COLORADO PHYSICAL THERAPY NETWORK

CPTN CLINIC CREDENTIALING CHECK LIST

1)		COMPLETED CLINIC MEMBERSHIP APPLICATION
2)		PHOTOCOPY OF GENERAL LIABILITY INSURANCE FACE-SHEET
3)		PHOTOCOPY OF PROFESSIONAL LIABILITY INSURANCE COVERAGE FACE-SHEET
4)		W-9 FORM (ENCLOSED)
5)		JOB DESCRIPTIONS FOR THERAPY ASSISTANTS AND AIDES
6)		COMPLETE LIST OF EQUIPMENT
7)		EQUIPMENT CALIBRATION DATE REPORT
8)		EXPLANATION OF ANY “YES” ANSWERS ON QUESTIONS 9-16 IN OWNERSHIP SECTION
9)		COPY OF WHICHEVER IS APPLICABLE: A) PARTNERSHIP AGREEMENT B) ARTICLES OF OPERATING AGREEMENTS C) C) ARTICLES OF INCORPORATION AND BYLAWS
10)		COPY OF LEASE
11)		COPY OF FIRE INSPECTION
12)		CREDENTIALING CHECK LIST IS COMPLETE AND INCLUDED FOR EACH THERAPIST BEING CREDENTIALED
13)		$1380 ANNUAL MEMBERSHIP FEE - CAN BE ASSESSED ON A MONTHLY OR A QUARTERLY BASIS

****ABOVE INFORMATION MUST BE COMPLETED AND RETURNED FOR EACH FACILITY BEING CREDENTIALED BEFORE CPTN WILL PROCESS THE APPLICATION****

COLORADO PHYSICAL THERAPY NETWORK

Membership Guidelines

OWNERSHIP

The clinical business is unequivocally, principally (51%) owned and controlled by a Physical Therapist, Occupational Therapist, Speech Language Pathologist or a combination thereof.

There must be no monetary gain, directly or indirectly, by any referral source

INSURANCE AND MALPRACTICE

Minimum malpractice/liability insurance of $1 million/3 million

All owners, partners and employees are covered by malpractice/liability insurance.

LEGAL

All employees are covered by Worker's Compensation insurance. The business is covered for property damage and premises liability.

The facility is in compliance with all federal, state and local laws and regulations.

All professional therapists practicing at the facility are in compliance with all applicable national and state laws and regulations.

The clinical staff practice is in compliance with all state laws governing the practice of Occupational, Physical and Speech therapy, including laws of incorporation.

Each of the clinic's clinical staff must hold a current Colorado Physical Therapy License, or a current Colorado Occupational Therapy License, or CCCSP. No clinical staff member shall have engaged in conduct subject to disciplinary action by the State of Colorado as set forth in the Physical Therapy Practice Act. Further, no clinical staff member shall have engaged in conduct subject to disciplinary action of his or her professional organization's ethical standards (or equivalent) committee or board.

Each CPTN approved therapist in the facility shall sign a statement agreeing to be bound by the *CPTN Provider Agreement.*

PHYSICAL PLANT

The physical plant is in compliance with all state and local fire, safety and building codes.

The clinic provides functional, safe, sanitary surroundings for patients, personnel and the public.

The facility provides 500 square feet of working space per therapist (exception: home health).

Parking and accessibility to buildings are adequate for the facility's caseload and meet state and federal requirements.

Equipment and space plan are adequate for the facility's caseload.

There is evidence of annual calibration of equipment.

There is evidence of policy and implementation of infection control.

Hand washing facilities are adequate.

Work surfaces, floors, and linens are clean.

Lighting is adequate.

STANDARDS OF CARE

The physical, occupational therapist or speech pathologist provides the majority of direct patient care.

The ratio of physical therapists to assistants and aides is in compliance with the Colorado State Physical Therapy Practice Act.

Assistants do not evaluate patients or initiate or change treatment programs.

Aides do not evaluate patients, initiate or change treatment programs, carry independent patient loads, perform Level II procedures as described by Workers' Compensation RVS.

Aides work only under the on-site supervision of the therapist.

The professional staff has adequate time for each patient. Time is allowed for initial evaluation and treatment (30 to 60 minutes) and the average number of patients scheduled per therapist does not exceed two (2) per hour.

Patient's initial appointment is scheduled promptly as is appropriate for his/her diagnosis.

The facility has a flexible scheduling process for appointments.

Treatment usually begins within 10 minutes of the patient's scheduled appointment.

The patient's need for privacy is met.

