AGREEMENTS AND FORMS

Number	Name	Revision Date
	Hardship Waiver Exception Request	03/2018
	Authorization Agreement For Electronic Funds Transfer	08/2017
1514	Disclosure of Ownership and Control Interest Statement Form	12/2011
	Trading Partner Agreement Instructions and Enrollment Form for Providers	01/2014
	Trading Partner Agreement Instructions and Enrollment Form for Vendors and Clearinghouses	01/2014
W-9	Request for Taxpayer Identification Number and Certification	12/2014
	Participation and Payment Agreement	07/2017
	Preceptor/Protocol Agreement Form	01/2017

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Hardship Waiver Exception Request

Date: _____

Contact Name: _____

Organization Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone Number: ( ) _____ - _____

NPI: _____

EIN: _____

Provider Type/Specialty: _____

Application Reference ID: _____

Reason for Waiver Request:

This request must document the basis for the waiver request including a discussion of the impact on beneficiary access to care if the fee is imposed. Include any comments on the financial or legal records that might be needed to make a determination of hardship. Examples of sufficient documentation to support the request may include historical cost reports, recent financial reports, bank statements, income statements, cash flow statement and/or tax returns.

_____

_____

_____

_____

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_____

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_____

If you have any questions or need additional information, please contact Medicaid Provider Enrollment at (888) 289-0709, Option 4.

Please return the completed Hardship Waiver Exception Request to SC Medicaid via fax at (803) 870-9022.

South Carolina Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____

Doing Business As Name (DBA) _____

Provider Address

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____ Medicaid Provider Number _____

Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Provider EFT Contact Information

Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution Address _____

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____

Financial Institution Routing Number _____

Type of Account at Financial Institution (select one) ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (select one)

☐ Provider Tax Identification Number (TIN)

☐ National Provider Identifier (NPI)

REASON FOR SUBMISSION: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01. 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

INSTRUCTIONS TO APPLICANTS FOR MEDICAID PROVIDER ENROLLMENT REGARDING REQUIRED DISCLOSURES
Part 1

1. If you are an individual practitioner or in a group of practitioners that is not organized as a business proprietorship, limited liability corporation, partnership, or corporation, whether it be for profit or not for profit, you are not required to complete Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please indicate if you are enrolling only as an individual practitioner and are exempt from these disclosure requirements.

☐ **Yes** ☐ **No**

By answering "Yes", you are enrolling as an individual only and therefore exempt from disclosure requirements as required by Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please complete all of Part 1. If "No" is checked, proceed to Part 2.

2. Provide the following information about yourself (individual practitioner only).
PLEASE NOTE: If you are not required to have a National Provider Identifier (NPI), please indicate "NA" in the NPI Field below.

*Full Name: First	M.I.	Last	Suffix	Title (MD, etc.)
*SSN:	*Date of Birth (mm/dd/ccyy): / /		*Gender:	
Provider Number: (If Known)	*NPI:	Email address:		
*Primary Practice Location Name and Address:		*Telephone Number:		
Name	Street Address	City	State	Zip + 4

Fields marked with an * must be completed.

3. Have you ever been convicted of a criminal offense in relation to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP)? ☐ **Yes** ☐ **No**

If "Yes", list the charge(s), where convicted, the date, and disposition status of the conviction.
(Attach additional page(s) if necessary.)

Charge(s)	City/State of Conviction	Conviction Date	Disposition Status
		/ /	
		/ /	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH the SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS).

*Print or Type Full Name: _____

*Signature: _____ *Date: _____

Please send this page (Part 1) with your completed Medicaid enrollment application. Do not send Part 2 of the Disclosure form if you are exempt from Disclosure requirements. All other applicants for Medicaid enrollment must complete and submit only Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT
PART 2

General Instructions

Federal Medicaid regulations (42 CFR 455.100 – .106) require that all Medicaid providers disclose the name, address, and other identifying information for each person with an ownership or control interest in the provider and any subcontractor in which the provider has a 5% or more interest. All applicants, except an individual practitioner or group of practitioners as defined in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program. The provider must also screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

Please answer all questions as of the **current date**. If the **"Yes"** block for an item is checked, list the requested additional information in the area provided; attach additional pages and/or documentation as needed, referencing the item number to which the information corresponds. Return the original to the South Carolina Department of Health and Human Services (SCDHHS); retain a copy for your files. Failure to provide this form and/or incomplete information will result in a refusal by SCDHHS to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

This form is to be completed for all programs established by Title XIX and Title XXI and **must be submitted within 35 days of any changes to provider information.** Completion and submission of this form is a condition of approval or renewal of a contract or agreement between the disclosing entity and SCDHHS. Any substantial delay in completing the form should be reported to SCDHHS.

