Network Provider Credentialing Application & Agreement

Credentialing: (800) 510-4194; credentialing@starthearing.com

Business Owner Information:

Required	Business Name (legal):	
	Address:	City, State, Zip Code
	Phone:	Email:
	TIN #	NPI #

Provider Information: *Please attach a roster for more than one provider, - include all required fields below for each provider and indicate their locations*

Required	First:	Middle:	Last:
	Maiden/Former/Other Names:	DOB:	State:
	Email:		
	CAQH #	NPI #	License # _____ Au.D. _____ HIS/HAD/HAS

Dispensing Location Information: *Please attach a roster for more than one location - include all required fields below for each location*

Required	Business Name (legal):		
	Business Name (DBA):		
	Address:		City, State, Zip Code:
	Phone:		Email:
	TIN #	NPI #	
	Type of Service: Office Only Mobile Only Physical Office & Mobile		**Mobile Locations Only:** Please include a separate document listing your service area. If multiple ZIP codes, you can attach an Excel file when you email your application.

Provider Portal Location Staff: *Providers will receive login – please provide additional staff you would like to have access. All emails must be unique. Additional names can be provided on separate sheet, if needed.*

Required	Name:	Role **OWNER**	Email:
	Name:	Role **CREDENTIALING**	Email:
	Name:	Role **BILLING**	Email:

Please include the following attachments when you send your application to Start Hearing Credentialing.

- **Professional (Malpractice) Liability Insurance Certificate**
  - Required Minimum Coverage Limits - $1 million per occurrence/$3 million aggregate
  - All Professionals must be covered
  - Start Hearing to be named as certificate holder
- **Business License (if applicable)**
  - Includes any city, county or state business license required by the city, county, or state, where the business is located, to do business.
- **Current W-9**
- **Provider Roster** (if applicable)
- **Dispensing Location Roster** (if applicable)
- **Service Area** (Mobile locations only)

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START HEARING

Direct Deposit Information:

AUTHORIZATION TO MAKE (EFT) ELECTRONIC FUND PAYMENTS VENDOR ACKNOWLEDGES AND AGREES THAT THE TERMS AND CONDITIONS OF ALL AGREEMENTS OR PURCHASE ORDERS WITH START HEARING CONCERNING THE METHODS AND TIMING OF PAYMENTS FOR GOODS AND/OR SERVICES SHALL BE AMENDED AS PROVIDED HEREIN. VENDOR WILL NOTIFICY START HEARING OF ANY CHANGES IN DEPOSISTORY FINANCIAL INSTITUATION OR OTHRE PAYMENT INSTRUCTIONSS 15 DAYS IN ADVANCE		
Company Name on Bank Account	Bank Account #	Routing #(9 digits)
Financial Institution Name	Street Address	City, State, ZIP
Bank SWIFT or BIC #	Email (Payment Notifications)	Type: Checking Savings

Business Owner Attestation and Disclosure:

I certify that I am answering no to all the following questions		
NO	Has your current business ever been disciplined, reprimanded or fined by any state licensing agency or other authorizing agency that monitors healthcare providers?	Has your business license ever been suspended, excluded, reprimanded or debarred from, or otherwise become ineligible to participate in any state or federal government programs, Medicare and Medicaid?
	To your knowledge, are you the subject of an investigation by any licensing board or other state or federal investigative body as of the date of this form?	In the past 5 years, has your business had any malpractice or professional liability suits settled, arbitrated, litigated or mediated?
	Has your business license ever experienced a voluntary or involuntary termination, limitation, reduction, loss, denial or non-renewal of a professional membership or clinical privileges?	Have you ever been convicted of a felony? Have you ever been named as a defendant and/or convicted of any criminal offense related to the provision of healthcare items or services?
If you have answered yes, please give dates and details on separate sheet		
I certify that I am answering yes to all the following questions		
YES	Is your office ADA compliant?	Is your practice HIPAA compliant?
	Does your office comply with OSHA/CDC standards and those set by the profession for barrier control techniques, sterilization, infection control, and handling of hazardous materials and/or waste?	Do you maintain professional liability/malpractice (errors & omissions) coverage to at least the limits of $1 million per incident and $3 million aggregate.

I certify that the information in the Start Hearing credentialing packet is complete and accurate to the best of my knowledge. I understand that my eligibility as a participating business entity in the Start Hearing network depends on the approval of this information and I agree to notify Start Hearing of any changes to my business licensure or professional liability coverage within ten business days. I confirm that my office(s) comply with CDC/OSHA infection control standards and ADA accessibility requirements. I understand that Start Hearing may review information from third-party entities such as state licensing boards and malpractice carriers, and I authorize the release of such information as necessary.

By submitting this Quick Credentialling application, I acknowledge that it is subject to review and approval by Start Hearing. Upon approval, I will be credentialed as a Start Hearing Network Provider and agree to adhere to the Terms and Conditions outlined in Exhibit G of the Start Hearing Provider Manual and all associated policies and procedures. By signing, I agree to be bound by these Terms and Conditions and all provisions of the Start Hearing Provider Manual as if fully included herein.

The “Owner” and “Business” understand and agree that it shall be solely responsible for ensuring that the entity, its employees and hearing professionals comply with Start Hearing Network policies and procedures, Start Hearing credentialing requirements, Start Hearing Provider Manual, Start Hearing Provider Guides.

Business Owner Signature:	**Printed Name & Title:**	**Date:**
Start Hearing Signature:	**Printed Name & Title:** Amber Knettel - VP Start Hearing	**Date:**

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)

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 . . . . . ☐

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.)

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