



Doral Dental Services of Illinois, LLC  
A subsidiary of Doral Dental

**Illinois Cover Page**

→ **Provider:** \_\_\_\_\_

→ **License Number/Doral ID:** \_\_\_\_\_

→ **NPI:** \_\_\_\_\_ **Organizational NPI:** 1932178183

→ **Specialty - Mark One:**

- General Dentist
- Oral Surgeon
- Pedodontist
- Orthodontist
- Other \_\_\_\_\_

<b>Forms Needed</b>	<b>Initial Enrollment or Re-enrollment</b>	<b>Changing or adding locations and/or payee (TIN)</b>	<b>Changing or adding locations and/or payee (SSN)</b>
Illinois Cover Page	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Office Information Page	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Provider Enrollment Application – HFS 2243 (R-7-09)	<input checked="" type="checkbox"/>		
Agreement for Participation – HFS 1413 (R-6-09)	<input checked="" type="checkbox"/>		
Enrollment Disclosure – HFS 1513 (N-6-09)	<input checked="" type="checkbox"/>		
Alternate Payee – HFS 2307 (R-9-06)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Power of Attorney – HFS 2306 (R-10-06)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
W-9 (Rev 11-2007)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Please note: A TIN that is owned by one provider can have a total of four individuals billing under that TIN (the owner and three associates). A TIN that is owned by three or more providers may have unlimited providers billing under the TIN. The state of Illinois requires that all enrollment forms have original signatures. The forms must not have anything crossed out nor can they contain any white-out. **FORMS WITH CORRECTIONS WILL NOT BE ACCEPTED!**

→ Please check the appropriate selection(s) below:

- New IL-HFS Provider
- Changing Location
- Adding Location
- FQHC Location (FQHC # \_\_\_\_\_ )
- Payee or Billing Change
- Re-enrollment
- Other \_\_\_\_\_

**Please List Office Information:**

Office Name: BETHANY FOR CHILDREN & FAMILIES

Physical Address: 1830 6TH AVE  
MOLINE, IL 61265

Phone Number: 3097977700

County: Rock Island

**Effective Date:** 4.1.2009

**Billing Entity (TIN/SSN):** 362166973

Check here if billing address is different from above

Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

LID: New

PID: New



3015 E. New York St. Ste. A2 – 273  
Aurora, IL 60504-5162  
Telephone 800.710.2629  
Facsimile 866.715.7363  
www.doralusa.com





**Doral Dental Services of Illinois, LLC**  
*A subsidiary of Doral Dental*

**OFFICE INFORMATION**  
**Please complete one form per location**

→ **Provider Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

→ **General:**

Do you see patients of all ages?     Yes     No    If no, minimum age \_\_\_\_\_ maximum age \_\_\_\_\_

Are you accepting new Illinois Department of Public Aid patients?     Yes     No

Services Provided:     Crowns     Dentures     RCT     Other (Please list) \_\_\_\_\_

Restrictions/Office Notes: \_\_\_\_\_

Check all setting(s) that apply where you will be seeing Illinois Healthcare and Family Services / AllKids Beneficiaries:

- Office Setting
- School Setting (Pre-K, K-8th grade, High School, etc.)
- Mobile Unit Setting (Nursing Homes, Extended Care Facilities, etc.)

Office Contact(s): \_\_\_\_\_

Phone/Email: \_\_\_\_\_

→ **Languages spoken at office (Check all that apply):**

- English     Mandarin     Cantonese     Hmong     Philippine     Italian
- Spanish     French     Russian     Hindi     Vietnamese     Greek
- Arabic     German     Laotian     Other (Please list) \_\_\_\_\_

→ **Office Hours:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							

**Doral Use Only:**

Application Received By:

Application Received Date:

Notes:



3015 E. New York St. Ste. A2 – 273  
 Aurora, IL 60504-5162  
 Telephone 800.710.2629  
 Facsimile 866.715.7363  
 www.doralusa.com





# PROVIDER ENROLLMENT APPLICATION ILLINOIS MEDICAL ASSISTANCE PROGRAM

(Must be Typed or Printed Legible and Do Not Use Highlighter On Any Documents.)  
All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type or print NONE.