Disclosure of Social Security Number (SSN): Disclosure of a SSN is used for the purpose of determining whether persons and entities named in an application are federally excluded parties and to verify licensure. **Refusal to provide a SSN will result in rejection of the provider's application to participate in the Medicaid program or termination of any existing provider agreement or contract.**

I. Instructions / Definitions: Providers that must have a National Provider Identifier (NPI) must include the NPI. If currently enrolled in South Carolina Medicaid with multiple NPI numbers, a separate Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514) must be completed for each NPI number.

I. Identifying Information			
[a] Name of Provider (Disclosing Entity): Doing Business As (trade or company name):			
Street Address		City, State, Zip + 4	
County	Provider Number(If Known)	NPI	Telephone Number
[b] Federal Employer Identification Number (FEIN):			

[c] Type of Entity (Applies to either For Profit or Non-Profit)

- ☐ Limited Liability Corporation (LLC)
- ☐ Partnership
- ☐ Corporation
- ☐ Business Proprietorship or Company
- ☐ Sole Proprietor
- ☐ Governmental Unit
- ☐ Other (Please specify)_____

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.
Ownership interest is defined as the possession of equity in the capital, the stock or the profits of the disclosing entity. ***A disclosing entity*** is a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Control interest is defined as the direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, ***a person with an ownership or control interest*** is a ***person*** or ***corporation*** that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

II. Individuals and Organizations with Ownership or Control Interest

[a] List names, addresses, date of birth and SSN for individuals, or list names, addresses and the FEIN for organizations, having direct or indirect ownership or control interest, **as defined on pg. 2,** in the entity listed in Section I. Attach additional pages, if needed, for any additional names and addresses. **If Sole Proprietor or Business Proprietorship or company is checked in Section I, skip this section.**

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] Are any persons / entities with ownership or control interest in the provider also owners of other Medicare / Medicaid providers? If yes, list name of the owner from Section II [a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

☐ Yes ☐ No

Name of Owner from Section II [a]	Name of Other Provider or Entity	NPI/SSN	FEIN

III. Subcontractors

[a] Please list any subcontractors of the disclosing entity (provider), **as defined on pg. 2**, in which the disclosing entity has a direct or indirect ownership of 5% or more.

☐ Not Applicable

Name of Subcontractor	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] List the following information for individuals or organizations having direct or indirect ownership or a control interest, **as defined on pg. 2,** in any subcontractor in which the disclosing entity (provider) has a direct or indirect ownership of 5% or more. Attach additional pages, if needed, for additional names.

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

IV. Relationships

Are any of the individuals identified in Sections I, II or III related to each other? ☐ Yes ☐ No

If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child, etc).

Name of Person 1	Name of Person 2	Relationship

V. Managing Employees

[a] List current managing employees as indicated below. "Managing employee" means general manager, office or business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations.
Attach additional pages, if needed, for additional names.

Name/Title	Address	SSN	Date of Birth

[b] Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☐ Yes ☐ No
If Yes, give date for change: Date / / . List names, titles, and SSN of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	SSN

VI. Management Company

A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm as well as the managing employees of the firm (i.e., CEO, CFO, etc). Attach additional pages, if needed, for additional names.

Is the provider/entity/facility operated by a management company?
☐ Yes ☐ No
If Yes, what is the term of the agreement?
Beginning Date / / to Ending Date / /

Name of Management Co.	Address	FEIN

Name(s) of Managing Employee(s)	SSN	Date of Birth

VII. Instructions / Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; and felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

VII. Criminal Offenses

If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and FEINs for organizations, or attach documentation or additional pages if needed.

[a] As listed in **Sections II or III**, have any individuals and organizations with a direct or indirect ownership of 5% or more in the disclosing entity (provider), or any subcontractor(s) in which the provider has a direct or indirect ownership of 5% or more, been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)?

