Contracted Provider Tax ID Change Notification Form

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

Jeff Bagstad – fax 763-847-4010

Reason for Tax ID Change:

☐ Change in Ownership ☐ Incorporation ☐ Merger with Other Existing Provider Entity

Other:

Effective Date of Tax ID Change:

Accounts Receivable:

☐ Purchased
* all payments should go to new business entity

☐ Not Purchased
* payments for claims with dates of service prior to tax ID change effective date should go to old business entity, payments for claims with dates of service on or after the tax ID change effective date should go to new business entity

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

☐ W9

☐ Updated Site & Provider Listing Info Sheet

☐ Updated Eletronic Funds Transfer form (if applicable)

* Aspirus requests notification of tax ID changes be made via this form at least 60 days prior to the effective date of the change.
* Please be advised that claims submissions for new tax IDs may need to be held by providers until verification is made that the Aspirus system has been updated.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

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

You must be registered with a clearinghouse to enroll in EFT (Electronic Fund Transfer). For more information visit https://www.aspirushealthplan.com/Business/ProviderResources and select Provider EDI Resources.

After your 835 registration has been established, please have your clearinghouse send confirmation of your registration to our administrator, at: 835ahp@optum.com.

Return completed, signed form via Email to: Credentialingahp@optum.com or Fax to: 763.847.4814.

PROVIDER INFORMATION

Provider Name		Tax ID Number	
Mailing Address	City	State	Zip Code

Type of Account *(check one)* ☐ Checking ☐ Savings

Required: Include a voided check with this request. A letter from your financial institution with your business name, bank routing number and account number will also be accepted. We are unable to process your request without proper documentation.

Special Instructions: *(include specific NPIs or types of services if applicable)*

AUTHORIZATION

The Provider hereby requests that claims reimbursement be made electronically into the financial institution named on attached voided check or financial institution letter. Electronic signatures must be certified.

I represent that I am the account holder and certify under penalty of perjury that I have completely read and fully understand the terms and conditions of this form and that all the representations made by me on this form are true, correct and complete. I understand that there may be consequences for providing false information or omission of relevant information. I understand that I may be subject to penalties under law if I provide false or untrue information.

Provider Contact Name	Provider Contact Email	Provider Contact Phone
Authorized Provider Signature		Date

ASPIRUS® HEALTH PLAN

Completed by:	
Contact email:	

Established Provider Information Change Form

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

***EXISTING* or *NEW* Billing Information**		***OLD* Billing Information** *(if applicable)*	
Name:		**Name:**	
NPI:		**NPI:**	
Address:		**Address:**	
City/State/Zip:		**City/State/Zip:**	
Phone:	**Fax:**	**Phone:**	**Fax:**
Website Address:		**Website Address:**	
Hours:		**Hours:**	
EXISTING* or *NEW* Site Information** ***(Site 1)		***OLD* Site Information** *(if applicable)* ***(Site1)***	
Name:		**Name:**	
NPI:		**NPI:**	
Address:		**Address:**	
City/State/Zip:		**City/State/Zip:**	
Phone:	**Fax:**	**Phone:**	**Fax:**
Hours:		**Hours:**	
EXISTING* or *NEW* Site Information** ***(Site 2)		***OLD* Site Information** *(if applicable)* ***(Site 2)***	
Name:		**Name:**	
NPI:		**NPI:**	
Address:		**Address:**	
City/State/Zip:		**City/State/Zip:**	
Phone:	**Fax:**	**Phone:**	**Fax:**
Hours:		**Hours:**	

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

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

Add	**Term**	***Mental Health Services***	**Add**	**Term**	***Substance Related Disorder Services***
☐	☐	Adult Inpatient Mental Health Services (IAMH)	☐	☐	Adult Inpatient Substance Related Disorder Services (IASA)
☐	☐	Adolescent Inpatient Mental Health Services (ITMH)	☐	☐	Adolescent Inpatient Substance Related Disorder Services (ITSA)
☐	☐	Adult Outpatient Mental Health Partial Hospital/Day Program Services (OAMH)	☐	☐	Adult Outpatient Substance Related Disorder Services (OASA)
☐	☐	Adolescent Outpatient Mental Partial Hospital Day Treatment Services (OTMH)	☐	☐	Adolescent Outpatient Substance Related Disorder Services (OTSA)