Oklahoma Foundation for Medical Quality, Inc. (OFMQ)
Reviewer Application

OFMQ use only:
Date received: _____
Format HC/E copy

Choose one:
☐ New application – date submitted: _____

☐ Re-verification – date submitted: _____

License Number: _____ Expiration Date: _____

Type of Review - OFMQ conducts two different types of review for the Oklahoma Health Care Authority (OHCA):

Retrospective Review – Review that is conducted after services are provided to a patient. The review is focused on determining the appropriateness, necessity, quality, and reasonableness of healthcare services provided. All inpatient hospital admissions and outpatient hospital observation stays are subject to post-payment utilization review and quality of care review. A sample of inpatient hospital admissions are subject to Diagnosis-Related Group (DRG) Validation reviews. *Retrospective reviews provide peer reviewers anonymity in their review.*

Medical Education/Intervention Team (MEIT) – Quality interventions and education reviews are performed to identify, educate, and closely monitor care delivery of medical providers who have provided substandard care in SoonerCare programs. Reviewers will complete expedited and standard review of multiple encounters for ten or more patients treated by the medical provider under review. For all Serious Risk or Gross and Flagrant Violations, care is reviewed by two independent peer reviewers. MEIT reviewers agree to present their peer review findings during a Focused MEIT meeting (along with the additional peer reviewer, OFMQ's Medical Director, and representatives of OHCA) scheduled at an agreeable time in Oklahoma City. *This type of review is not anonymous.*

As a peer reviewer, I am interested in participating in:

☐ Retrospective Review

☐ Medical Education/Intervention Reviews

Please print name & credentials:

_____
Last First Middle Credentials (MD, DO, etc.)

Date of Birth:_____ Last 4 of SSN:_____

Alternate Name(s): _____

515 Central Park Drive • Suite 101 • Oklahoma City, OK 73105
p: **405.898.0843** • f: **405.858.9097** • www.ofmq.com

Mailing Address:_____

If you are part of a group practice, please list the **Name of the group and note the City and State**

_____

Provide phone #, fax #, and your email: Mark the box, indicating the best way to contact you.

☐ Home Phone: _____ ☐ Work Phone/Extension: _____

☐ Cell Phone: _____ Fax # and contact: _____

☐ Email: _____

Affiliated Hospitals

Please list the **name, city and state** of facilities which you are affiliated with:

_____

_____

If you have no hospital privileges, indicate 'NONE'

Applicant Initials: _____

Certification(s) and Subspecialty(ies)

Current Board Certifications:
(Certifications only. Board eligible or Board qualified status is not recognized by URAC as a certification.)

A list of board certifications and subspecialties recognized by the American Board of Medical Specialties follows. Please check a box in **list A** reflecting your board, **list B** for your certification, and **list C** for your subspecialty.

