
13. Enter all appropriate licensing information for each state in which the group member will render services for IHCP members. A copy of each license must be attached to the application.
14. Please refer to Attachment A and list the specialty number(s) in this field that best describes the group member's area(s) of expertise. The primary specialty is listed first with additional specialties listed under the primary.

Service Location Links

15. Enter the alpha suffix for each group service location where this group member will be rendering services. The alpha suffix is the alpha character that follows the nine-digit provider number used in field 33 on the HCFA-1500 form. For example, if you place 303030330B in field 33 of the HCFA-1500 form, then 303030330 is the provider number and B is the service location alpha suffix.
16. Enter the state in which the service location specified in field 15 is located.
17. Enter the group member Medicare number that corresponds to the performing (rendering) Medicare number for the group. This number should be a six-digit number that matches the group's Medicare number followed by one or more alpha characters. You must attach the Medicare number assignment letter to this application or a copy of a remittance advice notice from Medicare with the correct Medicare number for the rendering provider, or a copy of a remittance advice notice from Medicare with the correct Medicare number for the rendering provider. Billing Medicare numbers will not be added to group member provider numbers.
18. Please refer to attachment A and list the specialty number in this field that will be the primary specialty practiced by the group member at the service location specified in field 15.
19. For the service location specified in field 15, enter the effective date of participation for the group member.

Note: Please complete numbers 15-19 for each location where the group member renders services.

20. The 590 Program is a State medical assistance program providing reimbursement for medically necessary covered medical services provided off site to individuals who reside in State institutions. Check the box labeled yes if you wish to participate in this program.
21. The group member, rendering practitioner, must sign the application certifying that your group is authorized to bill for the services rendered by the group member. An original signature is required for enrollment.
22. Enter the date the group member signs the application in this field.
23. Print the name of the authorized officer of the group provider entity who is certifying the relationship between the group and the group member.
24. Print the title of the officer listed in field 23.
25. Enter the e-mail address of the officer listed in field 23 or a main e-mail address for the group if applicable.
26. Enter the telephone number of the officer listed in field 23.
27. Enter a fax number for the officer listed in field 23 if applicable.
28. The officer listed in field 23 must sign the application to certify the relationship between the group and the group member. An original signature is required for enrollment.
29. Enter the date the application is signed by the officer listed in field 23.

Medicaid/Children's Health Insurance Program Provider Agreement

The group member and the authorized officer of the group must both sign the Provider Agreement. Applications received without the provider agreement signed by the group member being enrolled and the authorized officer of the group will be returned to the group.

Note: A group member who leaves the group to form a sole proprietorship must contact Provider Enrollment for a Billing Provider Application to continue participation in the IHCP. The group must notify Provider Enrollment whenever a group member leaves the group.

Mailing Instructions

Once you have fully completed the application, signed the provider agreement, and enclosed copies of all required licenses, forms, and certifications, please send the entire packet to:

EDS – Provider Enrollment

P.O. Box 7263

Indianapolis, IN 46207-7263

Once your enrollment application and agreement have been reviewed, EDS will notify you in writing of the status of your enrollment. Please allow 15 business days for mailing and processing time.

Questions

Please visit our Web site at www.indianamedicaid.com or contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 with any questions about this application.

Service Location Links

Note: All group service locations must be IHCP-enrolled locations! If no billing service location is enrolled, please submit this group member application along with a billing provider application.

Please link the group member to the following group provider service locations of the group billing provider number listed in field number 1 on this application:

15. Service Location Alpha Suffix	16. Service Location State	17. Individual Medicare Number	18. Primary Specialty	19. Effective Date

20. Do you wish to participate in the 590 Program? Yes No

I certify, under penalty of law, that the information stated in this application is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I will be considered for suspension from the IHCP and/or prosecution for Medicaid fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board, or organization to provide all information that may be required in connection with my application for participation in the IHCP and the Indiana Children’s Health Insurance Programs. I further certify that the rendering practitioner number issued to the group member will not be used as the primary payee for billing purposes.

