Chiropractic Care of Minnesota, Inc.

Chiropractic Application for Network Participation

Submission Checklist

Please review your application materials to confirm that all items listed below are completed or provided as noted before you submit your Application for Network Participation.

Signatures, initials and dates are very important to remember:

- ❑ Completed **Credentialing Guidelines**
  — Signature and Date
- ❑ Completed **Application for Network Participation**. If a question does not apply, mark "N/A."
  - ❑ Signatures and/or initials are required on the following pages:
    Page 4, Question 36
    — Applicant Initials
    Page 5, Questions 40 & 41 (Attestation)
    — Date and Signature
  - ❑ Copy of **x-ray supervisor certificate** (if applicable)
- ❑ Completed **Satellite Application**
  — Signature and Date
- ❑ Completed **Liability Claim Reporting Form** (if applicable)
  — Signature and Date
- ❑ Completed **Form W-9**
  — Signature and Date
- ❑ **Network Participation Agreement**.
  — Sign, date and return the entire agreement
  — Keep a Copy of the Agreement and Fee schedule for your records.
- ❑ Copy of Declaration of Insurance — Proof of current professional liability insurance is required for application.

  Limits in the amount of **1 million** per claim and **3 million** aggregate are required.
- ❑ Go to www.chirocaremn.org to obtain a "CCMI Certificate Holder" form. Complete and send the form to your malpractice insurance company.

Submission Notes

Changes or Corrections:

Initial any changes or corrections made to the attached Network Participation Application Documents.

DO NOT USE CORRECTION FLUID OR TAPE.

Medicare Practitioner Number

Chiropractic Care of Minnesota, Inc. requires that you have a Medicare practitioner number to be considered for network participation. We are unable to accept an application without a Medicare practitioner number. Please contact Medicare regarding the steps required in order to obtain your number.

For Minnesota Practitioners

State law requires that you submit all claims electronically.

Our Right to Request Additional Information

Chiropractic Care of Minnesota, Inc. reserves the right to request additional information from an applicant/participating practitioner in order to complete the credentialing review process.

Your rights

Review Information:
All applicants have the right to review information obtained by Chiropractic Care of Minnesota, Inc. for use in the evaluation of their credentialing application and to correct erroneous information submitted by another party. This evaluation may include information obtained from any outside primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank, etc.)

Status:
All applicants have the right, upon their request, to be informed of their credentialing status.

Please contact Chiropractic Care of Minnesota, Inc. at (888) 638-7719 with any questions you may have regarding your application.

Mail Network Participation Application Materials to:

Chiropractic Care of Minnesota, Inc.
1750 Howe Avenue, Suite 300
Sacramento, CA 95825-3369

A fax may also be accepted at:
(916) 929-2285

Our mission is to provide the best healthcare services through Doctors of Chiropractic participating in a fair practice environment.

Chiropractic Care of Minnesota, Inc.

Chiropractic Application for Network Participation

1. Name _____
   (as shown on license): Last (include Sr., Jr., III etc) First Middle
2. a. Gender: ___Male ___Female b. Birth date____ /____ /____ c. Social Security Number _____- _____ -_____
3. Please list all licenses in state(s) where you have been licensed and/or treated patients in the past five (5) years. ***If you need additional space, please use page 6***.
   Chiropractic License number: _____ State: _____ License Expiration Date___ /___ /___
   Chiropractic License number: _____ State: _____ License Expiration Date___ /___ /___
4. a. ___ Individual NPI Number:_____ ***(Required)***
   b. ___Organizational NPI Number:_____ ***(Required if W-9 indicates other than Individual/Sole Proprietor)***
   c. ___Medicare Number:_____ ***(Required)***
   d. ___Federal Tax Identification Number:_____
5. **Chiropractic College Education and Training**

School Name	Degree(s)	State	Dates Attended	Year Graduated

6. a. **Office Address--**List the address where patients will be treated. For all additional offices complete the attached *Satellite Office Application*:
   Clinic/Practice Name **(required)**:_____
   Street _____ Suite #_____
   City _____ County _____ State _____ Zip Code (+4)_____ - ____
   Day phone # ( )_____ Fax # ( )_____ ___ **None**
   E-mail address _____ Website address _____
   b. Do you submit claims electronically? (***Required in MN)*** ❑ Yes ❑ No
   c. Do you have any partners/associates at this location? ❑ Yes ❑ No
   d. If you answered, "Yes" above, please list your partners/associates below:

Last Name	First Name	Middle Initial	Specialty

7. Please indicate nearest cross streets: _____
8. Check all communication services available outside of normal business hours to direct patients in an emergency situation.
   ___After hrs. phone #( )_____ ___ Cell #( )_____ ___ Answering service
   ___Answering machine ___ No after hours service
9. Is your office located in a a. ___ Commercially zoned building b. ___ Home
   c. ___ Gym/health spa/salon d. ___ No office, I travel to clients
   Home office, gym, health spa, or salon only --
   Does the facility charge a fee in order to access chiropractic services? e. ___Yes ___No
   Do you have a separate room dedicated solely to providing chiropractic services? f. ___Yes ___No
   If you indicated "home", please answer the following:
   Do patients have to walk through any part of the living quarters? g. ___Yes ___No
   Is there a separate office entrance with signage? h. ___Yes ___No
10. **Billing Information**
    Address where payment is to be sent (if different than office address):
    Street or P.O. Box_____ Suite #_____
    City _____ County_____State _____ Zip Code (+4)_____ - _____

