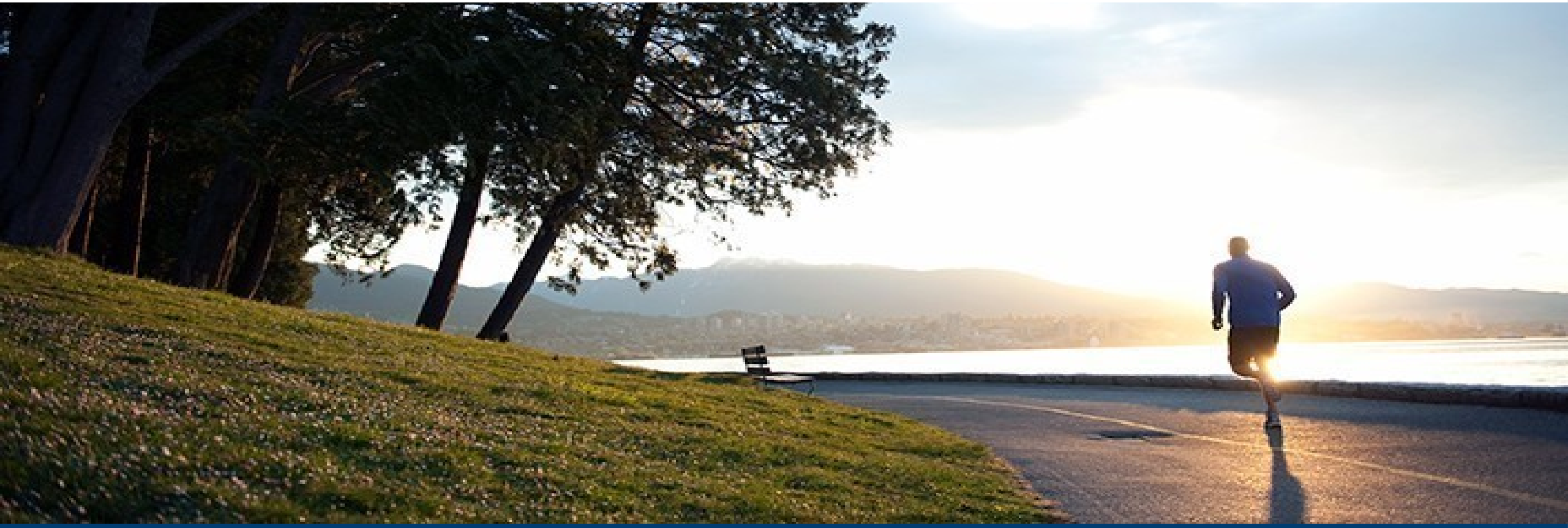
UNITEDHEALTH GROUP



Provider Relief Fund (PRF)

HRSA
Health Resources & Services Administration

PRF and ARPA–R Attestation Portal

Vision: Healthy Communities, Healthy People

All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Step 1 Eligibility | Step 2 Billing TIN(s) | Step 3 Verify Payment Information | Step 4 Attestations | Confirmation

Step 1 Eligibility

The US Department of Health and Human Services (HHS) has announced $175 billion in relief funds to hospitals and other healthcare providers on the front lines of the coronavirus response as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act. This funding, along with additional relief funding outside of the CARES Act*, supports healthcare-related expenses or lost revenue attributable to COVID-19 and ensures uninsured Americans can get treatment for COVID-19. This site is open to all providers that have received a Provider Relief Fund payment and/or other COVID-19 response payments, such as the Rural Health Clinic (RHC) COVID-19 Testing and Mitigation Program, regardless of network affiliation or payer contract. HHS is contracting with UnitedHealth Group to facilitate delivery of the funds.

HHS plans to make publicly available the names of payment recipients and the amounts received for all providers who either attest to receipt of a payment and acceptance of the Terms and Conditions or who retain payments for more than 90 days and are deemed to have accepted the Terms and Conditions. By accepting funds, the recipient consents to HHS publicly disclosing the payments that recipient has received from the Provider Relief Fund and/or other COVID-19 response payments.

Eligibility

You must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 90 days of Automated Clearing House payment or 90 days for check payment issuance. Should you choose to reject the funds, you must also complete the attestation to indicate this. This Payment Portal will guide you through the attestation process to accept or reject the funds.

Do you or your organization meet **one or more** of the following criteria?

- Billing entity that received Medicare fee-for-service (FFS) payments from the Centers for Medicare and Medicaid Services (CMS) in 2019
- Rural acute care general hospital, Critical Access Hospital (CAH), Rural Health Clinic (RHC), or Community Health Center located in a rural area
- Rural Health Clinic (RHC) that has a Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) and is listed in either in the CMS Provider of Service file or the CMS Survey & Certification's Quality, Certification and Certification and Oversight Reports (QCOR)*
- Indian Health Service (IHS), Tribal or Urban Indian Health program
- Skilled Nursing Facility (SNF)

(•) Yes
( ) No

*This website / portal is primarily used to administer attestation and payment of relief funds from the CARES Act, the Paycheck Protection Program and Health Care Enhancement Act, and the American Rescue Package. It is also used to administer attestation and payment of relief funds from other HHS programs. These programs may have separate Terms and Conditions. For additional information, please visit hhs.gov/providerrelief or call the provider support line at (866) 569-3522; for TTY dial 711.

