PROVIDER SUBSTITUTE W-9/OFFICE INFORMATION SHEET

HEALTHPLEX®
THE DENTAL BENEFIT EXPERTS℠

Taxpayer Identification

Please complete the following in place of a W-9 form. Provide the TIN or SSN that you would like Healthplex to pay claims to.

Tax Identification # for IRS Form 1099 Reporting

Name for IRS Form 1099 Reporting

Name for directory listing, if different from above

Check The Appropriate Box ☐ Check Individual/Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other _____

For 1099 Issuance, please provide the effective date with the IRS* / /

Organizational NPI# associated with the practice

Certification

I certify that:

1. The number shown on this form is my correct taxpayer indentification number (or I am awaiting a number to be issued to me), and
2. I am not subject to backup withholding.

Owner's Signature Date Phone

Print Name of Owner

Office Address

City State Zip County

**To ensure the name and Tax ID match, please refer to your IRS-issued, estimated tax payment pre-printed coupons if available. Use the same name and number above as on your last IRS filing.*

Please mail, fax or email this completed form to:

Healthplex, Inc.
Attn: Provider Relations Department
333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608

F 516 228 9571
E providerrelations@healthplex.com

PROVIDER SUBSTITUTE W-9/OFFICE INFORMATION SHEET

Office Information

Owner's Name

Practice Name

Office Address

City State Zip County

Phone Number Fax Number

Email Address

Office Hours Mon: _____ Tues: _____ Wed: _____

Thurs: _____ Fri: _____ Sat: _____ Sun: _____

Is the office accessible by public transportation? ☐ Yes ☐ No

Have any of the providers in the office been trained on cultural competency? ☐ Yes ☐ No

Does your office support electronic prescribing? ☐ Yes ☐ No

Is your office currently accepting new Healthplex patients? ☐ Yes ☐ No

Type of Specialty Providers in Office

☐ General ☐ Endodontics ☐ Oral Surgery ☐ Orthodontics

☐ Pedodontics ☐ Periodontics ☐ Prosthodontics

Languages spoken in the office by staff

List all practicing dentists*:

1. Name _____ Specialty _____ License # _____

   Individual NPI # _____ Medicaid # _____ Languages _____

   ☐ Owner ☐ Employee

2. Name _____ Specialty _____ License # _____

   Individual NPI # _____ Medicaid # _____ Languages _____

   ☐ Owner ☐ Employee

3. Name _____ Specialty _____ License # _____

   Individual NPI # _____ Medicaid # _____ Languages _____

   ☐ Owner ☐ Employee

4. Name _____ Specialty _____ License # _____

   Individual NPI # _____ Medicaid # _____ Languages _____

   ☐ Owner ☐ Employee

**Please list any additional providers on a separate page.*

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Please answer the following questions.

Are you willing to treat patients with special needs? ☐ Yes* ☐ No

*** By answering "yes," your office is willing to treat children and adults who have, or are at increased risk for: chronic physical, developmental, behavioral, or emotional conditions or disabilities, and patients with substance abuse, HIV/AIDS, deafness or hard-of-hearing, blindness or visual impairment, co-occurring disorders, homelessness, or any other special needs or conditions. These patients may require health and related services of a type or amount beyond what is generally required.**

Is the office wheelchair accessible? ☐ Yes ☐ No

Can the patient be treated in his/her own wheelchair? ☐ Yes ☐ No

Can you see patients after normal business hours who require urgent dental care? ☐ Yes ☐ No

Please indicate which of the following treatments/services are available through your office:

- ☐ Behavior Management Techniques
- ☐ Nitrous Oxide
- ☐ Anesthesiologist Comes to the Office
- ☐ IV Sedation
- ☐ Treatment in the Operating Room

Does your office see and treat children 6 and under? ☐ Yes** ☐ No

**If yes, please indicate what age range: _____

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