11. Please indicate the hours you are available to see patients each day.

	Mon. *(From/To)*	Tues. *(From/To)*	Wed. *(From/To)*	Thurs. *(From/To)*	Fri. *(From/To)*	Sat. *(From/To)*	Sun. *(From /To)*
A.M.	_____	_____	_____	_____	_____	_____	_____
Lunch	_____	_____	_____	_____	_____	_____	_____
P.M.	_____	_____	_____	_____	_____	_____	_____
Total hrs.	_____	_____	_____	_____	_____	_____	_____

12. Please indicate the average time interval between the time that a patient calls your office to schedule an appointment and when he/she is first seen by you.

    a. Urgent patient: ___ within 24 hours ___ more than 24 hours
    b. Non-urgent new patient: ___ five (5) business days or less ___ more than five (5) business days

13. Average number of patients you see daily: _____

14. Indicate the number of staff members (other than yourself) who are available to assist with checking patients in and/or patient care (e.g., check on patients, change face paper, place patients on tables, assist patients with equipment, apply or remove physiotherapy): _____

15. a. Are you able to proficiently read and write in the English language? ___ Yes ___ No
    b. Check all languages you and/or your staff speak fluently:

	DC	Staff		DC	Staff		DC	Staff		DC	Staff
American Sign Language	___	___	German	___	___	Lao	___	___	Spanish	___	___
Cambodian	___	___	Hmong	___	___	Mandarin	___	___	Tagalog	___	___
Cantonese	___	___	Japanese	___	___	Portuguese	___	___	Vietnamese	___	___
French	___	___	Korean	___	___	Russian	___	___	Other _____	___	___

16. Indicate the number of: a. private treatment/exam rooms: _____ b. open bay: _____

17. Check any of the following areas in your office that are accessible to disabled persons:
    a. ___ Office b. ___ Treatment room(s) c. ___ Rest rooms d. ___ Parking

18. Do you have x-ray equipment in your office? a. ___ Yes b. ___ No

19. Check all treatment techniques, modalities or devices used in your practice:

___ Activator	___ Cervical Drop Headpiece	___ Kale	___ Pro-Adjuster
___ Cox (Flexion/Distraction)	___ Cold Laser	___ Koren Specific	___ Straight
___ Diversified	___ Concept Therapy Institute	___ Logan Basic	___ Stressology
___ Extremity/Extravertebral	___ Contact Reflex Analysis	___ Manipulation Under Anesthesia	___ Sweat
___ Gonstead	___ Coupled Technique	___ Manual Adjusting	___ TMJ
___ Sacral Occipital Tech. (S.O.T.)	___ Cranial/Cranial Work	___ Meric	___ Terminal Point
___ Thompson (Drop Table)	___ Crane Technique	___ Motion Palpation	___ Toftness
___ Applied Kinesiology	___ DNFT	___ Network	___ Toggle Recoil
___ ASBE	___ DRX-9000/Vax-D	___ Neural Organization Tech.	___ Torque Release
___ Atlas Orthogonal	___ Full Spine	___ Net (Neuro Emotional Tech.)	___ Total Body Modification
___ Barge Analysis	___ Grostic	___ NUCCA	___ Upledger
___ BEST	___ Herbology	___ Non-Invasive Acupuncture	___ Van Rumpt
___ Biophysics	___ HIO (Hole in One)	___ Palmer Package	___ Vector Point Therapy
___ Blair	___ Homeopathy	___ Pettibon	___ Vertebral Axial Decompression
___ Carver Technique	___ Integrated Drop Table	___ Pierce/Pierce Stillwagon	___ Versendal
___ Other_____			

20. For the treatment techniques, modalities or devices you checked above, please indicate your primary, secondary and tertiary technique, modality or device along with its percentage of use in your practice. List any other techniques, modalities or devices used on the "Other" lines along with their percentage of use in your practice:

Primary: _____ Used _____ % out of 100% of the Time
Secondary: _____ Used _____ % out of 100% of the Time
Tertiary: _____ Used _____ % out of 100% of the Time
Other: _____ Used _____ % out of 100% of the Time
Other: _____ Used _____ % out of 100% of the Time
Other: _____ Used _____ % out of 100% of the Time