### SECTION A: PROVIDER

1. New Enrollment  Re-Enrollment  Name Change  Reinstatement Request  2. Provider Type

3. Provider Name

4. Primary Office Address

5. City  6. County

7. State  8. Zip Code  9. Telephone:  10. Fax:

11. E-mail Address (3)

12. National Provider Identification # - NPI  **Report Additional NPI's In Section D** 13. FEIN

14. SSN  15. License/Certification  16. DEA

17. Medicare Part A#  18. Organization Type  19. Control of Facility  20. Fiscal Year

21. CLIA #

### SECTION B: SERVICE/SPECIALTY

22. Category of Service

23. Provider Specialty: Primary Specialty  Secondary Specialties

24. Physician UPIN No.  25. OBRA Qualifications (Physicians Only)

26. Hospital Admitting Privilege: (Physicians Only)

Hospital Name  Address

Hospital Name  Address

27. Pharmacy Location  28. Pharmacist In Charge  29. License #

30. Electronic Billing? Yes  No  31. If Yes, Pharmacy Software Vendor Name  32. Pharmacy NCPDP#

33. Transportation: Taxi Base/Meter/Flag Rate  34. Taxi Mileage Rate  35. Medicare: Hydraulic Manual Lift or Ramp Yes  No

36. Long Term Care Medical Bed Capacity  37. Long Term Care Medicare Fiscal Intermediary

38. Long Term Care Building ID Code

**SECTION C: FORMER PARTICIPATION**

39. Change of Ownership Yes  No  Effective Date

40. Former Provider Number  Former Provider Name

**SECTION D: ADDITIONAL NPI - National Provider Identification #**

41. NPI  NPI  NPI

NPI  NPI  NPI

**SECTION E: PAYEE INFORMATION**

42. Name  43. Telephone:

44. DBA

45. Street Address

46. City  47. State  48. Zip Code  49. TIN Type Code

50. SSN/FEIN  51. Billing Provider/Pay To NPI #

52. Medicare Part B#  53. PIN  54. DMERC#

Name  Telephone:

DBA

Street Address

City  State  Zip Code  TIN Type Code

SSN/FEIN  Billing Provider/Pay To NPI #

Medicare Part B#  PIN  DMERC#

**SECTION F: CERTIFICATION/SIGNATURE**

I understand that knowingly falsifying or willfully withholding information may be cause for the denial or termination of participation in the Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws..

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services, to verify the information provided on this application with other state and federal agencies. I further certify that I will review and comply with the Department's policies, rules and regulations including but not limited to those found at the following websites:

Illinois HFS website address: <http://www.hfs.illinois.gov/>  
Illinois HFS Handbook updates are available: <http://www.hfs.illinois.gov/handbooks>  
Illinois HFS Laws and Rule Regulations: <http://www.hfs.illinois.gov/lawsrules/index.html>

Check this box if you want a provider handbook mailed

Signature:  Date

Printed name of person signing above



## AGREEMENT FOR PARTICIPATION ILLINOIS MEDICAL ASSISTANCE PROGRAM

WHEREAS, →

\_\_\_\_\_ Full Legal as well as an Assumed (d.b.a.) name.

→

\_\_\_\_\_ (HFS Provider Number, if applicable)

hereinafter referred to as ("the Provider") is enrolled with the Illinois Department of Healthcare and Family Services hereinafter referred to as ("the Department") as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Healthcare and Family Services clients;