HRSA Health Resources & Services Administration

All data displayed here is sample data for example purposes only.

Privacy Act Statement

The following statement serves to inform you of the purpose for collecting personal information required by the covid19.linkhealth.com website and how it will be used.

AUTHORITY: 31 U.S.C. 3512, 3711, 3716, 3721, 1321; note E.O. 13520

PURPOSE: To collect information to determine eligibility for Provider Relief Fund payments and process payment to you.

ROUTINE USES: The information collected is used by HHS to determine eligibility for payments from the Public Health and Social Services Fund, maintain an accounting of payments, and process payments from the Fund. Examples of other permissible uses include, but are not limited to, a contractor (and/or to its subcontractor) who has been engaged to perform services on an automated data processing (ADP) system used in processing financial transactions, to appropriate law enforcement agencies when relevant to an investigation, to the Treasury Department, and to auditing organizations conducting financial or compliance audits. A complete list of routine uses may be found at https://www.federalregister.gov/documents/2015/[illegible]/03/[illegible]15-279[illegible]0/privacy-act-of-1974-system-of-records-notice

DISCLOSURE: Voluntary. If you choose not to provide your information, absence of the requested information may result in administration delays or the inability to process payments to you under the CARES Act.

Continue

CARES
PROVIDER RELIEF FUND

Step 1 Eligibility — Step 2 Billing TIN(s) — Step 3 Verify Payment Information — Step 4 Attestations — Confirmation

Step 2 Billing TIN(s)

Billing Tax ID Number(s)

Please enter the Taxpayer Identification Number (TIN) (either Employer Identification Number or Social Security Number) connected to the billing entity you entered in the previous step. You may enter up to 20 TINs as long as they are attached to the same billing entity. TINs must have all 9 digits entered to be accepted.

Billing TIN(s)

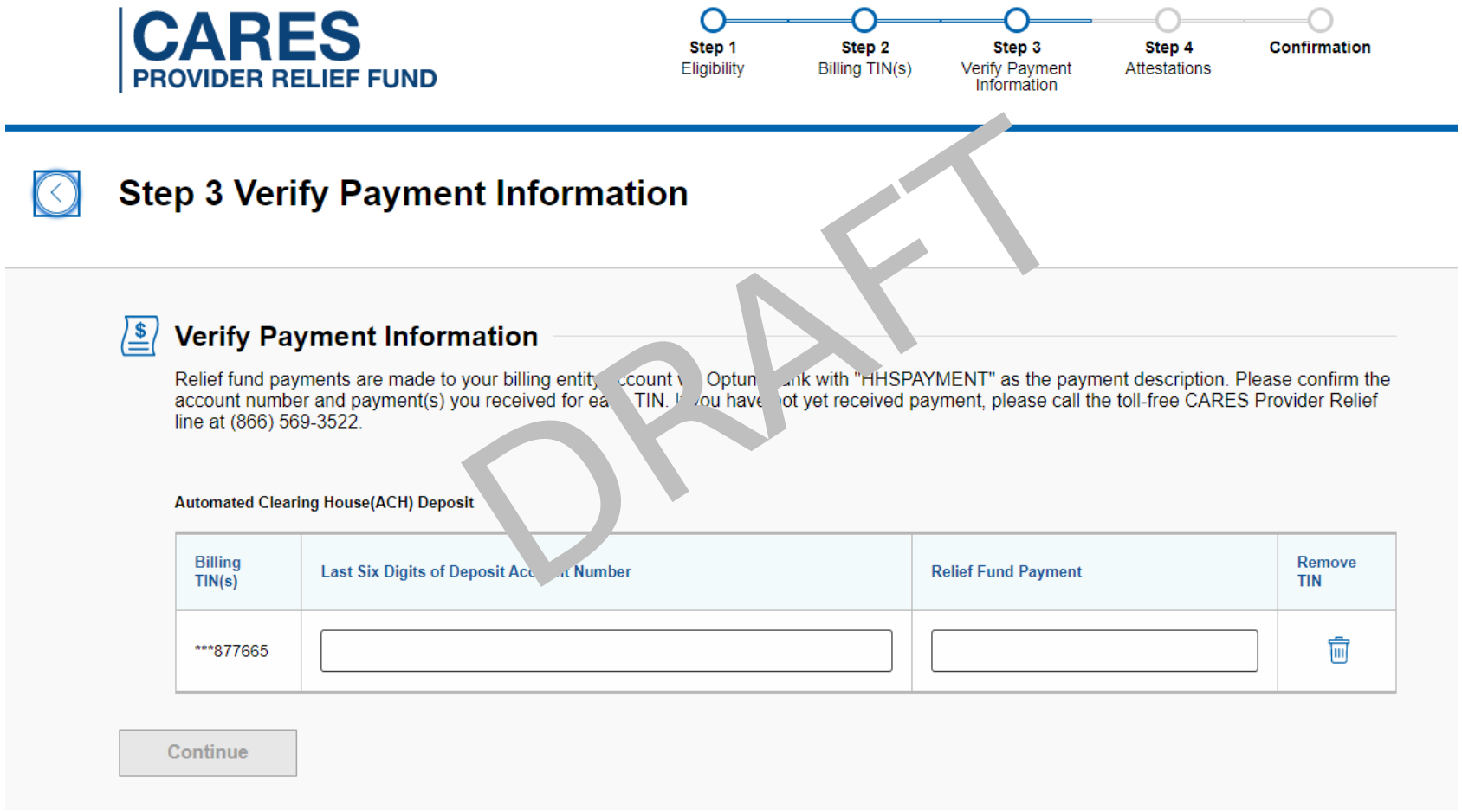
998877665

Type, or copy/paste TIN(s) here. Multiple TINs should be separated by commas.