There is evidence of continuity of care (The patient is rarely or only occasionally treated by a substitute therapist)

All therapists upon initial application to CPTN will provide documentation to show satisfactory evaluation of five (5) CPTN patients. Failure to comply with this will result in non-credentialing. The therapist may reapply for membership and must again meet this evaluation review.

All professional staff possess current knowledge and skills as evidenced by professional development such as continuing education, teaching, publications, research, etc.

CPTN approved therapists are encouraged to be members of the APTA, AOTA, or ASHA.

All professional staff engage in ongoing professional development activities.

cptn COLORADO PHYSICAL THERAPY NETWORK

Application for Membership (Clinic)

General Information

Clinic Name____

Address________________________________ How Long? Years__________ Months__________

______________________________ Phone: ( )________________ FAX: ( )________________

____

Registered Trade Name____

Billing Address______________________________ Office Manager______________________________

______________________________ On-Site Clinical Supervisor______________________________

____

Previous Address? ______________________________ How Long? Years________ Months________

____

Identifying Numbers: Anthem (BC/BS)________________ CCIA________________ Other________________

Tax ID#: 1) ________________ 2) ________________ 3) ________________

Malpractice Information

Please attach a photocopy of malpractice insurance for all therapists, assistants, and aides in your clinic

1. Has there ever been any claim or complaint filed with a government agency or made in a lawsuit against the clinic or the practice of physical therapy?

   Yes________ No________

2. CPTN requires a minimum of $1,000,000 each incident / $3,000,000 aggregate malpractice liability for each practicing therapist. Is your malpractice insurance in compliance?

   Yes________ No________

3. Are all owners, partners and employees who participate in patient care covered by malpractice insurance?

   Yes________ No________

Employee Information

Please complete and enclose the CPTN therapist application form for each therapist in your clinic who will be providing services to CPTN patients.

1. How many therapists are practicing at this clinic? ____ Part-time (up to 30 hrs/week) ____ Full-time (over 30 hrs/week)
2. How many therapy assistants/aides are employed at this clinic? ____ Part-time (up to 30 hrs/week) ____ Full-time (over 30 hrs/week)
3. Please attach a copy of the job responsibilities/description of therapy assistants/aides in your clinic

Facility Information

1. What is the square footage area of the clinic? ______________________________
2. List treatment focus programs

   ____

3. Is your clinic wheelchair accessible? ____Yes ____ No
4. Describe parking availability and accessibility to your clinic

   ____

5. Attach a list of equipment in your clinic.
6. Attach your records of the most recent equipment calibration survey.
7. Attach a copy of the most recent fire inspection.

Ownership Information

1. Identify by name, address and phone number the persons, partners, or corporations who now or will in the future have a financial interest in the form of loans or equity ownership in the business for which membership is requested.

NAME	HOME ADDRESS	% OWNERSHIP

2. Is the clinic owned as a partnership? ____ Yes ____ No If yes, attach a copy of the partnership agreement.

3. Is the applicant a statutory limited liability company** ____ Yes ____ No If yes, identify all members and manager by name, address and type of interest. Attach a copy of the articles of organization and operating agreement. (** A newly authorized form of doing business as a corporation that is treated as a partnership for tax purposes)

4. Is the applicant a corporation? ____ Yes ____ No If yes, identify all officers, directors, and shareholders by name, address and %age of interest. Attach a copy of articles of incorporation and bylaws with the officer/director/shareholder lists.

5. Does the applicant have legal possession of the premises by: a) ownership ____; b) lease ____; c) other ____ If lease, please supply copy of lease. If other, please supply explanation. If owned, please supply a deed copy.

6. Does the applicant receive the benefit of any financial assistance or support in the operation of its business, directly or indirectly, from any person, partnership, corporation or company? ____ Yes ____ No If yes, please specify:

7. Have you or has any other professional at your facility, in any jurisdiction, ever had a license to practice therapy denied, revoked, suspended, voluntarily relinquished, modified or restricted in any way? ____ Yes ____ No

8. Have any claims, complaints or suits ever been legally upheld against you, or any others in the facility, with respect to professional conduct, duties or obligations? ____ Yes ____ No

9. Has your membership, or the membership of any other professional at your facility, in any professional society, organization or association, ever been denied, suspended, terminated or threatened, or is any such action pending? ____ Yes ____ No

10. Have you, or any associate or employee at your facility, ever been investigated by Medicare or Medicaid for violation of their statutes, rules or regulations? ____ Yes ____ No

11. Within the last three years have you, or any business associate affiliated with your facility, made as assignment for the benefit of creditors, filed a petition in bankruptcy, had a petition in bankruptcy filed against you or had a receiver appointed over a substantial amount of your assets? ____ Yes ____ No

12. Has the facility operated under a different business name within the last three years? ____ Yes ____ No If yes, please supply explanation.