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program policy and billing provisions as set forth in the applicable Healthcare and Family Services Medical Assistance Program rules and handbooks.
2. The Provider agrees, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations. Hospitals are further required to be certified for participation in the Medicare Program (Title XVIII) or, if not eligible for or subject to Medicare certification, must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
3. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX and XXI of the Social Security Act and with all other applicable Federal and State laws and regulations.
4. The Provider agrees that any rights, benefits and duties existing as a result of participation in the Medical Assistance Program shall not be assignable without the written consent of the Department.
5. The Provider shall receive payment based on the Department's reimbursement rate, which shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from charges sent to the Department.
6. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to the Department for payment. Provider acknowledges that it understands the laws and handbook provisions regarding services and certifies that the services will be provided in compliance with such laws and handbook provisions. Provider further acknowledges that compliance with such laws and handbook provisions is a condition of payment for all claims submitted. Any submittal of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.
7. The Provider agrees to furnish to the Department or its designee upon demand all records associated with submitted claims necessary to disclose fully the nature and extent of services provided to individuals under the Medical Assistance Program and maintain said records for not less than three (3) years from the date of service to which it relates or for the time period required by applicable Federal and State laws, whichever is longer. The latest twelve months of records must be maintained on site. If a Department audit is initiated, the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.
8. The Provider, if a medical transportation provider, agrees that vehicle operators(s) shall have an appropriate Drivers License and vehicle(s) shall be properly registered.
9. The Provider, if not a practitioner, agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.
10. The Provider agrees to exhaust all other sources of reimbursement prior to seeking reimbursement from the Department.

11. The Provider agrees to be fully liable to the Department for any overpayments, which may result from the Provider's submittal of billings to the Department. The Provider shall be responsible for promptly notifying the Department of any overpayments of which the Provider becomes aware. The Department shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the Department.
12. The Provider (if a hospital, nursing facility, hospice or provider of home health care or personal care services) agrees to comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.
13. The Provider certifies that there has not been a prohibited transfer of ownership interest to or in the provider by a person who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12-4.25.
14. The Provider agrees to furnish to the Department or the U.S. Department of Health and Human Services (HHS) on request, information related to business transactions in accordance with 42 CFR 455.105 paragraph (b). The Provider agrees to submit, within 35 days of the date of the request by the Department or HHS, full and complete information about:- (1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
15. The Provider certifies the following owners/stock holders own 5% or more of the stock/shares. If additional space is needed for names, please use separate page. If there is no information to disclose, write NONE on PRINT NAME line. This section MUST be completed for enrollment purposes and an entry is required.

<u>None</u>		
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP

16. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws.
17. Requested effective date 4.1.2009 The Provider certifies that all services rendered on or after such date were rendered in compliance with and subject to the terms and conditions of this agreement.

**Under penalties of perjury, the undersigned declares and certifies that the information provided in this Agreement for Participation is true, correct and complete.**

ILLINOIS DEPARTMENT OF HEALTHCARE  
AND FAMILY SERVICES

→ by: \_\_\_\_\_  
(Provider Signature)

by: \_\_\_\_\_  
Division of Medical Programs

→ \_\_\_\_\_  
(Print Name of Signature above)

→ \_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## ENROLLMENT DISCLOSURE STATEMENT ILLINOIS MEDICAL ASSISTANCE PROGRAM

**1. Identifying Information**

Provider Name	DBA Name	Provider No.	NPI
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Provider Office Street Address  
1830 6TH AVE

City, County, State Moline, Rock Island, IL	Zip Code 61265	Telephone ( 309 ) 7977700
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2. (a) List the name, address, and SSN/EIN of each person and/or entity with direct or indirect ownership or control interest in the disclosing entity or any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. List any additional names, addresses, and SSN/EIN under "Remarks" on page 2.

Name	Address	SSN/EIN

(b) If any persons listed in 2(a) are related to each other as spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage, list that relationship (i.e. John Smith and Mary White are siblings).

(c) Check type of entity:  Sole Proprietorship    Partnership    Corporation    Unincorporated Associations  
 Other, please specify \_\_\_\_\_

List the name, address, and SSN of the Directors, Officers, Partners, and Managing Employees of the Disclosing Entity. List any additional names, addresses, and SSN under "Remarks" on page 2.

Name	Address	SSN

(d) Are any of the individuals/entities listed in 2(a) also current or previous owners of other Medicare/Medicaid entities?

Yes    No   If yes, for each affiliation list the individual/entity name from 2(a); the name, address, and provider number of the affiliated entity, along with the affiliation date. List any additional information as needed under "Remarks" on page 2.

