CCPHO APPLICATION FOR MEMBERSHIP

Information

Provider Name: _____Degree:____ Gender: ____NPI Number: _____DOB:_____

SSN: _____ DEA #: _____ State LIC#: _____ CAQH# (if applicable):_____

Primary Specialty: _____ Board Certified: _____Yes _____No

Secondary Specialty: _____ Board Certified: _____Yes _____No

Language(s) Spoken: _____Primary Care Physician: _____Yes _____No

Accepting New Patients? _____Yes _____No Age Range: _____***to***_____

Do you currently have a pending application at Fawcett Memorial Hospital?____Yes____No **If Yes, what is your application date**?_____

Hospital Affiliations

Please list which hospitals you are a current medical staff member:

_____	_____	_____
Primary Hospital Affiliation	City	Privilege Type & Effective Date
_____	_____	_____
Other Hospital Affiliation	City	Privilege Type & Effective Date
_____	_____	_____
Other Hospital Affiliation	City	Privilege Type & Effective Date

Please list physicians who see your patients in your absence: _____

(Due to Limited space, you may list on-call physicians on page 2 of this application.)

TIN

Group/Practice Name _____ Group/Practice TAX-ID Number_____

Addresses

Billing Information (exactly as it appears on your claim forms)

Name (if different from above) _____

Street, Suite or PO Box _____

City, State, Zip _____

Telephone & Fax _____

Primary Office Address

Street, Suite _____

City, State, Zip _____

Telephone, & Fax _____

Email address _____

Does provider bill from this address? _____Yes _____No

Secondary Office Address

Street, Suite _____

City, State, Zip _____

Telephone & Fax _____

Email address _____

Does provider bill from this address? _____Yes _____No

Third Office Address

Street, Suite _____

City, State, Zip _____

Telephone & Fax _____

Email address _____

Does provider bill from this address?_____Yes _____No

PAGE 2... ***continuation of list of on call physicians' if any, if not please leave blank.***

CCPHO Physician Participation Agreement

By this Agreement, _____ (Physician) accepts and understands the conditions for membership in Charlotte County Physician Hospital Organization (CCPHO), a Florida not-for-profit corporation.

A. The CCPHO is a physician-hospital organization which has as its purposes:

1. Recognize and maintain economic needs of the members of Fawcett Memorial Hospital (Physicians) and Fawcett Memorial Hospital (Hospital);
2. To prepare to address the health care market place now and in the future;
3. To support the provision of quality medical service in the most cost-effective manner; and
4. To accomplish all objectives through joint, cooperative action.

B. The CCPHO has two classes of members, the Hospital and Physicians. The following conditions of membership apply to all participating physicians:

1. To participate in any managed care agreement that meets the minimum criteria set out on Attachment A to this Agreement and with which the CCPHO contracts;
2. To participate in and cooperate with the quality assurance and utilization review programs of the CCPHO;
3. To maintain current membership in good standing of the Medical Staff at Hospital;
4. To pay annual dues in the amount of $350.00 or as otherwise prospectively defined by the CCPHO; and
5. To agree to address all grievances through the review process established by the CCPHO; and
6. To automatically renew membership on an annual basis; cancellation requires both thirty (30) days notice and compliance with terms of any managed care agreements.

C. Physician has received and reviewed the Bylaws of the CCPHO and understands that:

1. Membership dues are not an investment and membership will not offer any form of financial return from the CCPHO;
2. Membership in the CCPHO has no effect on or relationship to Hospital Medical Staff privileges, except that loss of staff membership results in termination of CCPHO membership; and
3. Physician Members shall always have the right to elect a number of directors equal to one (1) plus the number of directors elected by the Hospital members.

I have read and understand the Physician Participation Agreement, as well as the information on "Addendum A." I hereby request membership as a Physician Member in the CCPHO.

CCPHO Managed Care Application Attestation

Information given in or attached to this application is accurate and complete to the best of my knowledge.

_____ _____

Signature Date

_____

Print Name

Practitioner Rights – Charlotte County PHO application – Addendum A

Right to Review

The practitioner has the right to review information obtained during the credentialing process for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing board), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request to the credentialing department.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the PHO offices. The provider will be notified of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied by primary sources, the practitioner may correct such information by submitting written explanation to the PHO. The practitioner shall have 30 days after notification to submit the written explanation. Upon receipt of notification from the practitioner, the PHO will document receipt of the corrected information in the practitioner’s credentialing file.

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.*