Total: *(not to exceed **100%**)*

21. Do you record on each visit the patient's account of:
    a. His or her progress? ___ Yes ___ No b. Details of treatment procedures? ___ Yes ___ No
    c. Objective findings? ___ Yes ___ No d. Follow-up plan? ___ Yes ___ No
22. Do you consider all possible causes of a patient's complaints including subluxations, or do you consider subluxations only?
    a. ___ All possible causes b. ___ Investigate subluxation(s) only
23. Do you treat non-neuromusculoskeletal conditions?
    ___ Yes ***If yes, please explain on page 6.***
    ___ No
24. Do you refer patients who are not improving with a trial of chiropractic care or with a non-neuromusculoskeletal condition or disease to a medical doctor?
    ___ Yes
    ___ No ***If no, please explain on page 6.***
25. Do you perform:
    a. Breast exams? ___ Yes ___ No b. Gynecological exams? ___ Yes ___ No c. Prostate exams? ___ Yes ___ No
    d. Rectal exams? ___ Yes ___ No e. Colonic irrigations? ___ Yes ___ No f. Obstetrics? ___ Yes ___ No
    If you answered "Yes" to questions 25a through 25f, please explain on page 6.
26. Do you routinely perform vascular history and/or screening procedures prior to initiating a treatment plan of cervical manipulation?
    ___Yes
    ___No ***If no, please explain on page 6.***
27. Do you order x-rays for all patients?
    ___ Yes ***If yes, please explain on page 6.***
    ___ No
28. If the quality of an x-ray film is marginal, whether taken by you or another facility, do you always reshoot the x-rays or request they be retaken?
    ___ Yes
    ___ No ***If no, please explain on page 6.***
29. Do you instruct your patients in home therapeutic exercises for neuromusculoskeletal conditions?
    ___ Yes
    ___ No ***If no, please explain on page 6.***
30. Check all current memberships/certifications in chiropractic-related specialty boards, academies or colleges, and indicate dates certified, inclusive of end dates:
    ___ **None** ___ Qualified Medical Evaluator (state appointed) ___ Independent Medical Examiner
    ___ Industrial Disability Examiner ___ Disability Evaluator ___ Other_____

Specialty Area	Certification No.	Date Certified	Expiration Date

31. **Work and Practice History**
    For the previous five (5) years up to the present, account for all work, practice and other activities including time spent in military service, previous practices, extended travel, etc. ***Please include <u>all</u> current practice locations***. List all in chronological order with date span, location and type of activity. If necessary, continue this listing on ***page 6*** of the application. ***For all gaps of six (6) months or greater, please provide an explanation on page 6 of the application.***

From/To (month/year)	Location (list the address, city, state and zip code)	Type of Activity/Practice
1. __/__ to **Present**		
2. __/__ to __/__		
3. __/__ to __/__		
4. __/__ to __/__		
5. __/__ to __/__		

32. **Physical and Mental Health Status**
Are you able to perform the activities for which you have requested the right to perform, with or without reasonable accommodations?

___Yes

___No ***If no, please explain on page 6.***

33. **Compliance with Laws Related to Patient Care**
Except for prior felony charges which did not result in a conviction, has any action ever been undertaken, whether formal or informal, still pending or completed, against you by any governmental agency or law enforcement body for your alleged failure to comply with laws, statutes, regulations, or other legal requirements which may be applicable to the practice of your profession or to your rendition of service to patients?

___Yes ***If yes, please explain on page 6.***

___No

34. **Chemical Dependency/Substance Abuse**
Do you currently use, or have you used within the last year, illegal drugs or prescription drugs without a prescription from a licensed physician?

___Yes ***If yes, please explain on page 6.***

___No

35. **Felony Convictions**
Have there ever been any felony convictions against you, except those for which records have been sealed or expunged, or are any felony charges pending against you?

___Yes ***If yes, please explain on page 6.***

___No

36. **Acknowledgments and Agreements**
Your signature on this application certifies to Chiropractic Care of Minnesota, Inc., and its clients (including HMOs, third party administrators and insurance carriers) your acknowledgment of and agreement to the following: You will truthfully report all relevant information to Chiropractic Care of Minnesota, Inc. as soon as possible if any of the events in the questions set forth above (re: "Physical and Mental Health Status," "Compliance with Laws Related to Patient Care," "Chemical Dependency/Substance Abuse" and "Felony Convictions") occur (i.e., if one of those questions must be answered contrary to your original answer) after you have signed and dated this form while your application is still pending and, if you are appointed, while you are a participant of Chiropractic Care of Minnesota, Inc.

Please initial: _____

37. **If you answer "Yes" to any of the following questions, give full details on the attached *Liability Claim Reporting Form*.**

a. Have any professional liability claims ever been filed against you, have you reported any liability claim to your insurance carrier, or have you ever received any letters of intent to sue?

___ Yes

___ No

b. Are any professional liability claims currently pending against you?

___ Yes

___ No

c. Has any judgment been made in any such professional liability case?

___ Yes

___ No

d. Has any settlement been made in any professional liability case in which you or your liability insurance carrier had to (or agreed to) make a monetary payment?

