Hospital and Ancillary Facility Application

PARAMOUNT
HMO/PPO, MEDICARE, MARKETPLACE

Please complete **all sections** of the application that are applicable to your facility. If the application is not complete or if requested documents are not submitted, the application will be returned. **Incomplete applications will not be considered for participation.**

Please submit individual applications for each Tax Identification Number (TIN) and Billing National Provider Identification Number (BNPI) combination. This includes separate applications for CBHC and SUD.

Documents Required (please check box to indicate document is attached)

☐ State License
☐ W-9 Form (Form W-9 (Rev. March 2024)
☐ Accreditation Letter(s) and/or Certificate(s) (include CLIA if applicable)
☐ Medical Liability Insurance Documentation
☐ Medicare Certification Letter
☐ Roster of employed practitioners who will provide services

Provider Information (if multiple TIN or BNPI complete a separate application for each one)

Legal/Organization/Facility Name:							
DBA (Doing Business As) Name:							
TIN:	BNPI:			Type: 1 ☐ 2 ☐		Medicare/PTAN:	
Address:							
City:	State:			Zip Code:			
Website:							
Hours of Operation:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:
Service Areas (Counties):				Number of Beds:			
Practice/Office website address:				Handicap accessibility? (Y/N):			
Languages spoken by office staff:				Public Transportation (in close proximity?) (Y/N):			
Are you currently seeing Paramount members? (Y/N):				Primary Billing Specialty:			
Remittance Information (where you want the payment sent)							
Checks payable to:							
Remittance Address:							
City:	State:			Zip Code:			
Phone:	Fax:			Email (if applicable):			
Accreditation, Licensure, and Certifications							
Accrediting Agency Name:							
Accreditation Status:				Accreditation Date:			
Have you ever been denied accreditation by any accrediting body? ☐ Yes ☐ No							

If yes, please provide details:	
Do you hold CMS Deemed Status Certification:	Last Survey Date:
License Number and Status:	CLIA Number (if applicable):

Hospital (check all services that apply)		
☐ Acute Inpatient Hospital	☐ Mammography	☐ Urgent Care
☐ Cardiac Surgery Program	☐ Physical Therapy	☐ Residential Behavioral Health
☐ Cardiac Catheterization Services	☐ Occupational Therapy	☐ OP Clinical Behavioral Health
☐ Critical Care Services – ICU units	☐ Speech Therapy	☐ Hospice
☐ Surgical Services (OP or ASC)	☐ Inpatient Psychiatric (Behavioral Health)	☐ Home Health
☐ Skilled Nursing	☐ Outpatient Infusion/Chemotherapy	☐ Inpatient Rehabilitation
☐ Diagnostic Radiology	☐ Emergency Services	☐ Long Term Care

Home Health Agency or Skilled Nursing Facility (check appropriate box and complete the questions below)	
☐ Home Health Agency	☐ Skilled Nursing Facility
CMS Star Rating:	If rating is less than 3 stars, your application will not be considered for credentialing.
Do you admit high risk patients (sex offenders, recovering substance abusers, etc.)? ☐ Y ☐ N	*If yes, please include a copy of the policy in place for this location as required per the Ohio Department of Health (ORC 3721.122)

Ancillary Facility (not hospital, home health agency, or skilled nursing facility) check all that apply		
☐ Ambulance	☐ Hospice	☐ Rural Health
☐ Ambulatory Surgical Center	☐ Palliative Care: ☐ Y ☐ N	☐ Speech Therapy
☐ Cardiac Monitoring	☐ Hyperbaric Medicine	☐ Urgent Care
☐ Clinic: Type 2 NPI	☐ Infusion Center	☐ Other
☐ Dialysis Center	☐ Laboratory	☐ Type 2 NPI
☐ Durable Medical Equipment	☐ Occupational Therapy	
☐ Federally Qualified Health Center	☐ Pain Management	
☐ Health Department	☐ Physical Therapy	
☐ Home Infusion	☐ Radiology	

Behavioral Health Providers (complete the questions below)		
Laboratory Services: ☐ Y ☐ N	Submit Lab Claims: ☐ Y ☐ N	
Gender Limitations:	Male only ☐ (check box)	Female only ☐ (check box)
Age Limitations:	Minimum Age:	Maximum Age:
Other Practice Limitations:	☐ Y ☐ N	If yes, explain:

Contact Information

Who will be designated as the contact person for Paramount relating to **BILLING** issues?

Name: Phone:

Title: _____ Email:

Who will be designated as the contact person for Paramount relating to **CREDENTIALING** issues?

Name: Phone:

Fax:

Title: _____ Email:

Who will be designated as the contact person for Paramount relating to **CONTRACT** issues?

Name: Phone:

Title: Email:

Authorization and Attestation

I am the authorized agent of the Applicant described above and have the authority to execute this document on behalf of the Applicant. I understand that as part of the credentialing application process to participate as a Provider with Paramount Health Care, all Applicants are required to provide sufficient and accurate information for proper evaluation of all criteria used by Paramount for determining initial and ongoing eligibility for Participation. I have verified that the above information is true and complete to the best of my knowledge and agree to inform Paramount promptly if any material change in such information occurs, whether before or after my entering into an agreement with Paramount for the provision of medical services.

Document Prepared by: _____ Signature:_____

Title: _____ Date: _____

Phone Number: _____

Please return completed application and contract by email to:

Paramount Health Care

P.O. Box 928

Toledo, OH 43697-0928

PHCProvider.Contracting@MedMutual.org (email)

Attention: Provider Contracting Department

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)

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.)

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 . . . . . ☐

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