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	**LIST B** General Certificates	**LIST C** Sub-specialty Certificates
☐ Allergy & Immunology	☐ Allergy & Immunology	
☐ Anesthesiology	☐ Anesthesiology	☐ Critical Care Medicine ☐ Hospice and Palliative Medicine ☐ Pain Medicine ☐ Pediatric Anesthesiology ☐ Sleep Medicine
☐ Colon and Rectal Surgery	☐ Colon and Rectal Surgery	
☐ Dermatology	☐ Dermatology	☐ Dermatopathology ☐ Pediatric Dermatology
☐ Emergency Medicine	☐ Emergency Medicine	☐ Anesthesiology Critical Care Medicine ☐ Emergency Medical Services ☐ Hospital and Palliative Medicine ☐ Internal Medicine-Critical Care Medicine ☐ Medical Toxicology ☐ Pain Medicine ☐ Pediatric Emergency Medicine ☐ Sports Medicine ☐ Undersea and Hyperbaric Medicine
☐ Family Medicine	☐ Family Practice	☐ Adolescent Medicine ☐ Geriatric Medicine ☐ Hospice and Palliative Medicine ☐ Pain Medicine ☐ Sleep Medicine ☐ Sports Medicine
☐ Internal Medicine	☐ Internal Medicine	☐ Adolescent Medicine ☐ Adult Congenital Heart Disease ☐ Advanced Heart Failure & Transplant Cardiology ☐ Cardiovascular Disease ☐ Clinical Cardiac Electrophysiology ☐ Critical Care Medicine ☐ Endocrinology, Diabetes & Metabolism ☐ Gastroenterology ☐ Geriatric Medicine ☐ Hematology ☐ Hospice and Palliative Medicine ☐ Infectious Disease ☐ Interventional Cardiology ☐ Medical Oncology ☐ Nephrology ☐ Pulmonary Disease ☐ Rheumatology ☐ Sleep Medicine ☐ Sports Medicine ☐ Transplant Hepatology
☐ Medical Genetics and Genomics	☐ Clinic Biochemical Genetics ☐ Clinical Cytogenetics ☐ Clinical Genetics (M.D.) ☐ Medical Molecular Genetics	☐ Medical Biochemical Genetics ☐ Molecular Genetic Pathology
☐ Neurological Surgery	☐ Neurological Surgery	
☐ Nuclear Medicine	☐ Nuclear Medicine	
☐ Obstetrics & Gynecology	☐ Obstetrics & Gynecology	☐ Critical Care Medicine ☐ Female Pelvic Medicine & Reconstructive Surgery ☐ Gynecologic Oncology ☐ Hospital and Palliative Medicine ☐ Maternal & Fetal Medicine ☐ Reproductive Endocrinology/Infertility
☐ Ophthalmology	☐ Ophthalmology	

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	**LIST B** General Certificates	**LIST C** Sub-specialty Certificates
☐ Orthopedic Surgery	☐ Orthopedic Surgery	☐ Orthopaedic Sports Medicine ☐ Surgery of the Hand
☐ Otolaryngology	☐ Otolaryngology	☐ Neurotology ☐ Complex Pediatric Otolaryngology* ☐ Plastic Surgery within the Head and Neck* ☐ Sleep Medicine
☐ Pathology	☐ Pathology-Anatomic/Pathology-Clinical ☐ Pathology-Anatomic ☐ Pathology-Clinical	☐ Blood Banking/Transfusion Medicine ☐ Clinical Informatics ☐ Cytopathology ☐ Dermatopathology ☐ Neuropathology ☐ Pathology-Chemical ☐ Pathology -Forensic ☐ Pathology- Hematology ☐ Pathology-Medical Microbiology ☐ Pathology – Molecular Genetic ☐ Pathology Pediatric
☐ Pediatrics	☐ Pediatrics	☐ Adolescent Medicine ☐ Child Abuse Pediatrics ☐ Developmental-Behavioral Pediatrics ☐ Hospice and Palliative Medicine ☐ Medical Toxicology ☐ Neonatal-Perinatal Medicine ☐ Pediatric Cardiology ☐ Pediatric Critical Care Medicine ☐ Pediatric Emergency Medicine ☐ Pediatric Endocrinology ☐ Pediatric Gastroenterology ☐ Pediatric Hematology-Oncology ☐ Pediatric – Hospital Medicine* ☐ Pediatric Infectious Disease ☐ Pediatric Nephrology ☐ Pediatric Pulmonology ☐ Pediatric Rheumatology ☐ Pediatric Transplant Hepatology ☐ Sleep Medicine ☐ Sports Medicine
☐ Physical Medicine and Rehabilitation	☐ Physical Medicine and Rehabilitation	☐ Brain Injury Medicine ☐ Hospice and Palliative Medicine ☐ Neuromuscular Medicine ☐ Pain Management ☐ Pediatric Rehabilitation Medicine ☐ Spinal Cord Injury Medicine ☐ Sports Medicine
☐ Plastic Surgery	☐ Plastic Surgery	☐ Plastic Surgery Within the Head and Neck* ☐ Surgery of Hand
☐ Preventive Medicine	☐ Aerospace Medicine ☐ Occupational Medicine ☐ Public Health and General Preventive Medicine	☐ Addiction Medicine ☐ Clinical Informatics ☐ Medical Toxicology ☐ Undersea and Hyperbaric Medicine
☐ Psychiatry & Neurology	☐ Psychiatry ☐ Neurology ☐ Neurology with Special Qualifications in Child Neurology	☐ Addiction Psychiatry ☐ Brain Injury Medicine ☐ Child & Adolescent Psychiatry ☐ Clinical Neurophysiology ☐ Epilepsy ☐ Forensic Psychiatry ☐ Geriatric Psychiatry ☐ Hospice and Palliative Medicine ☐ Neurodevelopmental Disabilities ☐ Neuromuscular Medicine ☐ Pain Medicine ☐ Sleep Medicine ☐ Vascular Neurology
☐ Radiology	☐ Diagnostic Medical Physics ☐ Diagnostic Radiology ☐ Interventional Radiology & Diagnostic Radiology ☐ Nuclear Medical Physics ☐ Radiation Oncology ☐ Medical Physics	☐ Hospice and Palliative Medicine ☐ Neuroradiology ☐ Nuclear Radiology ☐ Pain Medicine ☐ Pediatric Radiology
☐ Surgery	☐ Surgery ☐ Vascular Surgery	☐ Complex General Surgical Oncology ☐ Hospice and Palliative Medicine