21. Group Member’s Signature: _____ 22. Date: _____

23. Group Provider Officer’s Printed Name: _____

24. Officer’s Title: _____

26. Telephone #: () _____

28. Officer’s Signature: _____ 29. Date: _____



**M E D I C A I D / C H I L D R E N ' S H E A L T H
I N S U R A N C E P R O G R A M P R O V I D E R
A G R E E M E N T**

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs. As an enrolled provider in the Indiana Health Coverage Programs, the undersigned entity agrees to provide Medicaid-covered and Children's Health Insurance Program (CHIP)-covered services and/or supplies to Indiana Medicaid and Indiana CHIP members. As a condition of enrollment, Provider agrees to all of the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the state of Indiana Family and Social Services Administration ("IFSSA").
2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program or CHIP, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the state of Indiana Medical Assistance law, state of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify IFSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the state of Indiana.
5. To provide Medicaid-covered and CHIP-covered services and/or supplies for which federal financial participation is available for Medicaid and CHIP members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about Medicaid and CHIP members including at a minimum:
 - a. members' name, address, and social and economic circumstances;
 - b. medical services provided to members;
 - c. members' medical data, including diagnosis and past history of disease or disability;
 - d. any information received for verifying members' income eligibility and amount of medical assistance payments;
 - e. any information received in connection with the identification of legally liable third party resources.
7. To release information about Medicaid and CHIP members only to the IFSSA or its agent and only when in connection with:
 - a. providing services for members; and
 - b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid-covered and CHIP-covered services.
8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.
9. Provider also agrees to notify the IHCP in writing of the name, address, and phone number of any entity acting on Provider's behalf for electronic submission of Provider's claims. Provider understands that the State requires 30-days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP.
10. To submit claims for services rendered by the Provider or employees of the Provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-MR, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with

other entities or individuals to provide Medicaid-covered and CHIP-covered services rendered pursuant to this Agreement.

11. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by *42 Code of Federal Regulations, parts 489, subpart I, and 417.436*.
12. To abide by the *Indiana Health Coverage Programs Provider Manual*, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.
13. To submit timely billing on Medicaid and CHIP approved claim forms, as outlined in the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.
14. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable federal and/or state law.
15. To submit claim(s) for Medicaid or CHIP reimbursement only after first exhausting all other sources of reimbursement as required by the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages.
16. To submit claim(s) for Medicaid or CHIP reimbursement utilizing the appropriate claim forms and codes as specified in the provider manual, bulletins and notices.
17. To submit claims that can be documented by Provider as being strictly for:
 - a. medically necessary medical assistance services;
 - b. medical assistance services actually provided to the person in whose name the claim is being made; and
 - c. compensation that Provider is legally entitled to receive.
18. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients.) Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law.
19. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.
20. To make repayments to IFSSA or its fiscal agent, or arrange to have future payments from the Medicaid program and CHIP withheld, within sixty (60) days of receipt of notice from IFSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. A hospital licensed under *IC 16-21* has one hundred eighty (180) days to repay.
21. To pay interest on overpayments in accordance with *IC 12-15-13-3*, *IC 12-15-21-3*, and *IC 12-15-23-3*.
22. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid Program or CHIP.
23. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
24. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid and CHIP payments made to Provider, to assure the proper administration of the Medicaid Program and CHIP, and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 IAC 1-5* and in the *Indiana Health Coverage Programs Provider Manual*, and shall include, without being limited to, the following:
 - a. medical records as specified by *Section 1902(a)(27)* of Title XIX of the Social Security Act, and any amendments thereto;

- b. records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs or services;
 - c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program or Indiana CHIP;
 - d. documentation in each patient’s record that will enable the IFSSA or its agent to verify that each charge is due and proper;
 - e. financial records maintained in the standard, specified form;
 - f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.
25. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid program or CHIP.
26. To promptly correct deficiencies in Provider’s operations upon request by IFSSA or its fiscal agent.
27. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
- a. the petitioner is a person to whom the order is specifically directed;
 - b. the petitioner is aggrieved or adversely affected by the order;
 - c. the petitioner is entitled to review under the law.
28. Provider must file a statement of issues within the time limits listed below, setting out in detail:
- a. the specific findings, actions, or determinations of IFSSA from which Provider is appealing;
 - b. with respect to each finding, action or determination, all statutes or rules supporting Provider’s contentions of error.
29. Time limits for filing an appeal and the statement of issues are as follows:
- a. A hospital licensed under *IC16-21* must file an appeal of any of the following actions within one hundred eighty (180) days of receipt of IFSSA’s determination:
 - (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
 - (2) A notice of overpayment.
 - (3) The statement of issues must be filed with the request for appeal.
 - b. Other providers must file an appeal of determination that an overpayment has occurred within 60 days of receipt of IFSSA’s determination. The statement of issues must be filed within 60 days of receipt of IFSSA’s determination.
 - c. All appeals of actions not described in (a) or (b) must be filed within 15 days of receipt of IFSSA’s determination. The statement of issues must be filed within 45 days of receipt of IFSSA’s determination.
30. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.
31. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a Medicaid-covered or CHIP-covered service.
32. To comply with *42 Code of Federal Regulations, part 455, subpart B* pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to IFSSA, or its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, “pay to,” “mail to,” or home office), federal tax identification number(s), or change in the Provider’s direct or indirect ownership interest or controlling interest. Pursuant to *42 Code of Federal Regulations, part 455.104(c)*, OMPP must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
33. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedules A through D to this Agreement, which are incorporated here by reference, and to update this information as it may be necessary.
34. That subject to item 32, this Agreement shall be effective as of the date set out in the provider notification letter.