☐ Yes ☐ No

[b] As listed in **Sections V or VI**, have any directors, officers, agents, or managing employees of the disclosing entity (provider) ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)? ☐ Yes ☐ No

Name	Address	SSN/FEIN

VIII. Instructions / Definitions: Sanctions and other adverse actions include any revocation or suspension of a license to provide health care by any State licensing authority; any revocation or suspension of accreditation; and/or any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

VIII. Sanctions and Other Adverse Actions

Has your organization, under any current or former name or business identity, or any individuals and organizations listed in **Sections II, III, V, or VI,** ever had a final adverse action imposed against it? If yes, report the individual(s) or organization(s) involved, each final adverse action, when it occurred, and the Federal or State agency or the court/administrative body that imposed the action. ☐ Yes ☐ No

Individual/Organization	Adverse Action	Date	Taken by

IX. Instructions/ Definitions: Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership, including changes in any partnership arrangement, or any changes of ownership.

IX. Changes in Provider Status

If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.

[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date.
☐ Yes - Date: / / ☐ No ☐ Not Applicable

X. Instructions / Definitions: A chain affiliate is any free-standing health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

X. Chain Affiliation

[a]. Is this facility chain-affiliated? If Yes, list name, address and FEIN of parent Corporation below.
☐ Yes ☐ No

Name	Address	FEIN

[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and FEIN of parent Corporation.
☐ Yes ☐ No

Name	Address	FEIN

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicaid program. In doing so, you are attesting to meeting and maintaining the Medicaid requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this form, and the information contained herein is true, correct, and complete. If I become aware that any information listed on this form is not true, correct, or complete, I agree to notify Medicaid of this fact within thirty-five (35) days of discovery.

2. I authorize Medicaid to verify the information contained herein. I agree to notify Medicaid of a change in ownership, practice location and/or Final Adverse Action within 35 days of the reportable event. In addition, I agree to notify Medicaid of any other changes to the information on this form within 35 days of the effective date of change. I understand that any change in business structure of this provider may require the submission of a new application.

3. I understand that any deliberate omission, misrepresentation, or falsification of any information contained on this form or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicaid billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

4. I agree to abide by the Medicaid laws, regulations and program instructions that apply to me or to the organization. The Medicaid laws, regulations, and program instructions are available through SCDHHS. I understand that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in Medicaid.

5. Neither I, nor any managing employee listed on this form, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicaid or other Federal program beneficiaries.

6. I agree that any existing or future overpayment made to me or to the organization(s) listed on this form, by the Medicaid program, may be recouped by Medicaid through the withholding of future payments.

7. I understand that the Medicaid identification number issued to me can only be used by me or by a provider to whom I have reassigned my benefits under current Medicaid regulations, when billing for services rendered by me.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Name of Authorized Representative (Printed or Typed):	Title:
Signature:	Date:

Trading Partner Agreement Enrollment Instructions for Providers

The Trading Partner Agreement (TPA) Enrollment form may be found in the "Forms" section under "Provider Quick Links" on the SCDHHS website, http://provider.scdhhs.gov.

Please use the instructions outlined below to complete the TPA. Incomplete or incorrect TPAs will not be processed.