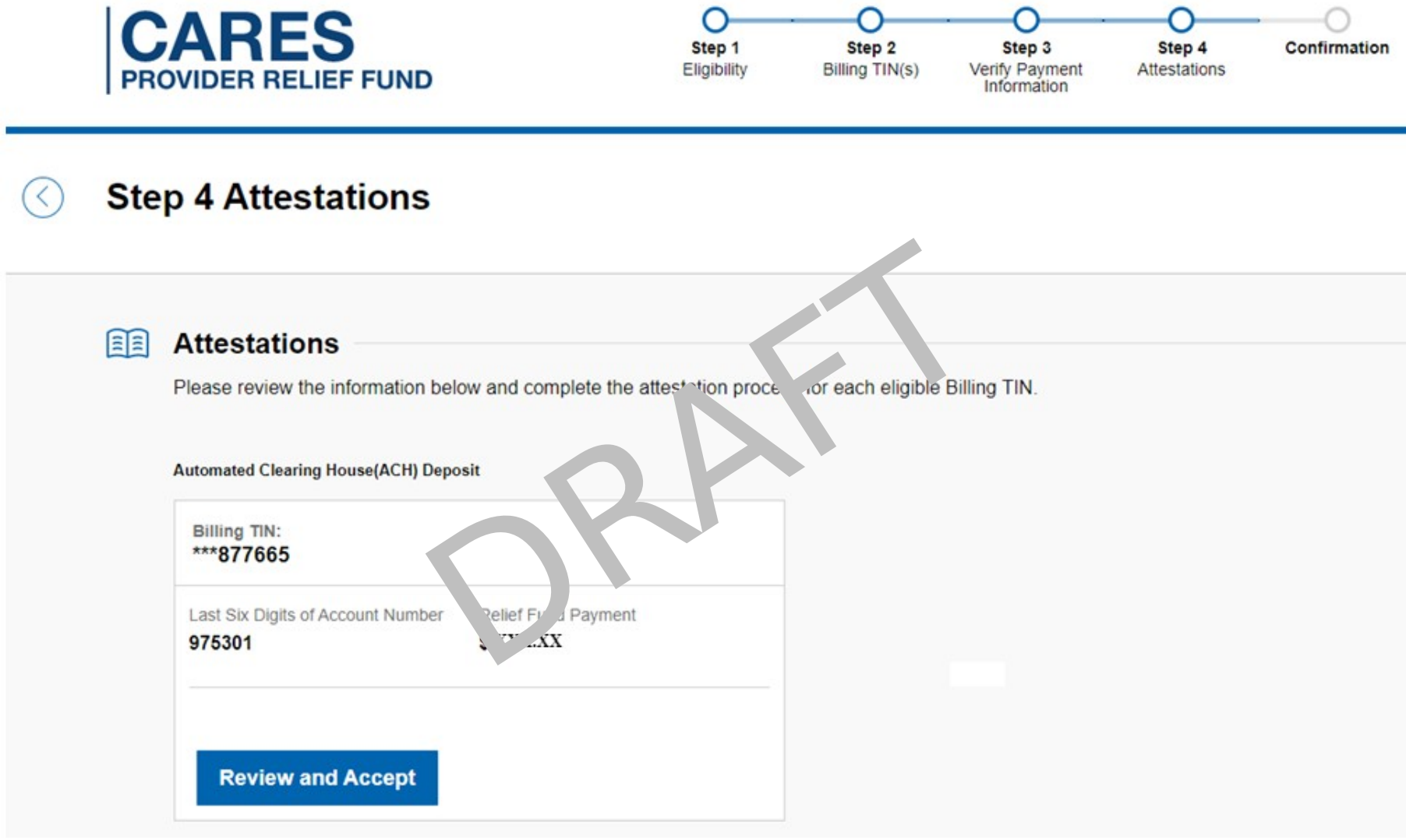
Continue

HRSA Health Resources & Services Administration

PRF and ARPA–R attestation portal: Attest ACH Payment



All data displayed here is sample data for example purposes only.



All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Attestation and Payment Confirmation

Payment Terms Attestation

Please attest to and accept the Terms & Conditions below for each TIN you have enrolled. The current TIN is shown in the box to the right. Once you complete the last TIN you will be asked to attest to each TIN in the list.

☐ I acknowledge receipt of **$100.10** from the Public Health and Social Services Emergency Fund ("Relief Fund"), and accept the Terms & Conditions. If you received a payment from funds appropriated in the Relief Fund under Division B of Public Law 116-127 and retain that payment for at least 90 days without contacting HHS regarding remittance of those funds, you are deemed to have accepted the following Terms & Conditions. This is not an exhaustive list and you must comply with any other relevant statutes and regulations, as applicable. Your commitment to full compliance with all Terms and Conditions is material to the Secretary's decision to disburse these funds to you. Non-compliance with any Term or Condition is grounds for the Secretary to recoup some or all of the payment made from the Relief Fund. These Terms and Conditions apply directly to the recipient of payment from the Relief Fund. In general, the requirements that apply to the recipient, also apply to sub-recipients and contractors under grants, unless an exception is specified.