Individual/Entity (2(a))	Name of Affiliated Entity	Affiliated Entity's Address	Affiliated Entity's Provider Number	Date of Affiliation

# ENROLLMENT DISCLOSURE STATEMENT

3. Has there been a change in ownership or control for the disclosing entity within the last year?  Yes  No

If yes, give date and name of prior owner(s) \_\_\_\_\_

If the prior owner is a relative of anyone listed in 2(a), state the individual from 2(a) and the relationship (spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage).

\_\_\_\_\_

4. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been convicted of a criminal offense:

Name	Ownership Interest/Position	Criminal Offense	Date

5. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been sanctioned (previously or currently) by any health care related program including, but not limited to, Medicare, Medicaid, or the Title XX services program since the inception of those Programs.

Name	Sanction	Date	State

**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 OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT WITH THE DEPARTMENT.**

→ \_\_\_\_\_ → \_\_\_\_\_  
 Name of Authorized Representative (Typed) Title

→ \_\_\_\_\_ → \_\_\_\_\_  
 Signature Date

Remarks:

## Illinois Department of Healthcare and Family Services

### HOSPITAL, PROFESSIONAL SCHOOL OR PRACTITIONER OWNED GROUP PRACTICE AS ALTERNATE PAYEE

- 1) The practitioner certifies that he or she is: a) an employee of the hospital or professional school or practitioner owned group practice and must, as a condition of his or her employment, turn over his or her fee for care or service to Healthcare and Family Services recipients to the hospital, school, or group practice; OR, b) an independent contractor under contract with the hospital and under the terms of that contract, the hospital submits the claims to the Department.
- 2) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice that, all owners, directors, members or practitioners of the group practice are licensed and eligible to participate, and at this time of application are in good standing in the Medical Assistance Program of Healthcare and Family Services.
- 3) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice, that the group practice shares facilities, equipment and personnel and maintains central patient records.
- 4) If this form is used for a hospital or school, no bills submitted by the practitioner are for services for which reimbursement has been made to the hospital or school or for which reimbursement will be sought by submission of a cost report, invoice or otherwise.
- 5) Bills submitted will only be for direct patient care rendered or supervised by that practitioner; e.g., services for which the practitioner assumes full responsibility as specified in Provider Handbooks.
- 6) The hospital, school or group practice shall be responsible for maintaining and making available to the Department all business and professional records sufficient to fully and accurately document the nature, scope, detail and receipt of services provided to Healthcare and Family Services recipients by the provider for whom this form has been submitted. The hospital, school or group practice shall be responsible for retaining such records for the period required under 89 Illinois Administrative Code 140.28, even if practitioner leaves the employ or otherwise terminates his or her relationship with the hospital, school or group practice.
- 7) The hospital, school or group practice will keep and make available to Healthcare and Family Services such records regarding any payments claimed by the hospital, school or group practice for providing services to Healthcare and Family Services recipients as the Department may request.
- 8) The hospital, school or group practice will keep and make available all financial records that may be requested by Healthcare and Family Services, specifically including records that set forth the terms of the relationship between the hospital, school, or group practice and its practitioners.
- 9) The hospital, school or group practice shall have sole financial responsibility for any bills submitted in the name of the practitioner for which it is the alternate payee. However, if the practitioner owns, directly or indirectly, 5% or more of the shares of stock or other evidence of ownership in a corporate hospital, school or group practice, or is an investor, owner or partner of the hospital, school, or group practice, the practitioner and the hospital, school or group practice are jointly and severally liable and responsible. This responsibility includes liability to repay any overpayments made by the Department. By signing this form the hospital, school, or group practice expressly authorizes Healthcare and Family Services to withhold overpayments from payments made by the Department, either as direct payments to the hospital, school, or group practice or made based on the hospital, school, or group practice being an alternate payee.
- 10) In the event the alternate payee designated on this form is not a licensed hospital, professional school or practitioner owned group practice, both the practitioner and the alternate payee designated understand and acknowledge that they shall be personally liable and responsible, jointly and severally, for any bills submitted to Healthcare and Family Services even though such bills were prepared, signed and/or submitted solely by the alternate payee or the alternate payee's agent. Liability hereunder shall include any civil and/or criminal liability, including but not limited to liability under the theory of accountability and liability for repayment of any overpayment received by the designated alternate payee, plus any penalty provided by statute.
- 11) The practitioner shall be responsible for the accuracy and truthfulness of all bills submitted on behalf of the practitioner. Bills submitted in the practitioner's name will be signed by him or her personally or by an authorized agent pursuant to a power of attorney. This power of attorney must be executed on Form HFS 2306 which shall be submitted to the Department prior to submittal of any bills signed by the agent. Practitioner understands and acknowledges that it is his or her personal responsibility to review any and all billings before such billings are submitted to Healthcare and Family Services on practitioner's behalf and/or in his or her name.
- 12) The parties signing this document acknowledge and agree that payments will be directed to the alternate payee for all dates of service beginning 4.1.2009 and thereafter (insert date no earlier than sixty days prior to submission of this document to the Department).