Field	Instructions
Reason for Submission	Select the appropriate transaction type being submitted: New Enrollment, Change Enrollment, or Cancel Enrollment. (*Select only one*)
Provider Name	Enter the complete legal name of institution, corporate entity, practice, or individual provider.
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it. Enter this information, if applicable.
Street	Enter the number and street name where a person or organization can be found.
City	Enter the city associated with the provider address field.
State/Province	Enter the ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country.
Zip Code/Postal Code	Enter the 5 digit or the 5 digit + 4 codes associated with the provider's add The zip code/postal code is part of the system of postal-zone codes (Zip stand for "zone improvement plan" introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
National Provider Identifier (NPI)	Enter the unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services.
Provider Federal Tax Identification Number (TIN)	Enter a Federal Tax Identification Number, also known as an Employer Identification Number (EIN), which is used to identify a business entity. A Social Security Number (SSN) may also be used for Individual provider enrollments.
Trading Partner ID	Enter the provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor. Leave this field blank if you have an X12 Submitter ID.
SC Medicaid Provider ID	Enter the 6-digit alphanumeric SC Medicaid Provider number assigned to the provider by SCDHHS. This will not be completed for new Trading Partner Agreement enrollments.
Type of Business	Select "Medicaid Provider".
Provider Contact Name	Enter the name of the contact in the provider's office for handling ERA issues.
Telephone Number	Enter the 10-digit telephone number associated with the contact person.
Telephone Number Extension	Enter the contact person's telephone number extension, if applicable.
Fax Number	Enter a 10-digit number at which the provider can be sent facsimiles.
Email Address	Enter an electronic email address at which the health plan might contact the provider.
Preference for Aggregation of Remittance Data	Select either the "National Provider Identifier (NPI)" or the "Provider Tax Identification Number (TIN)" checkbox to indicate the provider's preference for grouping (bulking) claim payment remittance advice. Enter the provider's NPI or TIN (EIN or SSN) in the space provided. Only one type may be selected. (Note: In most cases, this will be the NPI unless the provider is atypical and does not have an NPI.)
Using a clearinghouse, billing agent, or vendor to submit claims	Indicate if you are using a clearinghouse, billing agent, or vendor to submit your claims. If you select "Yes", enter the name of this entity. (If you will only be using the South Carolina Medicaid Web-based Submission Tool, enter "Web Tool" in this space.) If you select "No", please indicate the protocol(s) you will use to submit claims. (multiple selections are allowed)
South Carolina Medicaid Web-based Claims Submission Tool (Select Only One)	If you would like to access the SC Medicaid Web Tool, check the "Requesting Access" checkbox and indicate the number of IDs you require. (Individual IDs are required). If you bill as part of an existing group, leave this section blank. If you have an existing Web tool ID and you would like the NPI on this TPA linked, select the "Link to Existing ID" checkbox and indicate the Web Tool ID.
Transactions Requested	Leave blank unless you have an X12 Submitter ID.
TPA Authorization Agreement	Select the checkbox if you have read, understand, and are in agreement with TPA terms and conditions. (The TPA will not be processed if this is not checked)
Authorized Signature	Enter the signature of the individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.
Printed name of Person Submitting Enrollment	Print the name of the person signing the form.
Submission Date	Enter the date on with the enrollment or modification is being submitted.
Requested Effective Date	Enter the date the provider wishes to begin receiving/end an electronic remittance advice (ERA).

SC Trading Partner Agreement/Remittance Advice Enrollment

Fax to (803)870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Trading Partner Information

Provider Name: _____

Doing Business As Name (DBA): _____

Street: _____

City: _____ **State/Province:** _____ **Zip Code/Postal Code:** _____

National Provider Identifier (NPI): _____ **Provider Federal Tax Identification Number (TIN):** _____

Trading Partner ID: _____ **SC Medicaid Provider ID:** _____

Type of Business: ☐ Medicaid Provider ☐ Billing Service ☐ Clearinghouse ☐ Software Vendor

☐ Other (please specify): _____

Provider Contact Information

Provider Contact Name: _____

Telephone Number: _____ **Telephone Number Extension:** _____

Fax Number: _____ **Email Address:** _____

Preference for Aggregation of Remittance Data (e.g., Account number linkage to provider identifier):
☐ Provider Tax Identification Number (TIN): _____
☐ National Provider Identifier (NPI): _____

Claims Submission/Retrieval Information

Are you using a clearinghouse, billing agent, or vendor to submit your claims? ☐ Yes ☐ No

If Yes, please enter the name of the clearinghouse, billing agent, or vendor here: _____

If No, please indicate below which protocol(s) is/are used: (multiple selections are allowed)

☐ Secure FTP ☐ WS_FTP Pro ☐ CD ☐ Diskette

South Carolina Medicaid Web-Based Claims Submission Tool (Select One)

☐ Requesting Access: Number of IDs Requested _____ ☐ No Access Needed

☐ Link to Existing IDs: _____
(If you submit X12 claims directly to SC Medicaid, you must complete the "linked" Submitter ID Information found on the second page of this application)

Transactions Requested

☐ Yes ☐ No 270 – Eligibility IN	☐ Yes ☐ No 820 – Premium Payments	☐ Yes ☐ No 837P – Professional Claims
☐ Yes ☐ No 271 – Eligibility OUT	☐ Yes ☐ No 834 – Benefit Enrollment	☐ Yes ☐ No 837D – Dental Claims
☐ Yes ☐ No 276 – Claim Status IN	☐ Yes ☐ No 835 – Electronic Remittance Advice*	
☐ Yes ☐ No 277 – Claim Status OUT	☐ Yes ☐ No 837I – Institutional Claims	

TPA Authorization Agreement

☐ I have read, understand, and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____ **Requested Effective Date:** _____

*Please contact the Provider Service Center at 1-888-289-0709 for any questions regarding the electronic remittance advice enrollment process or the status of your enrollment.