Current Request

Billing TIN
***877665

Last Six Digits of Account Number
975301

Relief Fund Payment
$100.10

HRSA
Health Resources & Services Administration

☐ By receiving and accepting Relief Fund payment, you attest that in accordance with the "Coronavirus Aid, Relief, and Economic Security Act" or the "CARES Act", you are eligible for this payment. You acknowledge that you may be asked to submit to the review process established by the U.S Department of Health and Human Services, including its contractor (collectively, "HHS"), to determine your eligibility for this payment. Additionally, upon request by HHS, you will provide any and all information related to the disposition or use of the funds received under the Relief Fund for auditing and/or reporting purposes. I attest that I have the legal authority to act on behalf of the provider group that has received payment under the Relief Fund. For Electronic Funds Transfer / ACH Payments, HHS or its contractor may make adjustments to the payment whenever a correction or change is required. For example, if there is an error, you agree that HHS may correct the error immediately and without notice. Such errors may include, but are not limited to, reversing an improper credit, and correcting calculation and input errors. The right to make adjustments are not subject to any limitations or time constraints, except as required by law.

By providing your email and phone number, you agree that HHS or its contractor may send you communications or call you regarding Relief Fund payment. You understand that you need to give us the most up to date contact information.

Contact Information

Please complete the information below. All fields are required unless otherwise indicated.

First Name*

Middle Name (optional)

Last Name*

Email Address*

Phone Number*

Rendering/Service Address

Address 1*
123 Sample St

Address 2 (optional)

City*
Columbia

State*
Maryland

Zip Code*
21044

Billing Address

Address 1*
234 Sample St

Address 2 (optional)

City
Colu ia

State*
Maryland

Zip Code*
21033

I have read and agree to the Op m Pay Enrollment Agreement Terms and Conditions.

I'm not a robot
reCAPTCHA
Privacy - Terms

I Accept Payment | **I Reject Payment**

All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Step 1 Eligibility — Step 2 Billing TIN(s) — Step 3 Verify Payment Information — Step 4 Attestations — Confirmation

Confirmation

Thank you. Your Information has been received for the TIN(s) below. You will receive a confirmation email with reference number(s). You may print this page for your records.

Print

Automated Clearing House(ACH) Deposit

Reference Number: **HHS-43532343937**

Billing TIN:
*****877665**

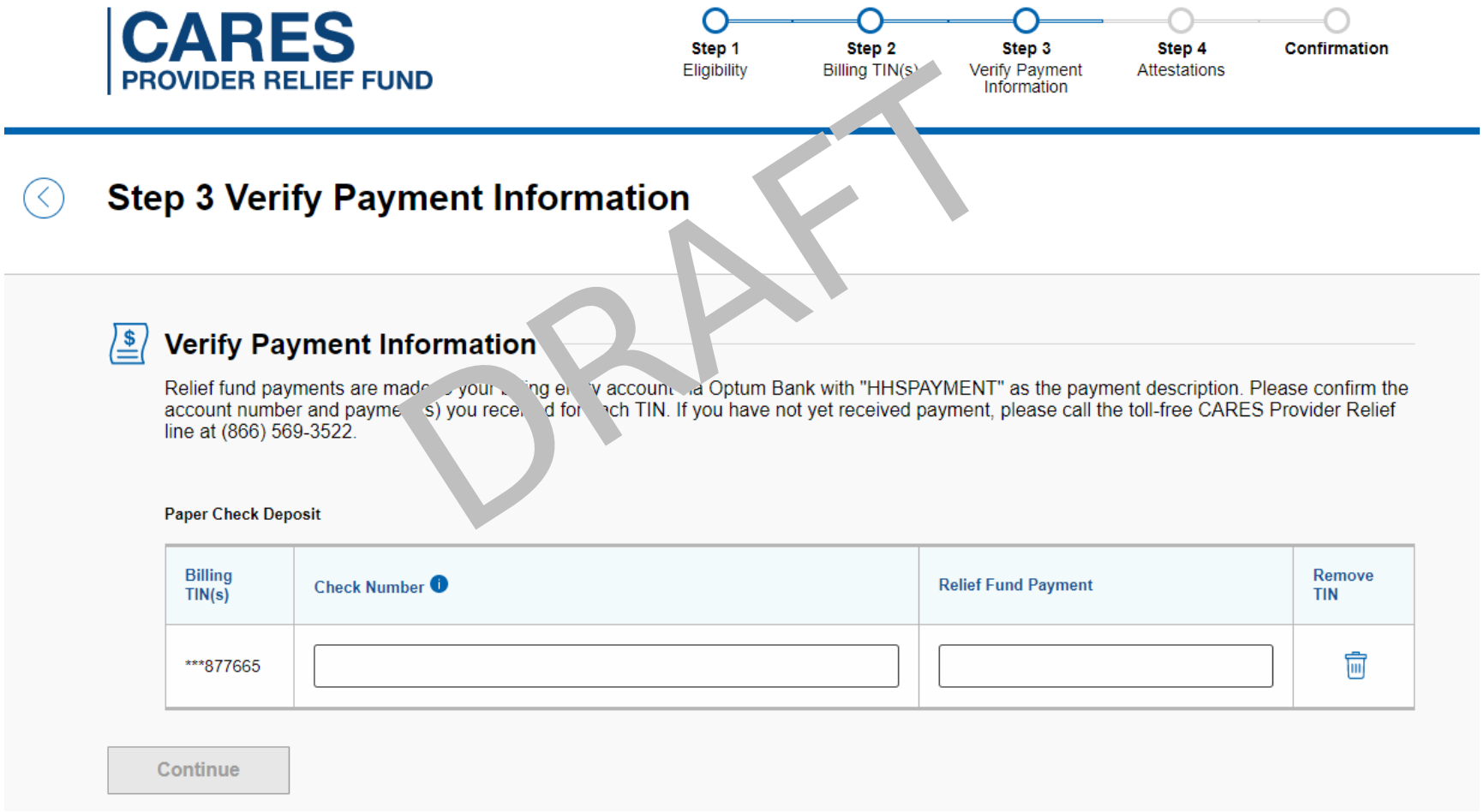
Last Six Digits of Account Number	Relief Fund Payment
975301	**$100.10**