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	**LIST B** General Certificates	**LIST C** Sub-specialty Certificates
		☐ Pediatric Surgery ☐ Surgery of the Hand ☐ Surgical Critical Carey
☐ Thoracic Surgery	☐ Thoracic and Cardiac Surgery	☐ Congenital Cardiac Surgery
☐ Urology	☐ Urology	☐ Female Pelvic Medicine & Reconstructive Surgery ☐ Pediatric Urology

*Subspecialties that have been approved, but not yet issued.

If your certification is NOT on the list, please document the specialty certification and the name of certifying board below.

Certification _____ Board _____

Are you a hospitalist? Yes ☐ No ☐Are you certified as a hospitalist or in hospital medicine? Yes ☐ No ☐

If your hospitalist certification is through an organization other than the American Board of Medical Specialties, please document the name of the certifying board in the area above.

If your specialty certification is Family Practice, do you deliver babies? Yes ☐ No ☐

Do you participate in your specialty Maintenance of Certification (MOC) program? Yes ☐ No ☐

Additional Required Information

Length of time providing direct patient care and dates: (IR-RCQ 1-2(a.iv)), IR-RCQ 1-4(b))

Document the dates reflecting when you have provided direct patient care on a full-time basis (37.5 or more hours a week). The years do not have to be consecutive, however if not consecutive, you must document the Month/year to Month/year of each occurrence of full time direct patient care.

Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____

Have you provided direct clinical care to patients within the past three (3) calendar years. **(IR-RCQ 1-6(b))**
Yes ☐ No ☐

Applicant Signature: _____ Date of Application: _____

Check the box beside any document you are enclosing and return with your application.
Required forms to finalize your application:

- ☐ Application
- ☐ OFMQ PR Attestations
- ☐ Curriculum Vitae
- ☐ Confidentiality of Information form
- ☐ Organizational Conflict of Interest and Disclosure of Affiliations
- ☐ W-9
- ☐ SFTP Application (OFMQ utilizes secure electronic file transfer to share records and return peer review assessment forms)

Reviewer Attestations

I have read and understand the Reviewer Application. By my signature, I attest to all of the following.

1. I will notify KFMC/OFMQ of any adverse change in licensure, certification, and/or sanction or disciplinary action within three (3) business days of the change. **(IR-RCQ 1-3(a.i))**

2. I will notify KFMC/OFMQ of any change in name, address, email address, phone contact, hospital affiliation, and group practice change within ten (10) business days of the change. **(KFMC)**

3. I am free of a history of disciplinary actions or sanctions. If at any time my status changes, I will notify KFMC/OFMQ within three (3) business days of the change.

4. I have read and understand the information included in the Peer Reviewer Orientation Manual outlining my roles as responsibilities as a Peer Reviewer. My attestation will serve as my written agreement with KFMC/OFMQ.