13. Is the facility owned, managed or controlled by or otherwise affiliated with a CPTN member or applicant? ____ Yes ____ No

14. Do you or any other professional at the facility have an agreement, written or oral, with any person, organization or institution for the referral of patients to your clinic? ____ Yes ____ No If yes, please supply explanation.

Membership Guidelines

1. Physical therapist (s) must own a controlling interest in a private practice physical therapy clinic.

2. All services must be rendered under the exclusive control and supervision of physical therapist (s).

3. Except for fees paid to CPTN, the member clinic must be entitled to payment of all compensation from CPTN patients or their third party payor for services rendered.

4. The clinic shall be independently operated without subsidization from any source in cash, or kind, including but not limited to discounted rental or free use of space, equipment or personnel and discounted or interest free loans.

5. No patient referral source may receive any compensation, directly or indirectly, from the clinic.

I hereby authorize CPTN to verify any information contained in this document and authorize it to inspect and review any of my professional and related business records.

I hereby agree to hold harmless and indemnify CPTN, its officers, directors, committee members, employees, agents and representatives from and against all claims, libility and costs (including reasonable attorney's fees) resulting from or arising out of any and all claims. suits or legal or equitable proceedings initiated, brought, pursued or made by me or my employees, agents or representatives in connection with or relating to CPTN's review, evaluation and final determination of my application, credentials, qualifications and records.

I hereby further authorize and consent to the release, upon written request to CPTN, of information to hospitals, medical associations and other medically related organizations and relvant agencies; and I hereby release from any liability any and all individuals and organizations who provide information to CPTN in good faith and without malice as provided hereunder.

I hereby swear the information supplied is accurate to the best of my knowledge.

Signature of Applicant | Date

Signature of Applicant | Date

Signature of Applicant | Date

Signature of Applicant | Date

Attachments

1. Photocopy of malpractice insurance for all employees who participate in patient care.
2. Applications for all CPTN therapists.
3. Job description for therapy assistants and aides.
4. Equipment list.
5. Equipment calibration date report.
6. Information indicated by *'d responses.
7. Copy of whichever is applicable:
   - A) Partnership Agreement
   - B) Articles and Operating Agreements
   - C) Articles of Incorporation and Bylaws
8. Lease.
9. Copy of fire inspection.

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ________ ☐ Exempt from backup withholding

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. 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.

Note: *If the account is in more than one name, see the chart on page 4 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. person (including a U.S. resident alien).

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.)

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

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.

U.S. person. 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.

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.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 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 recipient 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 that specifies the following five items:

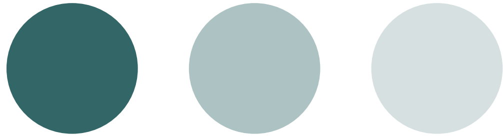
1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

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.



CPTN

C O N T R A C T   I N F O R M A T I O N

Beech Street	Acquired by MultiPlan – CPTN retains contract with Beech Street – over next 2 years will likely move to MultiPlan
Anthem Blue Cross/ Blue Shield	Moratorium on new clinic adds by Anthem in urban areas
Rocky Mountain Health Plans	
TheraMatrix/ Ford Motor Co.	
MedRisk	
GEHA/PPO USA Network	Contract termination eff. 12/31/10 – merge with United HealthCare
Cigna Healthcare	
Great-West Healthcare	7/01/10 – Merge with CIGNA effective
Cofinity (the old Sloans Lake)	
Colorado Access	
FOCUS Healthcare	In contract discussions with Coventry Health Care
CorVel Corp.	
Universal SmartComp	
First Choice of the Midwest	
Devon Health Services	

ANCILLARY PROVIDER CHECKLIST

Ancillary Providers must provide all the following documents and information to Cigna along with the signed contract; failure to submit this information and all necessary documents will result in a delay in your participation in the Cigna network of providers.