35. That this Agreement may be terminated as follows:
- a. By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by IFSSA; or
 - b. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.
36. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, HEREBY AGREES, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID OR CHIP RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO \$25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

Provider-Authorized Signature – All Schedules	
The owner or an authorized officer of the business entity must complete this section.	
I certify, under penalty of law, that the information stated in Schedules A, B, C.1, and C.2 is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each education institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Health Coverage Programs and the Indiana Children's Health Insurance Programs.	
Provider DBA Name _____	Tax ID _____
Officer Name _____	Title _____
Signature _____	Date _____
Telephone Number _____	
NOTE: Failure to complete this section will result in EDS returning the application for incomplete information.	

Group Member Authorized Signature	
Providers being enrolled as a group must complete this section.	
Group Member's Signature _____	Date _____
Provider Entity Name (Doing Business As) _____	
Name of Authorized Representative (printed) _____	
(Must be an authorized officer, owner, or partner)	
Signature _____	Date _____
Title _____	Telephone Number _____



**GROUP MEMBER ENROLLMENT
APPLICATION - ATTACHMENT A**

(FOR INDIVIDUAL PRACTITIONERS RENDERING SERVICES AS A MEMBER OF A GROUP)

Provider Specialty List

Please review the list and identify the specialties that best describe your practice. Record the three-digit number assigned to the specialties in the space provided on the application.

Provider Type	Provider Specialty
09 Advanced Practice Nurse	090 Pediatric Nurse Practitioner
	091 Obstetric Nurse Practitioner
	092 Family Nurse Practitioner
	093 Nurse Practitioner (Other)
	094 Certified Registered Nurse Anesthetist (CRNA)
	095 Certified Nurse Midwife
11 Mental Health Provider	114 Health Service Provider in Psychology (HSPP)
14 Podiatrist	140 Podiatrist
15 Chiropractor	150 Chiropractor
16 Nurse	160 Registered Nurse (RN)
	162 Registered Nurse Clinical (RNC)
17 Therapist	170 Physical Therapist
	171 Occupational Therapist
	173 Speech/Hearing Therapist
18 Optometrist	180 Optometrist
19 Optician	190 Optician
20 Audiologist	200 Audiologist
21 Case Manager	210 Care Coordinator for Pregnant Women
	211 HIV Case Manager
	212 First Steps
27 Dentist	270 Endodontist
	271 General Dentistry Practitioner
	272 Oral Surgeon
	273 Orthodontist
	274 Pediatric Dentist
	275 Periodontist
	277 Prosthesis

(Continued)

Provider Type	Provider Specialty
31 Physician	310 Allergist
	311 Anesthesiologist
	312 Cardiologist
	313 Cardiovascular Surgeon
	314 Dermatologist
	315 Emergency Medicine Practitioner
	316 Family Practitioner
	317 Gastroenterologist
	318 General Practitioner
	319 General Surgeon
	320 Geriatric Practitioner
	321 Hand Surgeon
	322 Internist (with Subspecialty) Subspecialty List: Adult Critical Care Medicine Adolescent Medicine
	323 Neonatologist
	324 Nephrologist
	325 Neurological Surgeon
	326 Neurologist
	327 Nuclear Medicine Practitioner
	328 OB/GYN
	329 Hematologist/Oncologist
330 Ophthalmologist	
331 Orthopedic Surgeon	
332 Otolaryngologist	
333 Pathologist	
334 Pediatric Surgeon	

(Continued)

Provider Type	Provider Specialty
31 Physician (Cont.)	335 Pediatrician (with Subspecialty) Subspecialty List: Adolescent Medicine Diagnostic Lab Immunology Developmental Pediatrics Medical Toxicology Neonatal-Perinatal Medicine Pediatric Allergy Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Dermatology Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Neurology Pediatric Otolaryngology Physical Medicine & Rehabilitation Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports & Fitness Medicine Pediatric Urology
	336 Physician Medicine & Rehab Practitioner
	337 Plastic Surgeon
	338 Proctologist
	339 Psychiatrist
	340 Pulmonary Disease Specialist
	341 Radiologist
	342 Thoracic Surgeon
	343 Urologist
	344 General Internist (Without Subspecialty)
	345 General Pediatrician (Without Subspecialty)

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. 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 enter in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-9.

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

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 an LLC that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page 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. Get 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 get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at www.irs.gov.

If you 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: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-9.

Part III—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

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

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

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

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

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

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to

report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payees must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

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 *
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor *
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee *
b. So-called trust account that is not a legal or valid trust under state law	The actual owner *
5. Sole proprietorship	The owner *
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner *
7. A valid trust, estate, or pension trust	Legal entity *
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

*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.

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

*You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN if you have one.

*List first and circle the name of the legal 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.)

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.