# Illinois Department of Healthcare and Family Services

**CERTIFICATION**

The parties to this agreement hereby certify under penalty of perjury that they are in compliance with 89 Illinois Administrative Code, Section 140.24 (d), in that: a) The medical practitioner has a contractual/salary arrangement, as a condition of employment with a hospital or professional school; b) The medical practitioner is part of a practitioner owned group practice consisting of three or more fulltime licensed practitioners or the equivalent thereof; c) The medical practitioner is employed by a practitioner who requires, as a condition of employment, that the fees be turned over to the employer; d) The medical practitioner has a contractual/salary arrangement or is employed by a governmental entity that requires, as a condition of employment that the fees be turned over to the governmental entity; e) The medical practitioner has a contractual/salary arrangement or is employed by a community mental health agency that is certified by the Department of Human Services under 59 Illinois Administrative Code, Ch. IV, Part 132 and is enrolled as a provider in the Illinois Medical Assistance Program; f) The medical practitioner has a contractual/salary arrangement or is employed by a Federally Qualified Health Clinic that is enrolled as a provider in the Illinois Medical Assistance Program. If at any time any of the conditions of this agreement are modified, the parties will immediately notify Healthcare and Family Services.

The parties acknowledge that false, inaccurate or incomplete information is grounds for cancellation of this alternate payee agreement or denial or termination of participation in the Medical Assistance Program and criminal and/or civil prosecution.

**TO BE COMPLETED BY PRACTITIONER**

→ (Signature of Practitioner)	→ (Date)	→ (Provider #)
→ (Printed Name)	→ (SSN)	 (Individual Medicare #)

**TO BE COMPLETED BY PAYEE**

The payee certifies that the following owners/stock holders own 5% or more of the stock/shares in the payee's interest. If additional space is needed for names, please use separate page. If there is no information to disclose, write **NONE** on **PRINTED NAME** line. **This section MUST be completed for enrollment purposes and an entry is required.**

None (PRINTED NAME)	(SSN)	% OF OWNERSHIP
[ ] (PRINTED NAME)	(SSN)	[ ] % OF OWNERSHIP
(Signature of Payee Representative) Thomas Tallman	Date	
(Print Name of Payee Representative)	(Group Medicare #)	

(Name of Hospital, Professional School, Practitioner Owned Group Practice, FQHC, Community Mental Health Agency or Government Entity)	(PIN - Practitioner ID number required when using a group Medicare number)
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<p>(CHECK ONE)</p> <p><input type="checkbox"/> Hospital <span style="margin-left: 200px;"><input type="checkbox"/> Government Entity</span></p> <p><input type="checkbox"/> Practitioner Owned Group Practice <span style="margin-left: 100px;"><input type="checkbox"/> Professional School</span></p> <p><input type="checkbox"/> FQHC (Provider Number _____ )</p> <p><input type="checkbox"/> Community Mental Health Agency (Provider Number _____ )</p>	(DMERC #) 362166973
	(Tax #) 3097977700
	(Telephone #)

(Doing Business As name, if applicable)  
BETHANY FOR CHILDREN & FAMILIES

PO Box 697

Moline, IL 61266

(Mailing address where payment is to be sent)

Check Box If practitioner Office Address should be changed to the Payee Address shown above.

