



## Network Provider Information Form (PIF)

**Note:** If you are not currently contracted with Hennepin Health or have not received an offer to contract with Hennepin Health, complete the Non-Network Provider Information Form found on our website at [www.hennepinhealth.org](http://www.hennepinhealth.org).

Submit completed forms and any questions via email to [hhnetworkmanagement@hennepin.us](mailto:hhnetworkmanagement@hennepin.us). **Remember to also include your W-9.** Please allow 30 business days for this information to be processed.

BUSINESS INFORMATION	
<b>Legal Business Name</b> <i>(as appears on W-9)</i>	
<b>DBA Name</b>	<b>Website Address</b>
<b>Federal Tax ID</b>	<b>TYPE 2 Organization NPI/UMPI</b>

ELECTRONIC CLEARINGHOUSE INFORMATION
<p>Hennepin Health accepts electronic claims submission and sends remittance advices through:</p> <ul style="list-style-type: none"> <li>Change Healthcare (formerly Emdeon): <a href="http://www.changehealthcare.com">www.changehealthcare.com</a> (877-271-0054)</li> <li>RelayHealth: <a href="http://www.relayhealth.com">www.relayhealth.com</a> (888-743-8735)</li> <li>ClaimLynx: <a href="http://www.claimLynx.com">www.claimLynx.com</a> (952-593-LYNX (5969))</li> </ul> <p>If you are not already registered with these clearinghouses, please contact them via the telephone or website address provided.</p> <p>Please complete the following regarding your claims submissions and remittance advices:</p> <p><b>Electronic Claims Submission Type</b> <input type="checkbox"/> 837I <input type="checkbox"/> 837P</p> <p> <input type="checkbox"/> Change Healthcare (formerly Emdeon)      <input type="checkbox"/> ClaimLynx  <input type="checkbox"/> RelayHealth      <input type="checkbox"/> Other         </p> <p><b>Remittance Advice (835)</b></p> <p> <input type="checkbox"/> Change Healthcare (formerly Emdeon)      <input type="checkbox"/> ClaimLynx  <input type="checkbox"/> RelayHealth      <input type="checkbox"/> Other         </p>

LOCATION INFORMATION			
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Primary Phone</b>		<b>Appointment Phone</b>	
<b>After Hours Phone</b>	<b>Fax</b>	<b>TDD</b>	
<b>Please specify your days/hours of operation</b> (e.g., M-F 8 a.m. - 5 p.m., Sat 8 a.m. - 1 p.m., Sun closed)			
<b>Publish location in directory?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Accepting new patients?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please list all hospital affiliations for this location</b>			
<b>Please specify all languages spoken at this location</b>			
<b>Service accessibility information:</b> <ol style="list-style-type: none"> <li>1. Does the organization provide Cultural Competency training? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>2. Do you offer flexible appointment hours at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>3. Is this location wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>4. Is transfer assistance available? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>5. Are private waiting areas available? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>6. What is the approximate distance from this location to public transportation? <ol style="list-style-type: none"> <li>a. 1 to 2 blocks <input type="checkbox"/></li> <li>b. 3 to 5 blocks (1/4 mile) <input type="checkbox"/></li> <li>c. 6 to 8 blocks (1/2 mile) <input type="checkbox"/></li> <li>d. 9 to 10 blocks (3/4 mile) <input type="checkbox"/></li> <li>e. 11-13 blocks (1 mile) <input type="checkbox"/></li> <li>f. More than 2 miles to public transportation <input type="checkbox"/></li> </ol> </li> <li>7. Is the exam room large enough for patient and additional person; including space for assistive equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>8. Is the exam room equipped with a chair scale available to persons with disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ol>			
<b>Please check the box if you have additional locations</b> <input type="checkbox"/> Visit <a href="http://www.hennepinhealth.org">www.hennepinhealth.org</a> to access the provider location roster.			