I acknowledge deposit from the Public Health and Social Services Emergency Fund ("Relief Fund").

Funds Accepted

HRSA Health Resources & Services Administration

PRF and ARPA–R attestation portal: Attest CHK Payment



All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Step 1 Eligibility — Step 2 Billing TIN(s) — Step 3 Verify Payment Information — Step 4 Attestations — Confirmation

Step 4 Attestations

Attestations

Please review the information below and complete the attestation process for each eligible Billing TIN.

Paper Check Deposit

Billing TIN:
*****877665**

Check Number	Relief Fund Payment
0000001013	**$100.10**

Review and Accept

Attestation and Payment Confirmation

Payment Terms Attestation

Please attest to and accept the Terms & Conditions below for each TIN you have entered. The current TIN is shown in the box to the right. Once you complete the first TIN you will be asked to attest to each TIN in the list.

Current Request

Billing TIN
***877665

Check Number
0000001013

Relief Fund Payment
$100.10

☐ I acknowledge receipt of **$100.10** from the Public Health and Social Services Emergency Fund ("Relief Fund"), and accept the Terms & Conditions. If you received a payment from funds appropriated in the Relief Fund under Division B of Public Law 116-127 and retained that payment for at least 90 days without contacting HHS regarding remittance of those funds, you are deemed to have accepted the following Terms & Conditions. This is not an exhaustive list and you must comply with any other relevant statutes and regulations, as applicable. Your commitment of full compliance with all Terms and Conditions is material to the Secretary's decision to disburse these funds to you. Non-compliance with any Term or Condition is grounds for the Secretary to recoup some or all of the payment made from the Relief Fund. These Terms and Conditions apply directly to the recipient of payment from the Relief Fund. In general, the requirements that apply to the recipient, also apply to sub-recipients and contractors under grants, unless an exception is specified.

☐ By receiving and accepting Relief Fund payment, you attest that in accordance with the "Coronavirus Aid, Relief, and Economic Security Act" or the "CARES Act", you are eligible for this payment. You acknowledge that you may be asked to submit to the review process established by the U.S Department of Health and Human Services, including its contractor (collectively, "HHS"), to determine your eligibility for this payment. Additionally, upon request by HHS, you will provide any and all information related to the disposition or use of the funds received under the Relief Fund for auditing and/or reporting purposes. I attest that I have the legal authority to act on behalf of the provider group that has received payment under the Relief Fund. For Electronic Funds Transfer / ACH Payments, HHS or its contractor may make adjustments to the payment whenever a correction or change is required. For example, if there is an error, you agree that HHS may correct the error immediately and without notice. Such errors may include, but are not limited to, reversing an improper credit, and correcting calculation and input errors. The right to make adjustments are not subject to any limitations or time constraints, except as required by law.

By providing your email and phone number, you agree that HHS or its contractor may send you communications or call you regarding Relief Fund payment. You understand that you need to give us the most up to date contact information.

Contact Information

Please complete the information below. All fields are required unless otherwise indicated.

First Name*

Middle Name (optional)

Last Name*

Email Address*

Phone Number*

Rendering/Service Address

Address 1*
123 Sample St

Address 2 (optional)

City*
Sample

State*
Maryland

Zip Code*
20000

I'm not a robot
reCAPTCHA
Privacy - Terms

I Accept Payment | I Reject Payment

Billing Address

Address 1*
123 Sample St

Address 2 (optional)

City*
Sample

State*
Maryland

Zip Code*
20000

Confirmation

Thank you. Your Information has been received for the TIN(s) below. You will receive a confirmation email with reference number(s). You may print this page for your records.

Print

Paper Check Deposit

Reference Number: **HHS-38690793815**

Billing TIN:
*****877665**

Check Number	Relief Fund Payment
0000001013	**$100.10**

I acknowledge deposit from the Public Health an Social Se ices Emergency Fund ("Relief Fund").

Funds Accepted

HRSA
Health Resources & Services Administration

PRF Phase 4/ARPA–R Application Portal

Vision: Healthy Communities, Healthy People

All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Sign In

Welcome to the Provider Relief Fund Application and Attestation Portal

This portal allows providers to apply for and attest to relief fund payments made for healthcare-related expenses or lost revenue attributable to COVID-19.