This Alternate Payee Request is (Check One Box and Circle Affected Payee Number):

ADD CHANGE                      PAYEE 1 2 3 4 5 6 7 8 9

**POWER OF ATTORNEY**

→ I, \_\_\_\_\_, do hereby make and appoint  
(Practitioner's Name)

BETHANY FOR CHILDREN & FAMILIES as my true and lawful attorney  
(Name of Agency)

in fact solely for the purpose of affixing my name to the HFS 1443, Provider Invoice, or HFS 2360, Health Insurance Claim Form, as appropriate. I understand and acknowledge that the person appointed must be a trusted employee over whom I have direct supervision on a daily basis or the person is employed by the hospital and must sign my name to the HFS 1443 or HFS 2360 along with his/her initials. I understand and acknowledge that said person will be acting on my behalf, and that I will be bound by the certification statement on each HFS 1443 or HFS 2360. I understand and acknowledge that this Power of Attorney in no way limits my rights, liabilities or duties relating to the provision of services under the Illinois Department of Healthcare and Family Services' Medical Assistance Program. I understand and acknowledge that I retain full responsibility for all claims submitted to the Department of Healthcare and Family Services under my name.

→ \_\_\_\_\_  
Practitioner Name  
(Printed)

Signature \_\_\_\_\_ ←

Date: \_\_\_\_\_ ←

1830 6TH AVE  
Address  
MOLINE, IL 61265

Thomas Tallman  
Agent Name  
(Printed)

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Completion of this form or compliance with instructions is voluntary; however, failure to do so may affect this Department's action. Form approved by the Forms Management Center.

## Request for Taxpayer Identification Number and Certification

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

<b>Print or type See Specific Instructions on page 2.</b>	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

### Part I Taxpayer Identification Number (TIN)

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

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

Social security number
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).

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

<b>Sign Here</b>	Signature of <input type="checkbox"/> U.S. person ▶	<input type="checkbox"/> Date ▶
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## General Instructions

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

### Purpose of Form

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

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

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

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

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

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

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

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

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

**PLEASE COPY THIS PAGE AND COMPLETE ONE FOR EACH INDIVIDUAL PROFESSIONAL AND INSTITUTIONAL CATEGORY THAT IS PART OF THIS BUSINESS AND SUBJECT TO THE IOWA MEDICAID PROVIDER AGREEMENT**

16. Type Code 4	17. Licensee or DBA Name	18. Tax ID (for billing entity) 36-2166973	
19. Requested Effective Date of Enrollment* 1/1/2010			
20a. Primary Service Address		City	State Zip
20a1. Primary Address Phone Number		Fax	Email
20b. Additional Service Address		City	State Zip
20b1. Additional Service Address Phone Number		Fax	Email
20c. Additional Service Address*		City	State Zip
20c1. Additional Service Address Phone Number		Fax	Email
21. Pay-to Address Post Office Box 697		City Moline	State IL Zip 61266-0697
22. Mailing Address		City	State Zip
23a. National Provider Identifier (NPI) ATTACH A COPY OF YOUR NPPES CONFIRMATION		23b. Taxonomy Code	
24a. Primary Professional License or Certification Number – PLEASE ATTACH A COPY OF YOUR LICENSE/CERTIFICATION DOCUMENTS		24b. 10-Digit CLIA Number	24c. State Issued
24d. Initial Effective Date	24e. Current Expiration Date	24f. CLIA Effective Date	24g. CLIA Expiration Date
25. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.			
26. Primary Specialty* (if applicable)		27. Secondary Specialty* (if applicable)	
28. Has there ever been disciplinary action against this provider's license by a licensing board in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION			
29. Has the provider ever been sanctioned by Medicare or any state health program? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION			
<b>Group Linkage Information*</b> Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:			
30a. Organizational NPI 1932178183	30b. Organizational Taxonomy 193200000X	30c. Organization location zip 61265	
Name of Person Completing This Form		Signature of Person Completing This Form	

Attach a copy of License