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- Copy of current and valid license (if applicable)
- Copy of current and valid Certificate of Insurance for both general and professional liability displaying occurrence and aggregate limits, policy numbers and expiration dates
- Completed copy of W-9 form
- Sample completed billing form specifically boxes 32 & 33 (to show how you will bill us)

Ancillary Legal Name (owner of Tax ID Number):	
Name & Provider Type (eg, Urgent Care Center; Radiology Center; Physical Therapy, etc) as it is to appear in Provider Directory	
Physical Location(s): Street, Suite City, State, ZIP [please use a separate sheet for multiple locations]	
Billing Address: *Street, PO BOX, Suite, City, State, ZIP*	
Main Telephone Number: Billing Telephone Number: Fax Number:	Email Address:
Chief Administrator (Name & Title, Address & Phone):	Contract Contact Person (Name & Title, Address & Phone):
Tax Identification Number (TIN):	NPI:
State License Number: (N/A if not applicable):	License Expiration Date:

ELECTION TO PARTICIPATE WITH CIGNA HEALTHCARE OF COLORADO AND AFFILIATES

This Election to Participate ("Election") confirms the undersigned health care provider's (who is referred to as "You") agreement to provide Covered Services to Participants enrolled with CIGNA HealthCare of Colorado, Inc. ("CIGNA") or any of its designated Affiliates. You acknowledge that You also wish to become a "Represented Provider" of Colorado Physical Therapy Network ("MCA") pursuant to its participation agreement with CIGNA ("MCA Agreement"), for so long as that MCA Agreement is in effect. You understand that your participation under this Election will become effective upon notice from CIGNA or MCA, and shall continue until termination of this Election. You understand that your participation under this Election may continue beyond termination of the MCA Agreement.

1. **Covered Services**. You will provide to Participants Covered Services that are within the scope of your health care practice, and pursuant to the applicable terms and conditions of the MCA Agreement and this Election.

2. **Payment**. To the extent that You are a participant with MCA for provision of Covered Services to Participants pursuant to the MCA Agreement, You will accept as full payment due from CIGNA or other Payor for rendering such Covered Services the amounts specified by MCA. For all other Covered Services, (a) You will accept as full and complete payment due from CIGNA, its Affiliates or other Payors for provision of Covered Services to Participants, payment in accordance with the respective standard or agreed upon reimbursement mechanisms applicable to Your practice; (b) CIGNA or MCA will notify You of the applicable compensation mechanisms; and (c) You understand and acknowledge that the applicable Payor is solely responsible for payment for Covered Services (except for applicable Copayments, Coinsurance or Deductibles).

3. **CIGNA Programs, Policies and Procedures.** You agree to cooperate with, and abide by CIGNA's programs, procedures, and policies, including but not limited to those regarding billing, provider credentailing, utilization management, quality assurance, medical record keeping and Participant grievances and appeals.

4. **Participant Hold Harmless for Covered Services**. Under no circumstances, including, without limitation, the termination of this Agreement, the non-payment by CIGNA or the applicable Payor, or their insolvency, will You seek payment for Covered Services provided pursuant to this agreement from any Participant or persons acting on their behalf. This provision shall not prohibit collection of applicable Copayments, Coinsurance or Deductibles in accordance with the terms of the applicable Service Agreement. You agree that this provision shall survive the termination of this agreement, for Covered Services rendered prior to the termination of this agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Participant. You agree that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between You and a Participant or persons acting on their behalf.

5. **Coordination of Benefits ("COB").** When CIGNA (or another Payor) is a secondary payor, under contractual coordination of benefits provisions or law or regulation, then CIGNA (or the other Payor, as applicable) will pay You the difference, if any, between the amount payable by the primary payor and the amount that would be paid to You under this agreement (without regard to withholds or risk sharing). If You bill CIGNA or a Payor as a primary payor and CIGNA or the Payor, as applicable, pays such bill, but CIGNA (or such Payor) is a secondary payor under law, regulation or contract, then CIGNA or such Payor are entitled to offset amounts paid against future payments due and owing to You.

6. **Defined Terms.** Capitalized terms used in this Election to Participate that are not specifically defined herein shall have the meaning provided in the MCA Agreement.

7. **Termination.** CIGNA may terminate this agreement upon prior written notice for any failure by You to comply with applicable provisions of the MCA Agreement, this agreement or any of those CIGNA policies and procedures of which You have been informed, and may terminate Your participation for any other reason with ninety (90) days prior written notice. Upon termination, each party will use best efforts to facilitate transfer of Participants' care or coverage, in a manner that minimizes disruption to the Participant.

8. **Limited Superseding Effect.** For so long as it is in effect, this agreement supersedes any and all other agreements between You and CIGNA (or any of its Affiliates) regarding provision of Covered Services to Participants with respect to those Programs covered by the MCA Agreement.

Signature:_________________________________ Date:
____

Printed Name: ____________________________Tax Identification Number:
____

Medicare Provider Number:__________________DEA Control Number: ______________________

Address: ___________________________________

____

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.*