*Please refer to the "Your Remittance Advice" area in the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider Web Page for instructions on how to complete updates to your Electronic Remittance Advice.

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

If you submit X12 files directly to SC Medicaid, please complete this page to indicate providers to link to your Submitter ID.

Do not use this page if you are submitting claims through a vendor or clearinghouse.

Individual providers who are a part of a Medicaid group ***must*** have a separate Trading Partner Agreement.

PROVIDER NAME	MEDICAID ID	NPI	STATE	ADD/REMOVE

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses

The Trading Partner Agreement (TPA) Enrollment form may be found in the "Forms" section under "Provider Quick Links" on the SCDHHS website, http://provider.scdhhs.gov.

Please use the instructions outlined below to complete the TPA. Incomplete or incorrect TPAs will not be processed.

Field	Instructions
Reason for Submission	Select the appropriate transaction type being submitted: New Enrollment, Change Enrollment, or Cancel Enrollment. (*Select only one*) Select "New Enrollment" to request a new SC Medicaid Submitter ID. Select "Change" or "Cancel" to add or remove providers on an existing Submitter ID.
Trading Partner Name	Enter the complete legal name of institution, corporate entity, practice, or individual provider.
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it. Enter this information, if applicable.
Street	Enter the number and street name where a person or organization can be found.
City	Enter the city associated with the provider address field.
State/Province	Enter the ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country.
Zip Code/Postal Code	Enter the 5 digit or the 5 digit + 4 codes associated with the provider's add The zip code/postal code is part of the system of postal-zone codes (Zip stand for "zone improvement plan" introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
National Provider Identifier (NPI)	Enter the unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services. ***(For future use)***
Provider Federal Tax Identification Number (TIN)	Enter a Federal Tax Identification Number, also known as an Employer Identification Number (EIN), which is used to identify a business entity. A Social Security Number (SSN) may also be used for Individual provider enrollments. ***(For future use)***
Trading Partner ID	Enter the provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor. Enter the X12 Submitter ID for the clearinghouse or vendor.
SC Medicaid Provider ID	Enter the 6-digit alphanumeric SC Medicaid Provider number assigned to the provider by SCDHHS. This will not be completed for new Trading Partner Agreement enrollments.
Type of Business	Select the appropriate type for your company.
Trading Partner Contact Name	Enter the name of the contact in the provider's office for handling ERA issues.
Telephone Number	Enter the 10-digit telephone number associated with the contact person.
Telephone Number Extension	Enter the contact person's telephone number extension, if applicable.
Fax Number	Enter a 10-digit number at which the provider can be sent facsimiles.
Email Address	Enter an electronic email address at which the health plan might contact the provider.
Protocol	Select the appropriate submission or retrieval method for X12 transactions.
South Carolina Medicaid Web-based Claims Submission Tool (Select Only One)	If you would like to access the SC Medicaid Web Tool, check the "Requesting Access" checkbox and indicate the number of IDs you require. (Individual IDs are required). If you would like to link providers, select the "Link to Existing ID" checkbox and complete Page 2 of the application. ***(Note: Linked providers must have a TPA on file for the Submitter ID listed on Page 1)***
Transactions Requested	Select the transaction types you wish to send and receive.
TPA Authorization Agreement	Select the checkbox if you have read, understand, and are in agreement with TPA terms and conditions. (The TPA will not be processed if this is not checked)
Authorized Signature	Enter the signature of the individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.
Printed name of Person Submitting Enrollment	Print the name of the person signing the form.
Submission Date	Enter the date on with the enrollment or modification is being submitted.
Requested Effective Date	Enter the date the provider wishes to begin receiving/end an electronic remittance advice (ERA).