Overview | Set Up One Healthcare ID | What You Need | Resources and Support

The Department of Health and Human Services (HHS) has announced $175 billion in relief funds, including to hospitals and other healthcare providers on the front lines of the coronavirus response as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act. This funding, along with additional relief funding outside of the CARES Act, supports healthcare-related expenses or lost revenue attributable to COVID-19 and ensures uninsured Americans can get treatment for COVID-19. This site is open to all providers who want to apply for a Provider Relief Fund payment, regardless of network affiliation or payer contract. HHS is contracting with UnitedHealth Group to facilitate delivery of the funds.

HHS plans to make publicly available the names of payment recipients and the amounts received, for all providers who attest to receipt of a payment and acceptance of the Terms and Conditions or who retain payments for more than 90 days and are deemed to have accepted the Terms and Conditions. By accepting funds, the recipient consents to the Department of Health and Human Services publicly disclosing the payments that recipient has received from the Relief Fund.

HRSA
Health Resources & Services Administration

All data displayed here is sample data for example purposes only.

Overview | **Set Up One Healthcare ID** | What You Need | Resources and Support

The Department of Health and Human Services has contracted with UnitedHealth Group to administrator Provider Relief Fund payments. Therefore, some steps in the process involve existing UnitedHealth Group tools. Specifically, you'll need to set up an One Healthcare ID in order to access the portal. The process will not involve credentialing or contracting with UnitedHealth Group, and the information you submit will be used to administer the Provider Relief Fund payment.

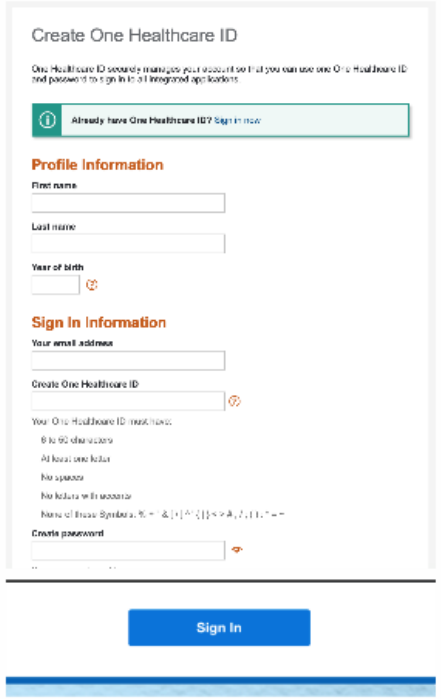
Set up One Healthcare ID

1. If you **do not** have an One Healthcare ID

You will need to create an One Healthcare ID to access the por[illegible]tart regis[illegible]tion here to begin.

2. If you **have** an One He[illegible]hcar[illegible]D al[illegible]ady

You can access the portal at the to[illegible]ight of the [illegible]ebpag[illegible] to sign in or sign in with One Healthcare ID here.



What You Need

1. Validate Taxpayer Identification Number (TIN)

This should be the organization TIN ("Filing TIN") you will use in applying for relief funds. An Organization TIN files a tax return but may not bill Medicare or Medicaid directly. The Organization TIN may have one or more subsidiaries that do not file tax returns (disregarded or consolidated entities). The Organization TIN should complete an application by listing all of the subsidiary TINs in the applicable field within the application form. TIN Validation can take 1-2 business days to process.

Important! Only one person can serve as the program administrator per TIN. This administrator accepts responsibility to act on behalf of their organization and must agree to make their name available to others within their organization. This person may reassign or transfer their administrator role to a new individual in their organization with One Healthcare ID at any time by calling (866) 569-3522: for TTY dial 711. New administrator processing can take 1-2 business days to complete.