___Yes

___No

38. **Professional Liability Insurance**

a. Have you ever been denied professional liability insurance, has your policy been canceled, has your liability insurer refused to renew your policy or placed limitations on the scope of your coverage, or has any liability carrier expressed any intent to deny, cancel, not renew, or limit your liability insurance or its coverage?

___Yes ***If yes, please explain on page 6.***
___No

b. Identify your professional liability (malpractice) insurer as requested below and attach proof that your current insurance coverage equals or exceeds minimum requirements for participation (see "Overview of Credentialing Guidelines").

Carrier_____Insurance Policy #_____Expiration Date___/___/___Policy Limits_____/_____

Street _____ City_____State_____Zip_____

39. **Actions or Pending Action Regarding Memberships, Privileges, Licensure and Certifications, and Contracting Programs**

Has any action, report or complaint, including any investigation, ever been undertaken; whether still pending or completed, on any of the following?

		Yes	No
a.	Your license or certificate to practice any profession in any country, state, or county?	___	___
b.	Any certifications related to chiropractic?	___	___
c.	Your privileges to practice within a hospital or clinical setting?	___	___
d.	Your affiliation with preferred provider programs, health maintenance organizations, Medicare, Medicaid, or other private, public or regulatory programs?	___	___
e.	Your status as a student in good standing in any internship, residency, fellowship, pre-ceptorship, or other clinical education program?	___	___
f.	Your membership or fellowship in any local, county, state, regional, national or inter-national professional organization?	___	___
g.	Your professional school faculty position or membership?	___	___

If you answered "Yes" to questions 39a through 39g, please give full details for each instance on page 6.

40. Authorization for Information Release

I authorize Chiropractic Care of Minnesota, Inc. to consult with, and obtain from, any and all individuals, educational institutions, the National Practitioner Data Bank, Federation of Chiropractic Licensing Boards, the Board of Chiropractic Examiners, Medicare/Medicaid, professional/trade associations, insurance companies, HMOs, PPOs and other organizations who can provide information bearing on my professional competence, character, health status, ethical qualifications and ability to work cooperatively with others. I also authorize the release of information concerning my professional or general liability claims, if any. I release from liability both those individuals and organizations who have provided this information and Chiropractic Care of Minnesota, Inc. in using this information.

Signature _____ **Today's Date** _____

41. Attestation

You fully understand that any misstatements in or omissions from this application will constitute cause for denial of your application for participation, or termination of your participation agreement. You hereby affirm that the information furnished by you to Chiropractic Care of Minnesota, Inc. is true and complete to the best of your knowledge. You further understand and agree that acceptance of your application does not constitute appointment or continued appointment as a network participant in Chiropractic Care of Minnesota, Inc. until such time as you receive written notice of approval of the application and your correspondence confirming your appointment or reappointment as a participant in one of Chiropractic Care of Minnesota, Inc.'s state-specific networks.

Signature _____ **Today's Date** _____

Please note: A photocopy or facsimile of this document is considered an original.

Detailed Explanation Sheet

Please provide a detailed explanation if you answered "Yes" to questions 23, 25 "a-f", 27, 33, 34, 35, 38 "a" and/or 39 "a-g" or if you answered "No" to questions 24, 26, 28, 29 and/or 32. You may also use this form to provide additional information regarding questions 3 (licenses) and/or 31 (work history).

Question Number _____

Explanation _____

_____

_____

_____

_____

_____

Question Number _____

Explanation _____

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Question Number _____

Explanation _____

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Question Number _____

Explanation _____

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Question Number _____

Explanation _____

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(If additional space is needed, please use a separate sheet)

Professional Liability Claim Reporting Form

INSTRUCTIONS: Of the three (3) choices shown below, please check the box that applies to you and follow the applicable instructions.

❑ **1. No claims to report – Instructions:** Check only if you have never had a claim and return form

❑ **2. Claims previously reported to ChiroCare – Instructions:** Complete A, B & C below and return form. **Your signature and date are required.**

A. Date of Incident _____ (month/year) **B.** Settlement amt $_____ **C.** Judgment _____

A. Date of Incident _____ (month/year) **B.** Settlement amt $_____ **C.** Judgment _____

❑ **3. New Claims to Report - Instructions:** Report each claim on a separate form and include all supporting documentation for each claim. Your responses should supply sufficient clinical detail to allow proper review and evaluation by ChiroCare's Credentialing Committee. **Your signature and date are required.**

Insurance Company _____ Insurance Policy Number_____

Client Name _____ Age_____ Gender_____
Accusation _____
Incident Date _____ Location_____
Other Defendants _____

Claim Status:
❑ Open
❑ Closed by way of ARBITRATION (Give dates and status) _____
❑ Closed by way of DISMISSAL of accusation (Give date) _____
❑ Closed by SETTLEMENT or JUDGMENT (Give date) _____
(Please provide dates and indicate the amount of settlement or judgment. If closed, indicate the amount paid on your behalf.)