_____

Please print name

_____ _____

Signature Date

Confidentiality Acknowledgement Statement

By signing this form, I hereby agree:

- I understand the policies and procedures set forth.
- I understand the following types of information are confidential:
  - Personally Identifiable Information
  - Personal Health Information
  - Provider Level Data
  - Sanction Reports, Recommendations, or Reviews
  - Quality Review Information
  - QIO Information
  - Proprietary or Intellectual Data, Information, and/or Property
  - Information Marked as Sensitive, Confidential, or Internal
  - IT Systems and Configurations
- I understand it is my fiduciary responsibility to maintain the integrity and confidentiality of OFMQ data and information.
- I understand some information may be protected by Federal, State and Local Laws prohibiting the unauthorized disclosure of confidential information.
- I understand various Federal, State and Local Laws impose legal penalties, including fines and/or imprisonment, for the violation of policy and confidentiality.

By signing below I attest I am aware of OFMQ's policies and procedures, confidentiality requirements, and penalties of violation. I acknowledge I understand it is my responsibility to obtain permission to remove or disclose any information collected from OFMQ. I further attest I recognize any violation of policy may result in the immediate termination of relationship with OFMQ and any penalties resulting from of a violation of policy or federal law are my sole responsibility.

Company Name (Print)

Name (Print) **OFMQ Point of Contact Name (Print)**

Signature **Date**

CONFIDENTIALITY OF INFORMATION
PEER REVIEWERS & CONSULTANTS

The Oklahoma Foundation for Medical Quality (OFMQ) is the Quality Improvement Organization (QIO- like entity) for the state of Oklahoma. Confidential information is available to OFMQ Peer Reviewers and Consultants during case review, onsite hospital visits, telephone review, Committee meetings, and other case review activities. Confidential information is defined by in 42 CFR § 476.101 as:

(1) Information that explicitly or implicitly identifies an individual patient, practitioner or reviewer.
(2) Sanction reports and recommendations.
(3) Quality review studies which identify patients, practitioners or institutions.

OFMQ is required to advise all Peer Reviewers and Consultants of the following:

1. Confidential information must not be disclosed to unauthorized sources within or outside of OFMQ.
2. Breach of confidentiality is subject to confidentiality provisions of the Social Security Act (the Act). Disclosure of such confidential information in any manner, except as specified within Section 1160 of the Act, is subject to fines and prosecution under the Act's mandated provisions.
3. Under the confidentiality provisions of 42 CFR § 476.101 et. seq., disclosing confidential information in any manner not permitted within 42 CFR § 476.103 et. seq. is subject to fines and prosecution under mandate and provisions of 42 CFR § 476.101 et. seq.
4. Under the confidentiality provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), disclosing confidential information (which includes but may not be limited to health information, individually identifiable health information, and protected health information as defined in 45 CFR § 160.103) in any manner not permitted within the HIPAA regulations is subject to fines and prosecution under mandate and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
5. As a subcontractor or consultant for OFMQ, you are also required to comply with applicable provisions of the HIPAA Security Rule.
6. By signing this statement, you declare you have read, understand, and will honor the Confidentiality of Information provisions of OFMQ and agree to abide by the same.

_____ _____

Signature Date

_____ _____/_____

Please PRINT name OK Medical License #/UPIN #

Attachments

Acknowledgement Form for Compliance and Conflict of Interest Training

This certifies that I have attended the annual compliance and conflict of interest training which includes reading and reviewing the OFMQ Policy and Procedure for Conflict of Interest. I understand and agree to comply with OFMQ's Conflict of Interest policy.

I acknowledge I understand what is expected of me regarding compliance and ethics matters. I acknowledge it is my right and responsibility to seek guidance on compliance and ethics issues when I am uncertain about what actions to take and to report situations to management when I have reason to believe there is a violation of our policies.