SC Trading Partner Agreement Enrollment

Fax to (803)870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Trading Partner Information

Trading Partner Name: _____

Doing Business As Name (DBA): _____

Street: _____

City: _____ **State/Province:** _____ **Zip Code/Postal Code:** _____

National Provider Identifier (NPI): _____ **Provider Federal Tax Identification Number (TIN):** _____

Trading Partner ID: _____ **SC Medicaid Provider ID:** _____

Type of Business: ☐ Billing Service ☐ Clearinghouse ☐ Software Vendor

☐ Other (please specify): _____

Trading Partner Contact Information

Trading Partner Contact Name: _____

Telephone Number: _____ **Telephone Number Extension:** _____

Fax Number: _____ **Email Address:** _____

Claims Submission/Retrieval Information

Indicate below which protocol(s) is/are used: (Multiple selections are allowed)

☐ Secure FTP ☐ WS_FTP Pro ☐ CD ☐ Diskette

South Carolina Medicaid Web-Based Claims Submission Tool (Select One)

☐ Requesting Access: Number of IDs Requested _____ ☐ No Access Needed

☐ Link to Existing IDs: _____

(If you submit X12 claims directly to SC Medicaid, you must complete the "linked" Submitter ID Information found on the second page of this application)

Transactions Requested

☐ Yes ☐ No 270 – Eligibility IN	☐ Yes ☐ No 820 – Premium Payments	☐ Yes ☐ No 837P – Professional Claims
☐ Yes ☐ No 271 – Eligibility OUT	☐ Yes ☐ No 834 – Benefit Enrollment	☐ Yes ☐ No 837D – Dental Clams
☐ Yes ☐ No 276 – Claim Status IN	☐ Yes ☐ No 835 – Electronic Remittance Advice	
☐ Yes ☐ No 277 – Claim Status OUT	☐ Yes ☐ No 837I – Institutional Claims	

TPA Authorization Agreement

☐ I have read, understand, and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____ **Requested Effective Date:** _____

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

If you submit X12 files directly to SC Medicaid, please complete this page to indicate providers to link to your Submitter ID.

Do not use this page if you are submitting claims through a vendor or clearinghouse.

Individual providers who are a part of a Medicaid group ***must*** have a separate Trading Partner Agreement.

PROVIDER NAME	MEDICAID ID	NPI	STATE	ADD/REMOVE

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

Form **W-9**
(Rev. December 2014)
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.

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; 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. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member 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.)

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 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 instructions for line 1 and 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. 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 on page 3.

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

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

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?* on page 2.

By signing the filled-out form, you:

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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and 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 under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 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 section 1446 withholding on your share of partnership income.

In the cases below, the following person must give 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:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (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, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% 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, payments made in settlement of payment card and third party network transactions, 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 *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

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

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. 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 line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. 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 line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

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 U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

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

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—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 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[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 reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

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 this page), 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 SSA 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, apply for a TIN and 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 U.S. 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 items 1, 4, or 5 below 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 line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

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 made in settlement of payment card and third party network transactions, 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 Regulations 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 Regulations 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 2.

***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, 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 (TIGTA) 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. commonwealths and 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.