SERVICES AT THIS LOCATION <i>(check all that apply)</i>	
<input type="checkbox"/> ACUPUNCTURE	<b>CHEMICAL HEALTH</b> (options below)
<input type="checkbox"/> AUDIOLOGY	<input type="checkbox"/> ASSESSMENT/DIAGNOSIS (RULE 25)
<input type="checkbox"/> CHILD AND TEEN CHECKUPS	<input type="checkbox"/> IP HOSPITAL TREATMENT
<input type="checkbox"/> CLINIC SVCS	<input type="checkbox"/> OP METHADONE TREATMENT
<input type="checkbox"/> CULTURALLY SPECIFIC SVCS (PLEASE SPECIFY)	<input type="checkbox"/> OP TREATMENT
<input type="checkbox"/> DIABETIES MANAGEMENT	<input type="checkbox"/> RESIDENTIAL NON-HOSPITAL TREATMENT
<input type="checkbox"/> DIAGNOSTICS	<input type="checkbox"/> OTHER (PLEASE SPECIFY)
<input type="checkbox"/> DOULA SVCS	<b>MENTAL HEALTH</b> (options below)
<input type="checkbox"/> EATING DISORDERS	<input type="checkbox"/> ADULT REHABILITATIVE MENTAL HEALTH SERVICES (ARMS)
<input type="checkbox"/> EYE EXAMS	<input type="checkbox"/> ASSERTIVE COMMUNITY TREATMENT (ACT)
<input type="checkbox"/> EYE WEAR – ONSITE	<input type="checkbox"/> BEHAVIORAL HEALTH HOME (BHH)
<input type="checkbox"/> GENDER HEALTH SVCS	<input type="checkbox"/> CERTIFIED PEER SPECIALIST
<input type="checkbox"/> HEALTH CARE HOME	<input type="checkbox"/> CHILDREN'S MENTAL HEALTH
<input type="checkbox"/> HOSPICE	<input type="checkbox"/> DAY TREATMENT
<input type="checkbox"/> LGBTQ	<input type="checkbox"/> DIALECTICAL BEHAVIORAL THERAPY
<input type="checkbox"/> DME (PLEASE SPECIFY)	<input type="checkbox"/> EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI)
<input type="checkbox"/> OCCUPATIONAL THERAPY	<input type="checkbox"/> IP TREATMENT
<input type="checkbox"/> PAIN MANAGEMENT	<input type="checkbox"/> INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES (IRTS)
<input type="checkbox"/> PHYSICAL THERAPY	<input type="checkbox"/> OP TREATMENT
<input type="checkbox"/> PRIMARY CARE CLINIC SVCS	<input type="checkbox"/> TARGETED CASE MANAGEMENT
<input type="checkbox"/> RESPIRATORY THERAPY	<input type="checkbox"/> OTHER (SPECIFY TYPE)
<input type="checkbox"/> SMOKING CESSATION	<b>TRANSPORTATION</b> (options below)
<input type="checkbox"/> TELEMEDICINE	<input type="checkbox"/> EMERGENCY MEDICAL
<input type="checkbox"/> URGENT CARE	<input type="checkbox"/> PROTECTED TRANSPORTATION
<input type="checkbox"/> OTHER (PLEASE SPECIFY)	<input type="checkbox"/> SPECIALIZED MEDICAL TRANSPORTATION
	<input type="checkbox"/> CURB TO CURB SERVICE
	<input type="checkbox"/> DOOR THROUGH DOOR SERVICE
	<input type="checkbox"/> DOOR TO DOOR SERVICE
	<input type="checkbox"/> OTHER (PLEASE SPECIFY)

**CONTACT INFORMATION**

**Contracting and Correspondence Mailing  
Street Address**

**City**

**State**

**Zip Code**

*Same as location address*

**Contracting Contact** *(name, email, phone)*

**Credentialing Contact** *(name, email, phone)*

**Billing Contact** *(name, email, phone)*

**Date of Form Completion**

Please note that once your completed form and W-9 is received, additional information may be requested. Thank you!

<b>Hennepin County General Accounting</b> <b>A-12 Government Center MC 128</b> <b>300 South 6th Street</b> <b>Minneapolis, MN 55487-0128</b> Email: <a href="mailto:OBF.Internet@hennepin.us">OBF.Internet@hennepin.us</a>	<b>SUBSTITUTE FORM W-9 and Vendor Information Form</b>
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**IMPORTANT TAX INFORMATION - PLEASE READ THIS NOTICE CAREFULLY**

This form was developed to comply with Internal Revenue Service (IRS) regulations and Minnesota statute and to assist Hennepin County in paying providers and vendors for their goods and services. You, as a payee, are required by law to provide us, as payer, your correct Taxpayer Identification Number (TIN). This information will only be shared with the IRS. The Minnesota Government Data Practices Act classifies the Social Security Number as private. Unless otherwise provided by law, the home address is also private. Direct questions to 612-348-2976.