Provide full disclosure of incident including condition and diagnosis at time of incident, treatment and procedures provided, and patient's condition subsequent to treatment and/or procedures:

_____
_____
_____
_____
_____
_____
_____

I understand that the information contained herein becomes part of my application as submitted.

Print Name _____

Signature _____ **Date** _____
[Your signature and date are required if you have any claims to report]

Network Management Department | **Phone:** 888.638.7719 | **facsimile** 916.929. 2285 | 1750 Howe Ave., Suite 300, Sacramento, CA 95825
www.chirocaremn.org

Chiropractic Credentialing Guidelines

Chiropractic Care of Minnesota, Inc. ("CCMI") is committed to providing cost-effective, quality chiropractic care to its members and clients through a network of highly professional and credible chiropractic practitioners (the Network). CCMI's credentialing department reviews all complete participation applications to ensure that applicants and practitioners meet CCMI's credentialing criteria. Only applicants who meet all of the credentialing criteria outlined herein will be approved for network participation.

CCMI uses its credentialing criteria to determine a chiropractor applicant's eligibility for participation in the Network. Chiropractors that have applied, but are not approved for participation in CCMI's network are referred to as **Applicants**. Chiropractors who have been approved for participation in the Network are referred to as **Practitioners**.

Once admitted to CCMI's network, Practitioners must continue to meet all credentialing/recredentialing standards for continued participation. Failure to meet or maintain any of the standards will result in declined participation or termination from the Network, as applicable.

All Applicants/Practitioners are credentialed in accordance with regulatory and/or Health Plan requirements in a manner that is non-discriminatory. Credentialing/recredentialing decisions are not made based on a race, ethnic/national identity, gender, age, religion, sexual orientation, procedures used (excluding treatment and examination techniques) or types of patients that the practitioner specializes in.

Applicants/Practitioners have the right, upon request, to be informed of the status of their credentialing or recredentialing application.

Your Right to Review Information:
All Applicants/Practitioners have the right to review information obtained by CCMI for use in the evaluation of their credentialing application and to correct erroneous information submitted by another party. This evaluation may include information obtained from any outside primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank, etc.).

Your signature on this document indicates you agree to undergo CCMI's credentialing/recredentialing process and to abide by CCMI's policies and procedures outlined herein, and detailed in CCMI's Chiropractic Practitioner Manual which is provided to CCMI Practitioners.

ADMINISTRATIVE REQUIREMENTS

Location & Facilities:
The suitability of an Applicant's office is reviewed upon initial credentialing. To be eligible for participation the office must satisfy CCMI's facility requirements.

The office must be located in a permanent structure that meets the following facility criteria:

- At least 1 private treatment AND/OR exam room with full walls and a solid door to protect patient confidentiality and afford privacy.
- Office must meet all local and state zoning and building laws.
- Patients must have on-site access to a restroom and hand washing facilities.

Offices located in gym/health spas or in a private home are subject to additional requirements, including:

- A separate entrance so the patient does not enter through the facility or home.
- A separate sign from that of the gym/health spa, home, or structure attached to the home, denoting that it is a professional practice.

Applicants may be required to submit photos of the office and/or accommodate an on-site visit in order for CCMI to determine if the entrance and/or home-office arrangement is acceptable for participation.

Daily Patient Volume & Adequate Access:
CCMI requires that Practitioners:

- be available for appointments a minimum of 12 hours per week,
- provide care within one day in urgent or emergent cases, and within five days for non-urgent cases, and
- provide 24-hour telephone availability in person or by answering machine or service to direct patients to emergency care facilities (if needed) and state the office's hours of operation.

PROFESSIONAL REQUIREMENTS

Licensure:
Applicants/Practitioners must have and maintain a current, unrevoked, unsuspended, and unimpaired license to practice Chiropractic in the state where applying or participating. To confirm, CCMI queries the National Practitioners Data Bank, the Federation of Chiropractic Licensing Boards, Medicare and Medicaid and the respective state boards for information related to current standing; malpractice activity and/or disciplinary actions; terminations, suspensions, restrictions, and/or reductions in privileges; and adverse

actions or convictions by other state or federal regulatory agencies.

Practitioners shall maintain all business and professional licenses, certifications, and/or approvals in good standing and free from suspension, restrictions, limitations, and/or probation as required under federal and/or state law, in order to legally and safely perform all necessary duties at all times while in the Network. Practitioners must also complete and maintain all continuing education hours as required. Failure to maintain unimpaired licensure shall result in termination from the Network.

Communication:
Applicants/Practitioners must have on-site fax capability. Applicants/Practitioners must be able to communicate and provide legible medical records in English, or must agree to provide any necessary translation/transcription services at his/her own expense. Applicants/ Practitioners must provide an e-mail address.

Insurance:
Applicants/Practitioners agree to allow CCMI to be a malpractice insurance certificate holder. Applicants/ Practitioners agree to provide proof of professional malpractice and liability insurance through an admitted carrier, with limits in the amount of the greater of $1M per claim and $3M aggregate, the amount required by state law, or an amount required by health plan. All minimum limits are subject to change and may vary by state or health plan.