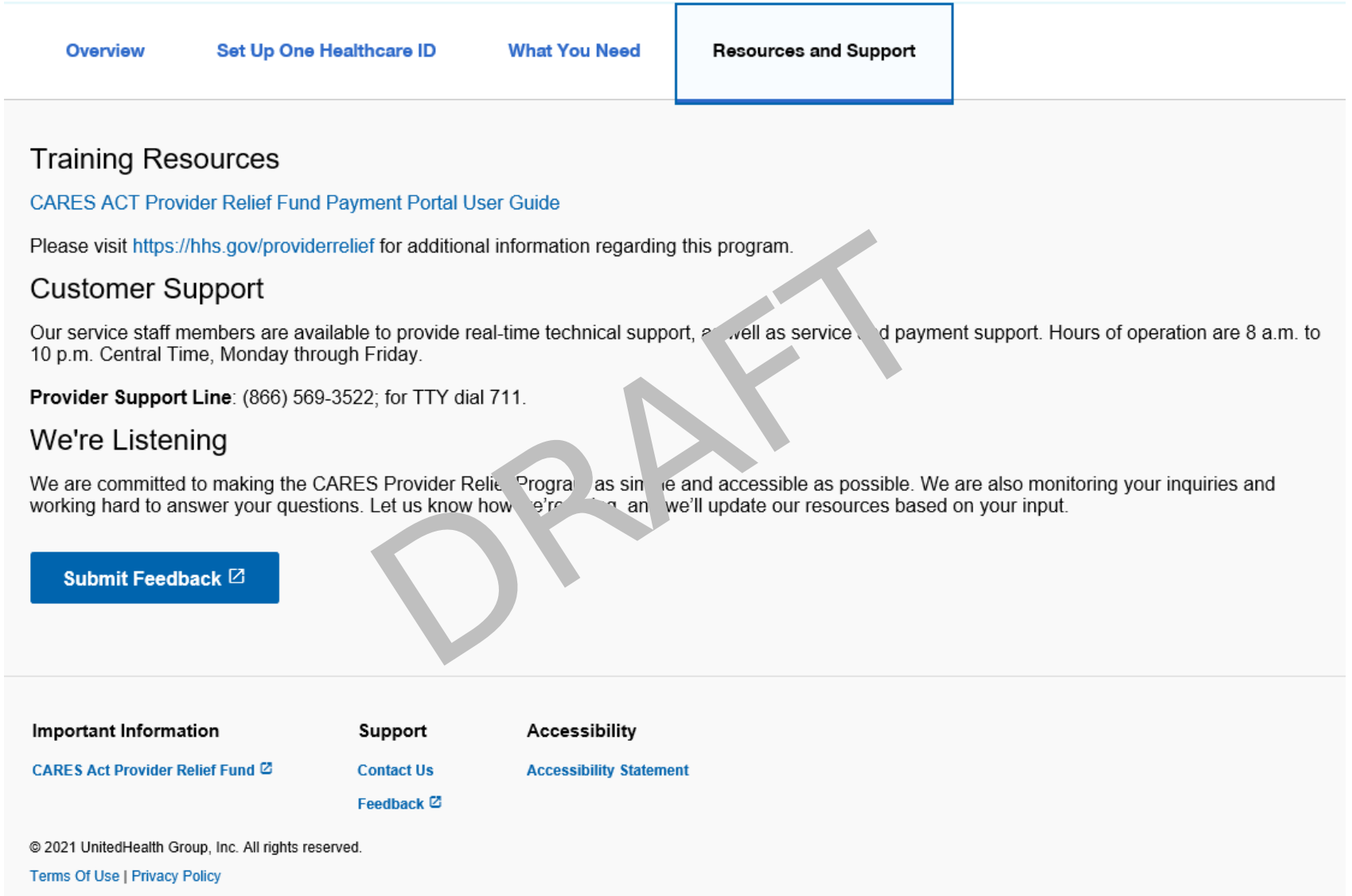
2. Confirm Revenue and Tax information

You will need to provide specific revenue and tax information through the portal once TIN Validation is complete.

3. Receive and Attest to Payment

Within 90 days of receiving this payment, you must sign an attestation confirming receipt of the funds and agreeing to the Terms and Conditions of payment. Should you choose to reject the funds, you must also complete the attestation to indicate this. The CARES Act Provider Relief Fund Payment Attestation Portal will guide you through the attestation process to accept or reject the funds. Not returning the payment within 90 days of receipt will be viewed as acceptance of the Terms and Conditions.

All data displayed here is sample data for example purposes only.



Overview | Set Up One Healthcare ID | What You Need | Resources and Support

Training Resources

CARES ACT Provider Relief Fund Payment Portal User Guide

Please visit https://hhs.gov/providerrelief for additional information regarding this program.

Customer Support

Our service staff members are available to provide real-time technical support, a well as service d payment support. Hours of operation are 8 a.m. to 10 p.m. Central Time, Monday through Friday.

Provider Support Line: (866) 569-3522; for TTY dial 711.

We're Listening

We are committed to making the CARES Provider Relie Progra as sim e and accessible as possible. We are also monitoring your inquiries and working hard to answer your questions. Let us know how e're an we'll update our resources based on your input.