PARTICIPATION AND PAYMENT AGREEMENT

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number.
- That services shall be provided to Medicaid recipients in compliance with Section 504 of the Rehabilitation Act of 1973, as amended; and the Age Discrimination Act of 1975, as amended; the Omnibus Budget Reconciliation Act of 1981, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursuant thereto, (45 CFR Part 80, 2014, as amended), the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- That provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489 Subpart I and 42 CFR §417.436(d).
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That for Medicaid purposes all fiscal and medical records shall be retained for a minimum period of five (5) years after last payment was made for services rendered, except that hospitals and nursing homes are required to retain such records for six (6) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the appropriate retention period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the appropriate retention period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the United States Department of Health and Human Services, Government Accountability Office and/or their designee during normal business hours. Failure of the provider to comply with this provision may result in the immediate termination of this agreement. SCDHHS may, upon good cause shown by the provider, and within the discretion of SCDHHS, allow the provider a reasonable amount of time to provide the documents requested. SCDHHS will notify the provider of any termination under this provision by Certified Mail, Return Receipt Requested, or nationally recognized overnight carrier.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is in accordance with the South Carolina State Plan for Medical Assistance.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy. That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- The provider may terminate this agreement upon providing SCDHHS with thirty (30) days written notice of termination. SCDHHS may terminate this agreement for good cause upon providing the provider with thirty (30) days written notice of termination. Notices of termination shall be sent by Certified Mail, Return Receipt Requested or nationally recognized overnight carrier, and be effective thirty (30) days after the date of receipt. For the purposes of this agreement, 'good cause' shall be a failure of the provider to abide by the terms of this agreement.
- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455 Subpart B (2014, as amended). Furthermore, the provider shall disclose any felony convictions under federal or state law in accordance with 42 CFR 1001 Subparts B and Subpart C (2014, as amended).
- That the provider shall comply with all applicable screening and enrollment requirements in accordance with 42 CFR 455 Subpart E (2014, as amended).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the SCDHHS action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (2014, as amended), SCDHHS regulation §§126-170, et seq., South Carolina Code of State Regulations (2012) Volume 10, as amended, and all applicable State laws and regulations.
- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".
- That participation, all services rendered, and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with the South Carolina Plan for Medical Assistance, bulletins, SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check or acceptance of an electronic deposit.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider shall comply with all applicable standards of Title VII of the Civil Rights Act of 1964, as amended; the Clean Air Act of 1970, as amended; the Federal Water Pollution Control Act, as amended; Section 6002 of the Solid Waste Disposal Act of 1965 as amended by the Resource Conservation and Recovery Act of 1976; and any regulations promulgated pursuant to any of these Acts.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That the provider shall comply with all terms and conditions of the Iran Divestment Act of 2014, S.C. Code Ann. §§11-57-10 et seq. (Supp. 2014, as amended).
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.
- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (45 CFR 162 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).
- Pursuant to the Standard Unique Health Identifier regulations (45 CFR 162 Subparts A & D), and if the provider is a covered health care provider as defined in 45 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.
- That the provider shall comply with all applicable provisions of 2 CFR Part 180 (2014, as amended) as supplemented by 2 CFR Part 376 (2014, as amended), pertaining to debarment and/or suspension. As a condition of participation, the provider should screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.
- That if the provider receives annual Medicaid payments of at least Five Million Dollars, the provider must comply with Section 6032 of the Deficit Reduction Act of 2005, Employee Education about False Claims Recovery.

State of South Carolina
Department of Health and Human Services

PRECEPTOR/PROTOCOL AGREEMENT FORM

1. A Nurse Practitioner, Nurse Midwife, Clinical Nurse Specialist, or Physician Assistant practicing in an extended role shall perform delegated medical acts pursuant to an approved written protocol between the nurse or physician assistant and the physician.

2. The approved written protocol shall include the following information at a minimum:

   A. General Data:

      1. Name, address, and license number of the nurse or physician assistant.
      2. Name, address, and license number of the physician preceptor/collaborator.
      3. Nature of practice and practice location(s) of the nurse or physician assistant and the physician.
      4. Date the protocol was developed and dates reviewed and amended.
      5. Description of how consultation with the physician is provided and if a provision for backup consultation has been established in the physician's absence.

   B. Delegated Medical Acts:

      1. The medical conditions for which therapies may be initiated, continued or modified.
      2. The treatments that may be initiated continued or modified.
      3. The drug therapies that may be prescribed.
      4. Situations that require direct evaluation by or referral to the physician.

3. The original protocol and any amendments to the protocol, dated and signed by the nurse or physician assistant and the physician, shall be available for review within 72 hours of request.

4. Individuals, who change practice settings or physicians, shall notify the Department of Health and Human Services (DHHS) in writing within 15 days. Individuals who discontinue their practice shall notify DHHS in writing within 15 days.

I, the undersigned, agree to serve as the physician preceptor/collaborator for _____ _____. My preceptorship is to extend to the limits described in the above written protocol.

_____ Physician Printed Name	_____ Enrollee Printed Name
_____ Physician Signature	_____ Enrollee Signature
_____ Physician License #	_____ Physician Assistant or Nurse License #
_____ Physician NPI #	_____ Physician Assistant or Nurse NPI #

Date_____

PLEASE FAX THIS COMPLETED FORM TO: Medicaid Provider Enrollment (803) 870-9022

01/2017