To the best of my knowledge, I do not have any conflict of interest that may be seen as competing with the interests of OFMQ nor does any relative or business associate. If a potential COI does exist, I acknowledge I have completed the necessary steps for disclosure. Further, if any situation should arise in the future which could potentially involve me in a conflict of interest, I will promptly and fully disclose the circumstances to my manager, Compliance Officer or Compliance Committee. I will fully cooperate in any investigation of conduct which may be in violation of our policies.

I have brought all compliance concerns of which I am aware to the attention of my manager, Compliance Officer or Compliance Committee.

By signing below I attest I have understood the content of this training and agree to abide by all laws, policies and guidelines referenced in this training.

Name:

Signature:

Date:

Return this completed page to the Compliance Officer.

Oklahoma Foundation for Medical Quality, Inc.
Personnel Conflict of Interest & Financial Disclosure Certification
Board of Directors, Officers, Directors, Key Employees, Peer Reviewers and Managers (OFMQ Leadership)

CONFIDENTIAL PROPRIETARY BUSINESS INFORMATION

Name: _____
Title: _____
Company Name & Address: _____
Telephone No.: _____
E-mail: _____
Report Type: ☐ Initial ☐ Annual ☐ Revised

The personal conflict of interest (PCI) certification is an OFMQ and contractor requirement and includes information regarding each individual's and his/her Immediate Family. "Immediate Family" means yourself/your Spouse/Domestic Partner and/or any Dependent of the respondent or a dependent child which includes a son, daughter, stepson or stepdaughter who is either unmarried and under age 21 and living in the respondent's house, or considered dependent under the U.S. tax code. An individual need not inquire of each family member regarding these items. Only disclose those things of which you are aware. If you later become aware of a financial matter that may cause a PCI, you must submit a revised PCI verification.

OFMQ is committed to providing full disclosure to contractors regarding its leadership whose financial or business interests create an actual, apparent or potential COI. Accordingly, this Certification document presents known current or future financial interest with sufficient detail to allow a conflict of interest evaluation for contracts outside of the scope and pervue. The information provided in this form will also be used to evaluate any potential COI with existing or projected OFMQ business opportunities with other state or federal agencies.

Please provide the following information, and if not applicable, state "none." Respond to each item individually. This information may be provided on a separate page and attached to this form if more room is required.

1. Do you or your immediate family member(s) have any current or known future employment, contracts or arrangements, regardless of size, held with any insurance organization or subcontractor of an insurance organization that is being or could be reviewed under existing or future contract(s)? (Note: do not include personal insurance policies)

   ☐ No ☐ Yes If Yes, please provide the following information for each organization:

Organization name	**Type of work performed**	**Period of performance**

2. Do you or your immediate family member(s) have any healthcare-related assets, healthcare sector mutual funds, holdings for healthcare related self-directed retirement plans from previous employers; or

any type of healthcare-related real estate held for investment with a value greater than $10,000 or assets held for investment which produced more than $2,500 income?

☐ No ☐ Yes If Yes, please list each one individually:

Description of asset/investment	Held by: (yourself or family)	Dollar Amount of Asset

3. Do you or any of your immediate family member(s) have loans over $10,000 from an individual, such as a friend or business associate, who is employed by a health-care related entity or has a business association with a healthcare-related entity? (Do not include loans you owe to a family member or creditor outside of healthcare – i.e. mortgage or car loans financed through a bank or financial institution).

☐ No ☐ Yes If Yes, please list each one individually:

Description of loan/liability	Held by: (yourself or family)	Creditor Name and Address

4. Do you or any of your immediate family member(s) have healthcare-related employment, including, sources of salary, severance, bonuses, fees, commissions, honoraria, other earned income?