Applicants/Practitioners also agree to carry general liability insurance in the amount of $250,000 per claim and $500,000 aggregate.

Adverse Impacts:
Applicants/Practitioners must disclose information that may adversely impact their ability to provide care, including:

- Illegal drug use (*including chemical dependency or substance abuse*) and any felony convictions.

CLINICAL REQUIREMENTS †
CCMI's required chiropractic practices include (but are not limited to) the following:
Practitioners agree to limit their practice on CCMI members to those methods listed on CCMI's Approved List of Chiropractic Techniques (ACT List noted below) and those techniques that conform to all applicable local, state, and federal laws. Practitioners are reimbursed by CCMI for approved medically necessary services only, as defined in the Practitioner Participation Agreement provided in the application packet (the "Participation Agreement"). CCMI will not reimburse for non-covered or excluded services.

Practitioners must abide by CCMI's clinical policies and procedures as detailed in CCMI's Chiropractic Practitioner Manual and/or summarized below.

Practitioners must:

- Agree to provide treatment to CCMI eligible enrollees, subscribers, or dependents thereof (Members) for covered neuromusculoskeletal (NMS) conditions. (***Note****: not all NMS conditions are covered through CCMI.*)
- Agree to refer Members, as appropriate and when requested, to other health care professionals for the evaluation and treatment of non-NMS conditions, NMS conditions that are not amenable or responsive to chiropractic care or for significant complicating factors or co-morbidities that have not been recently evaluated by the Member's Primary Care Physician (PCP).
- Agree to make methodical use of differential diagnosis (i.e., the distinguishing between two or more conditions or diseases with similar characteristics by systematically comparing their signs and symptoms). ***Differential diagnosis*** includes the process of ruling out non-NMS and non-mechanical conditions/diseases that require medical referral or concurrent care.
- Agree to use generally accepted evaluative and treatment techniques as specified in the **ACT LIST** below. The listed techniques are taught as part of the core curriculum in a majority of accredited chiropractic colleges. Any treatment technique or procedures not listed are considered experimental and investigational in nature:

  ACT LIST:
  - Activator Methods
  - Cox (Flexion/Distraction)
  - Diversified
  - Gonstead
  - Sacral Occipital Technique (SOT)
  - Thompson (Drop Table)
- Document and maintain appropriate medical records and chart notes. Medical records must be legible, contain appropriate patient identification, essential facts about the patient, complete medical history, pertinent examination findings, interim medical history and evaluations, initial clinical impression and diagnosis, information regarding diagnostic testing, and written plan of treatment. Reasons for medical referrals must be documented in the patient's chart. Progress notes must be contemporaneously documented within the patient record on each and every visit. All chart notes and records must be recorded (or transcribed) to English and signed by the treating Practitioner. Medical records must

contain all elements of a Subjective, Objective, Assessment, and Plan (S.O.A.P.) format in order to establish the medical necessity for care.

Radiology Guidelines †
Practitioners must abide by CCMI's radiographic guidelines and x-ray criteria. Applicants who x-ray all patients or who require x-rays prior to treating all patients will not be approved for participation. All Professional Radiology Standards apply.

The following nineteen CCMI Healthcare radiology criteria serve as a guide for exposing medically necessary radiographs:

1. **A recent history of significant trauma to rule out fracture or dislocation.**
   - Trauma must have occurred within the four (4) weeks prior to the visit.
   - Lifting, bending, physical exercise, sitting or sleeping wrong and awakening with pain, are consistent with strain/sprain or postural injuries and therefore would not meet the criteria of significant trauma, unless accompanied by a bone-weakening disorder. Bone-weakening disorders should generally be discovered during the initial history or through one of the other 19 criteria.
2. **Over 50 years of age *and* pain in the area of recent trauma *and* at least a "4" on a "1 to 10" Visual Analog Scale (VAS).**
3. **Over 70 years of age *and* having complaints in the area to be exposed.**
4. **Pertinent, consistent, and documented neuromotor deficits confirmed by appropriate neurological examination findings.**
   - Reflexes that are equally increased or diminished bilaterally would be considered normal findings and not neuromotor deficits.
5. **Unexplained and unintended weight loss (symptom of malignancy).**
6. **Reasonable suspicion derived from patient's history of ankylosing spondylitis or other inflammatory arthritis.**
   - Does not include osteoarthritis/spondylosis (i.e., non-inflammatory arthritides)
   - Reasonable suspicion of ankylosing spondylitis, Reiter's Syndrome, Systemic Lupus Erythematosus, Rheumatoid Arthritis, Psoriatic Arthritis, Down's syndrome and other inflammatory arthritides are typically derived from the patient's medical history and examination findings.
7. **Significant history of drug or chronic alcohol abuse (risk factors for osteomyelitis, osteoporosis, trauma).**
   - This would not generally apply to the taking or abusing of prescription drugs.
8. **History of cancer (possibility of metastatic cancer is greater).**
   - X-rays are intended to evaluate possible malignancies and/or metastasis to the spine based on suspicious history and/or physical examination findings.
9. **Significant history of prolonged steroid use (increased risk for infection, osteoporosis)**
10. **Fever of over 100 degrees Fahrenheit with a reasonable suspicion of infection/osteomyelitis based on history, presenting complaints and/or physical examination findings to establish the need for radiographs.**
11. **Failure to improve with an adequate trial of conservative therapy within the last thirty days and the presence of significant clinical findings suggesting underlying pathology.**
12. **Substantial examination findings (confirmed by pertinent orthopedic and neurological exams) that would warrant films to rule out pathology prior to initiating a course of treatment.**
    - A specific dermatomal pattern should be specified in the chart notes. X-rays are used to differentiate between a disc herniation and other space-occupying lesion.
13. **History of spinal surgery in the area to be treated.**
14. **History of surgery that might reasonably affect the proposed treatment.**
15. **Reasonable suspicion of bone demineralization**
    - This would include (but is not limited to) a hysterectomy patient who is not on hormone replacement therapy.
16. **Hard or soft tissue mass (i.e., tumors, suspected malignancy, exostosis) noted upon palpation.**
    - This does not apply to such entities as palpable fatty tumors or cysts, benign fibroids, muscle spasms, or muscle bunching.
17. **Prolonged <u>unremitting</u> symptoms <u>with</u> progressional severity or intensity, or prolonged <u>unremitting</u> symptoms of the severity to awaken the patient at night.**
    - Symptoms must have been present for over one-month.
    - Organic disease should be suspected and consistent with the history and examination findings.
    - Does not apply if history and exam clearly suggests a musculoskeletal disorder such as postural or chronic sprain/strain.

18. **Deformity with stiffness.**
    - This is intended for fractures or obvious dislocation.
    - Excluding patients that awaken with conditions such as antalgia or torticollis.
19. **Significant medical history (e.g., chronic inflammatory arthropathies, positive Rheumatoid factor, significant scoliosis confirmed through appropriate history and examination etc.) and supporting clinical findings, including (but not limited to) the following:**
    - Chronic inflammatory arthropathies
    - Dermopathy, suggestive of psoriasis, Reiter's syndrome, melanoma, and the like
    - Laboratory indicators such as significantly elevated erythrocyte sedimentation rate or alkaline phosphatase, positive rheumatoid factor, or monoclonal spiking on electrophoresis
    - Known or suspected cardiovascular disease (e.g., rule out Abdominal Aortic Aneurysm)
    - Confirmed significant scoliosis through history and examination (e.g., rib-hump, etc.)

CCMI Non-Approved Chiropractic Practices: †
Practitioners in the treatment of CCMI members may not use or bill for non-approved chiropractic practices, including, but not limited to:

- Radiographs that do not conform to Professional Standards or to CCMI's Radiology Guidelines.
- Ordering or rendering services that are not medically necessary and/or not clinically appropriate.
- Advising patients about prescription drugs or taking a patient off of prescription medication.
- Nutritional substance muscle testing.
- Experimental, investigative, or non-standard evaluation, diagnostic, or treatment procedures.
- Services or procedures that have not been found efficacious within the scientific community.

† **Note:**
If you have question(s) regarding the Clinical Requirements, Radiology Guidelines or Non-approved Chiropractic Practices, please call CCMI at (888) 638-7719 and ask to be connected to CCMI's Case Management Hotline for clarification.

PLEASE READ AND SIGN BELOW:
I have read, understand, and acknowledge CCMI's Chiropractic Credentialing Guidelines and criteria, as detailed herein. I hereby agree to undergo CCMI's credentialing and recredentialing processes.

I hereby certify that I understand and will abide by CCMI's administrative, professional and clinical guidelines as outlined above.

I understand that if I am approved for participation on CCMI's panel, failure to maintain any of the above requirements will result in my termination from participation from CCMI's panel.

_____

Signature **Date**

Print Name:

_____

Street Address: _____

City_____

State:_____

County: _____

Zip Code:_____

Phone Number:_____

NOTE:

- **Keep a signed copy of this document "Chiropractic Credentialing Guidelines" for your records.**
- **Return the ENTIRE original signed and dated document to CCMI with your completed application.**

Dear Practitioner:

Attached is the Internal Revenue Service form W-9, Request for Taxpayer Identification Number and Certification. Please take a few moments to complete this form, sign it, and return it to ChiroCare with your application materials.

This information is necessary in order for ChiroCare to report your claims payments under the correct taxpayer identification number. The IRS matches 1099 information to reported income; **it is imperative that ChiroCare have exactly the same information in our payment system as the IRS has in their system. Please complete the W-9 form with the Name and Taxpayer Identification Number you report to the IRS for tax purposes.**

What Name and Taxpayer Identification Number should you use? The correct name to use is determined by who receives and reports income from the claims payments ChiroCare produces.