**Failure to respond to this request can result in IRS-mandated withholding on future payments as well as other penalties.**

**If you are an existing Hennepin County vendor and wish to update your information, check this box:** *Update information only*

<b>Contract Number</b> (if available)		
<b>Taxpayer Identification Number</b> <small>(TIN): Enter your social security number (SSN) if an individual or federal employer identification number (EIN) if a business.</small>	<b>SSN / EIN:</b>	
<b>Provider Name and Remittance Address:</b> <small>NOTE: Name must match your social security card if you are an individual or sole proprietor. All other businesses must use the name that was used when your employer identification number was applied for.</small>	<b>Name:</b>	
	<b>Business Name, if different from above:</b>	
	<b>Remit Address:</b>	
	<b>City, State &amp; ZIP:</b>	
	<b>Remit Phone #:</b>	
	<b>Company Website/URL:</b>	
<b>Provider Order Address Information</b>	<b>Order Address:</b>	
	<b>City, State &amp; ZIP:</b>	
	<b>Order Contact Name:</b>	
	<b>Order Phone #:</b>	
	<b>Order Email Address:</b>	
<b>Purchase Order Preferences</b>	<b>By which method do you prefer to receive purchase orders?</b> <input type="checkbox"/> Email <input type="checkbox"/> US Mail	
<b>Business Structure</b>	<b>Number of Employees</b>	<b>NAICS Code</b> <small>(see <a href="http://www.naics.com/search">www.naics.com/search</a>)</small>

**Certification:** Under penalties of perjury, I certify that:

- 1) The number shown on this form is my correct taxpayer identification number, and the name shown is the correct corresponding name.
- 2) I am subject to 1099 reporting unless one of the following is checked:  
 Government Entity.  
 Tax Exempt Organization.  
 Corporation that does not provide medical services or billing/collection for medical services.  
 Other (please specify): \_\_\_\_\_
- 3) I am a U.S. person (including a U.S. resident alien).
- 4) 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 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.

**Certification Instructions:** You must cross out item 4 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting of interest or dividends on your tax return.

<b>Print and Sign Here:</b>	<b>Name Printed:</b>	<b>Title Printed:</b>	
	<b>Signature:</b>	<b>Phone:</b>	<b>Date:</b>

## HENNEPIN COUNTY CONTRACTOR AFFIRMATIVE ACTION (AA) CLASSIFICATION

The information requested below is used internally by Hennepin County to monitor and report on participation in county contracting. Your cooperation in completing this form is greatly appreciated.

Vendors who do not complete this information may be contacted by Hennepin County to provide the information requested. If you have questions completing this side of the form, please call: (612) 348-3181.

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1) **Check One:**

- Publicly held company<sup>1</sup>
- Non-profit entity
- Government entity
- Other



*If you chose one of these, STOP HERE.*

*If you chose "Other" please answer all remaining questions*

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2) **Check One:**

- Small Business Certified by CERT Program<sup>2</sup>
- NOT a CERT<sup>2</sup> Certified Small Business

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3) **Check One gender of majority owner:**

- Male
- Female

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4) **Check One ethnicity of majority owner<sup>3</sup>:**

- Black/African American
- Hispanic
- Asian or Pacific Islander
- American Indian or Alaskan Native
- White/Caucasian

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<sup>1</sup> **A Publicly Held Company** is a company whose stock is traded on the open market.

<sup>2</sup> **Small Business Enterprise Certification:**

While certification is not necessary to do business with Hennepin County, only CERT certified businesses can be counted toward the goal for Small Business Enterprise (SBE) participation in county contracting. Certification also boosts market exposure and qualifies businesses to access SBE program services. For further information about certification, please call 651-266-8900 or visit the Central Certification Program's website at: <http://cert.smwbe.com>.

<sup>3</sup> **Ethnicity and Gender Definitions:**

**Black/African American:** All persons having origins in any of the Black racial groups of Africa.

**Hispanic:** All persons of Mexican, Puerto Rican, Cuban, Central or South American descent or other Spanish culture of origin, regardless of race.

**Asian or Pacific Islander:** All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Sub-continent or the Pacific Islands, including, for example, China, Japan, Korea, Hawaii, Guam, the Philippine Islands and Samoa.

**American Indian or Alaskan Native:** All persons having origins in any of the original peoples of North America, and who maintain tribal affiliation or community attachment.

**White/Caucasian:** All persons with origins in any of the original peoples of Europe, North Africa or the Middle East.