☐ No ☐ Yes If Yes, please provide the following information for each organization:

Organization name	Type of work performed	Date started/Period of performance

5. If applicable, please provide a list of any healthcare-associated Board of Directors and/or equivalent governing body (e.g., board of trustees; teaching; board of managers; volunteer etc.) position(s) held by you and your immediate family (include even if compensation was not paid). ☐ N/A

Name of governing body	Name (your name or your immediate family member's name)	Position	Length of time in position

6. Do you or your immediate family members have financial interests in any of the following entities?
☐ No ☐ Yes If Yes, please provide the following information:

Entity	Percentage of Ownership
Health care facility	
Health payer organization	
Health plan or association of a health plan	
Educational institution that owns or is affiliated with a medical school and/or health facility	
Pharmaceutical company	
Laboratory	
DME (Durable Medical Equipment) supplier	
Medical transport services	
Health information technology vendor (including vendors of hardware and/or software and/or support services)	
Other (specify) supplier of health services	

7. Do you or your immediate family member(s) have non-employer, healthcare related travel-related reimbursements totaling more than $250 during the prior year have any financial investments in medical companies, healthcare or medical sector funds and other healthcare or medical sector investment vehicles including but not limited to corporations, partnerships, joint ventures and other business entities?

☐ No ☐ Yes If Yes, please provide a list below (dollar amounts not required):

Source of funds	Description

Continuing Obligations:
As a Board Member, Officer, Director, Manager, key contract, peer reviewer, or other OFMQ personnel, you are required to immediately provide written notification to the Compliance Officer concerning any changes in circumstances that may be identified as an organizational conflict of interest during the term of any contract, CMS administered or otherwise, including full or partial ownership, full or part time employment, service on any governing or advisory board, or any other business, contractual, or other interest in connection with an organization or facility included in the CMS list

By signing below, you agree to recuse and physically remove yourself from any discussion or decision involving any such organization or facility with which you have identified a relationship and to enter into any other or further mitigation plan determined to be necessary by the Board's Compliance Committee or the corporate Compliance Officer in light of any particular disclosure.

You agree to hold in strictest confidence any data, information or reports presented during a Board or related committee meeting or during your employment or association with OFMQ.

By signing below, you acknowledge your agreement with the above obligations. I hereby certify that to the best of my knowledge, the information contained in this Certification is accurate:

Date: _____

Your name (printed): _____

Your signature: _____

Once the Conflict of Interest Certification and Disclosure Form has been completed and signed, please return to:
Corporate Compliance Officer
Oklahoma Foundation for Medical Quality, Inc.
515 Central Park Drive, Suite 101, Oklahoma City, OK 73105
Phone: (405) 302-3202 Email: compliance@ofmq.com

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

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

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

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

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

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

KFMC SECURE FILE TRANSFER USER ACCESS

*NOTE: All fields marked with an asterisk are required and must be completed to obtain approval.
KFMC Fax Number: 785-273-0237

Access Request

***Request Date:**	***First Name:**	**Middle Initial:**	***Last Name:**

***Business E-Mail Address:**

***Job Title:**

***Business Name:**

***Specify Setting:** *(Check all that apply)*

- ☐ Hospital
- ☐ Healthcare System
- ☐ Physician Office
- ☐ Nursing Home
- ☐ QIN-QIO
- ☐ CMS
- ☐ State Agency
- ☐ Long-Term Care Facility
- ☐ Home Health Agency
- ☐ Vendor for Hospital
- ☐ Other (specify): _____

Provider Number (if applicable)**:**

***Business Address:**

Street City State Zip

***Work Phone:**	Extension:	Fax:

Upon requesting an SFTP account, you agree to access and use the account solely for the purposes intended; namely, to transfer and retrieve or otherwise gain access to documents and information stored on the account pertaining to specific assigned jobs. You agree not to associate, input or upload any virus, trojan horse, worm, time bomb or other malicious computer programming routines that are intended to damage, interfere with, intercept or otherwise harm KFMC's systems, SFTP accounts or other KFMC hosted technology.

Any use of your SFTP account for purposes other than those intended is strictly prohibited. KFMC reserves the right to revoke any account privileges if it is determined that unauthorized use or abuse has occurred.

Users should secure and safeguard their KFMC assigned user ID and password information to prevent unauthorized access to KFMC's SFTP and any information or documents contained thereon. KFMC will not assume any responsibility or liability in the event you do not take adequate precautions to safeguard and protect your assigned user ID and password information or in the event unauthorized access is gained to your SFTP account as a result

Signatures Required

***Applicant:**	***Date:**