For example, if you are a **sole proprietor** (filing a Schedule C on your personal tax return), and you report ChiroCare's claims payments to you for tax purposes using your own name and your personal social security number, then enter that information on the W-9. However, if you file your tax return using an Employee Identification Number (EIN), please enter that number and the name the IRS associates with that number on the W-9. Remember, whatever information you submit to the IRS when you file your taxes is the exact same information you should enter on the W-9.

If you are a member of a **partnership** (filing a partnership tax return with income flowing to you individually), use the name of your partnership and the partnership's taxpayer identification number.

If you are an employee of a **corporation** and the corporation is collecting, billing, and filing tax returns on the practice, then use the name and tax identification number of the corporation.

Do not list more than one name or number. Only list the name and number of the entity under which you want to have the income reported. ChiroCare will enter this information into our claims system and issue both your claims checks and the yearly report totals to the IRS on form 1099 based on the information obtained from your W-9 form.

There are penalties for reporting incorrect information. The IRS charges $50 for every 1099 that contains incorrect information and instructs ChiroCare to backup withhold 31% on all payments to anyone who does not supply the correct information to ChiroCare. By completing the W-9 form correctly, you can insure that neither ChiroCare nor you are penalized for reporting incorrect information. Thank you for your assistance.

Sincerely,

Chiropractic Care of Minnesota, Inc.

Form **W-9**
(Rev. December 2011)
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 (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Exempt payee

☐ 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 the "Name" line 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.

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

			–		–				

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).

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 ▶**

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,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 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 payee 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 to Form W-9 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.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. 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 entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

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/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

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 a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 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 or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use 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 apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but 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. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. 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 item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

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 tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

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 [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. 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
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] 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.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the 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.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

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.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Chiropractic Care of Minnesota, Inc.

Chiropractic Satellite Office Application

(Please photocopy this form and complete for each satellite office.)

1. Name _____ State License # _____
   (as shown on license): Last First Middle (Jr., III, etc.)
2. a. ❑ Individual NPI Number:_____ ***(Required)***
   b. ❑ Organizational NPI Number:_____ ***(Required if W-9 indicates other than***
   c. ❑ Medicare Number:_____ ***Individual/Sole Proprietor)***
3. a. Satellite Office Address: (List the address where patients/clients will be treated.)
   Clinic/Practice Name **(required)**:_____
   Street:_____Suite #_____
   City_____ County _____State_____Zip Code (+4)_____ -____
   Day Phone # ( ) _____ Fax? ❑ Yes ❑ No Fax # ( )_____
   b. Do you submit claims electronically? ***(Required in MN)*** ❑ Yes ❑ No
   c. Do you have any partners/associates at this location? ❑ Yes ❑ No
   d. If you answered, "Yes" above, please list your partners/associates below:

Last Name	First Name	Middle Initial	Specialty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Please indicate nearest cross streets:_____
5. Effective Date_____/_____/_____
   Month Day Year
6. Tax Identification # _____ Name Assigned to Tax ID #_____
7. Billing Address: (Where payment is to be sent, if different than Satellite office address)
   Street_____Suite #_____
   City_____ County _____State_____Zip Code (+4)_____ -____
8. Is your office located in a a. ❑ Commercially zoned building b. ❑ Home
   c. ❑ Gym/health spa/salon d. ❑ No office, I travel to clients

   Home office, gym, health spa, or salon only --
   Does the facility charge a fee in order to access chiropractic services? e. ❑ Yes ❑ No
   Do you have a separate room dedicated solely to providing chiropractic services? f. ❑ Yes ❑ No
   If you indicated "home", please answer the following:
   Do patients have to walk through any part of the living quarters? g. ❑ Yes ❑ No
   Is there a separate office entrance with signage? h. ❑ Yes ❑ No
9. Check all communication services available outside of normal business hours to direct patients in an emergency situation.
   ❑After hrs. phone # ( )_____ ❑Cell # ( )_____ ❑Answering service
   ❑Answering machine ❑No after hours service
10. Please indicate the hours you are available to see patients each day.

	Mon. (From/To)	Tues. (From/To)	Wed. (From/To)	Thurs. (From/To)	Fri. (From/To)	Sat. (From/To)	Sun. (From /To)
	_____	_____	_____	_____	_____	_____	_____
Total hrs.	_____	_____	_____	_____	_____	_____	_____

11. Average number of patients/clients you see daily at this location: _____
12. Indicate the number of staff members (other than yourself) who are available to assist with checking patients in and/or patient care (e.g., check on patients, change face paper, place patients on tables, assist patients with equipment, apply or remove physiotherapy): _____
13. Indicate the number of: a. private treatment/exam rooms: _____ b. open bay: _____
14. Please check any of the following areas that are accessible to disabled persons:
    ❑ Office and treatment rooms ❑ Rest rooms ❑ Parking
15. Do you have x-ray equipment in your satellite office? ❑ Yes ❑ No
16. Please list all languages you and/or your staff speak fluently_____

Signature_____ **Date**_____