



Contracted Provider Tax ID Change Notification Form

*please complete this form in full & return to your provider relations representative via the following fax numbers

Candice Clements – fax 763-847-4891

Angie Jelinski – fax 763-847-4889

Chakeri Nichols – fax 763-847-4814

Aaron Thomson – fax 763-847-4112

Jody Sweet – fax 763-847-4952

Jeff Bagstad – fax 763-847-4964

Steven Handt – fax 763-847-4831

Reason for Tax ID Change:

Change in Ownership

Incorporation

Merger with Other Existing Provider Entity

Other: _____

Effective Date of Tax ID Change: _____

Accounts Receivable:

Purchased

*all payments should go to new business entity

Not Purchased

*payments for claims with dates of service prior to tax ID change effective date should go to old business entity, payments for claims with dates of service on or after the tax ID change effective date should go to new business entity

Please also complete & include the following forms to update your tax ID:

- W9
- Updated Site & Provider Listing Info Sheet
- Updated Electronic Funds Transfer form (if applicable)

*PreferredOne requests notification of tax ID changes be made via this form at least 60 days prior to the effective date of the change.

*Please be advised that claims submissions for new tax IDs may need to be held by providers until verification is made that the PreferredOne system has been updated.

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 (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

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

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

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

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



EFT (Electronic Fund Transfer) Pre-Authorization Claims Disbursement Form

You must be registered with a clearinghouse to receive the electronic remittance advice from PreferredOne to enroll in EFT (Electronic Fund Transfer). For more information visit www.preferredone.com/providers and select Provider EDI Resources. After your 835 registration has been established, please have your clearinghouse send confirmation of your registration to: 835@preferredone.com.

PROVIDER INFORMATION			
Provider Name		Tax ID Number:	
Mailing Address	City	State	Zip Code
Type of Account (<i>check one</i>) <input type="checkbox"/> Checking <input type="checkbox"/> Savings			
Required: Include a voided check. A letter from your financial institution with your business name, bank routing number and account number will also be accepted. We are unable to process your request without proper documentation.			
Special Instructions: (include specific NPIs or types of services if applicable)			

AUTHORIZATION	
I represent that I am the account holder and certify under penalty of perjury that I have completely read and fully understand the terms and conditions of this form and that all the representations made by me on this form are true, correct and complete. I understand that there may be consequences for providing false information or omission of relevant information. I understand that I may be subject to penalties under law if I provide false or untrue information.	
The Provider hereby requests that claims reimbursement be made electronically into the financial institution named on attached voided check or financial institution letter. Electronic signatures must be certified.	
Provider Contact Name	Provider Contact Email
Provider Contact Phone	
Authorized Provider Signature	Date

Return completed, signed form via:
Email: Credentialing@Preferredone.com
-OR-
Fax: (763) 847-4814



Completed by:

Contact email:

Established Provider Information Change Form

Type:	Add	Term	Change	What?
Effective Date of Add/Term/Change:				Billing Contact & Phone:
Corporate Name:				Clinic/Facility Name:
List in Provider Directory?		Yes	No	
Tax ID (as filed with IRS):				OLD Tax ID (if applicable):

EXISTING or NEW Billing Information		OLD Billing Information (if applicable)	
Name:		Name:	
NPI:		NPI:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:	Fax:	Phone:	Fax:
Website Address:		Website Address:	
Hours:		Hours:	

EXISTING or NEW Site Information (Site 1)		OLD Site Information (if applicable) (Site1)	
Name:		Name:	
NPI:		NPI:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:	Fax:	Phone:	Fax:
Hours:		Hours:	

EXISTING or NEW Site Information (Site 2)		OLD Site Information (if applicable) (Site 2)	
Name:		Name:	
NPI:		NPI:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:	Fax:	Phone:	Fax:
Hours:		Hours:	

Provider/Facility Information

List in Directory? (Y or N)	NPI	Name (First, MI, Last)	Degree	Specialty	Site # (1, 2,..)	CAQH ID	Effective Date	Term Date	*Telehealth Y/N

*Telehealth is defined as professional consultations, office visits, and office psychiatry services through technology-based services/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation.

Add	Term	Mental Health Services	Add	Term	Substance Related Disorder Services
		Adult Inpatient Mental Health Services (IAMH)	<input type="checkbox"/>	<input type="checkbox"/>	Adult Inpatient Substance Related Disorder Services (IASA)
		Adolescent Inpatient Mental Health Services (ITMH)	<input type="checkbox"/>	<input type="checkbox"/>	Adolescent Inpatient Substance Related Disorder Services (ITSA)
		Adult Outpatient Mental Health Partial Hospital/Day Program Services (OAMH)	<input type="checkbox"/>	<input type="checkbox"/>	Adult Outpatient Substance Related Disorder Services (OASA)
		Adolescent Outpatient Mental Partial Hospital Day Treatment Services (OTMH)	<input type="checkbox"/>	<input type="checkbox"/>	Adolescent Outpatient Substance Related Disorder Services (OTSA)