Submit Feedback

DRAFT

Important Information

CARES Act Provider Relief Fund

Support

Contact Us

Feedback

Accessibility

Accessibility Statement

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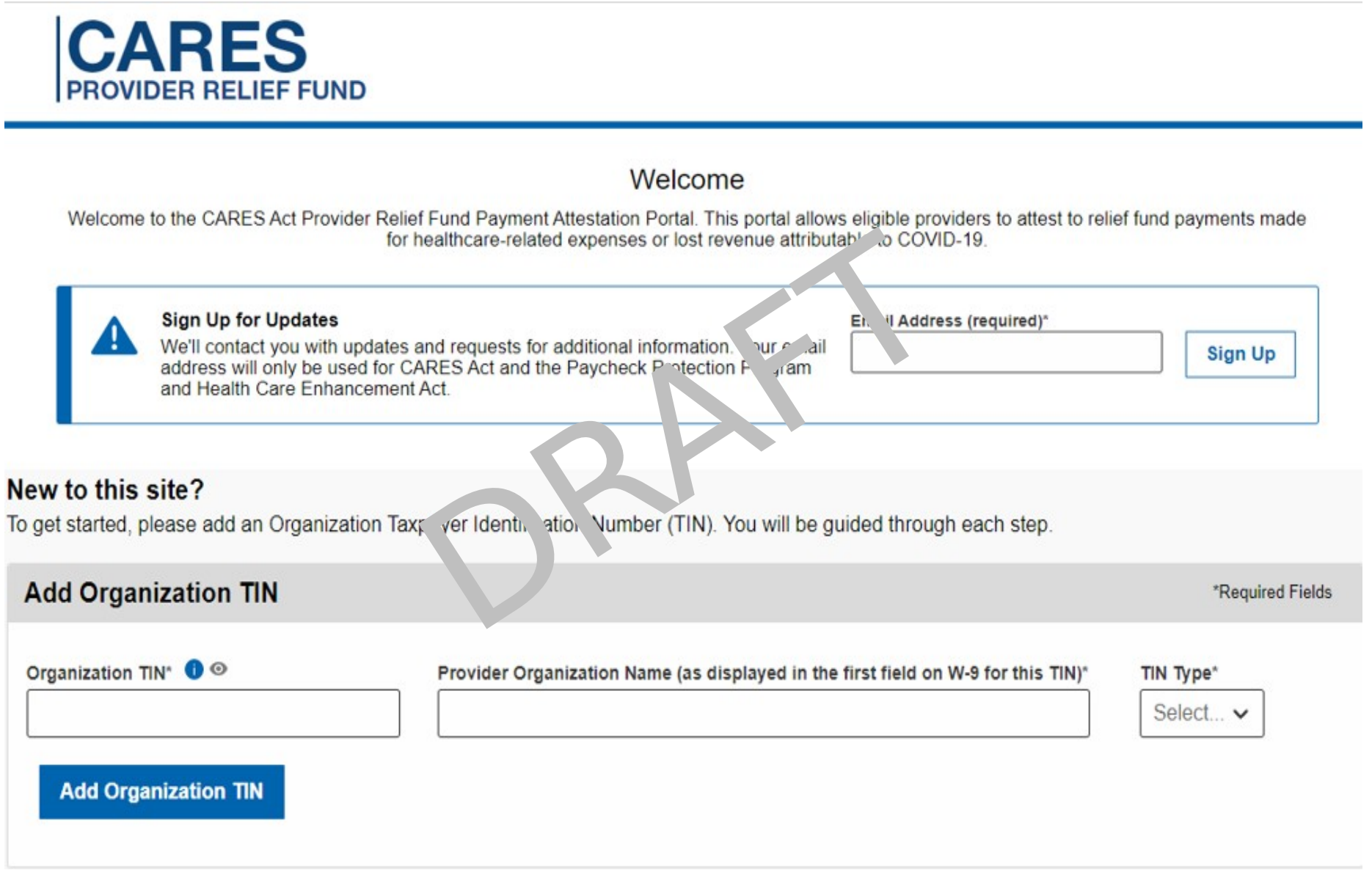
HRSA Health Resources & Services Administration



CARES
PROVIDER RELIEF FUND

Program Administrator Attestation

Program Administrator Attestation for Organization TIN xxxxx555

Please check all boxes and choose "I Accept" to complete the program administrator attestation.

- [x] I attest that I am submitting on my own behalf and I am a provider associated with this Organization TIN; or I have the authority to submit a request on behalf of the provider group(s) associated with this Organization TIN.
- [x] I certify that all information provided as part of the process is true, accurate and complete, to the best of my knowledge.
- [x] I understand that any person who knowingly and with intent to defraud the Government or the Company, files information containing materially false information, or conceals for the purpose of misleading the company commits a fraudulent insurance act.
- [x] I understand that only the person may submit information on behalf of an Organization TIN. I understand that my name and email will be shared if duplicate information is received for the same Organization TIN. If I am no longer able to submit information on behalf of the provider group associated with this Organization TIN, then I will withdraw my name and a different person will be added in my place.

I'm not a robot reCAPTCHA Privacy - Terms

I Do Not Accept | I Accept

HRSA Health Resources & Services Administration

CARES
PROVIDER RELIEF FUND

Tax Validation

Tax Validation

*Required Fields

Provider Organization Name (as displayed in the first field on W-9 for this TIN)*

Demo Inc.

Federal Tax Classification*

Select...

Exempt Payee Code

- 1 - An organization exem… tax u… section …(a), any IRA, or a custodial acc… under sec… 403…(7) if the account satisfies the requi…ents of sectio…401(f)
- 2 - The United States …any of its a…encies or instrumentalities
- 3 - A state, the District o… Colum…, a U.S commonwealth or possession, or any of thei… political subdivisions, agencies, or instrumentalities
- 4 - A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5 - A corporation
- 6 - A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S commonwealth or possession
- 7 - A futures commission merchant registered with the Commodity Futures Trading Commission
- 8 - A real estate investment trust
- 9 - An entity registered at all times during the tax year under the investment Company Act of 1940
- 10 - A common trust fund operated by a bank under section 58(a)
- 11- A financial institution
- 12 - A middleman known in the investment community as a nominee or custodian
- 13 - A trust exempt from tax under section 664 or described in section 4947

Exempt from FATCA Reporting Code

- A - An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B - The United States or any of its agencies or instrumentalities
- C - A state, the District of Columbia, a U.S commonwealth or possession, or any of their political subdivisions, agencies, or instrumentalities
- D - A foreign government or any of its political subdivisions, agencies, or instrumentalities
- E - A corporation that is a member of the same expa ed affili ed group as a corporation described in Regula section 1.1472-1((1)(i)
- F - A dealer in securities, commodities derivative f ancial instruments (including notional principal co tracts tures, forwards and options) that is registered as such unde e laws of the united states or any state
- G - A real estate investment trust
- H - A regulated investm t company as defined in section 851 or any entity registe at all times during the tax year under the investment ompany of 1940
- I - A mmon trust fund a defined in section 584(a)
- J - A ba efined in section 581
- K - A broke
- L - A trus exempt from tax under section 664 or described in section 4947(a)(1)
- M - A tax exempt trust under a section 403(b) plan or section 457(g) plan

Cancel | Continue

Addresses

Organization TIN Address

*Required Fields

Street Line 1*

Street Line 2

City*

State*

Select...

ZIP Code*

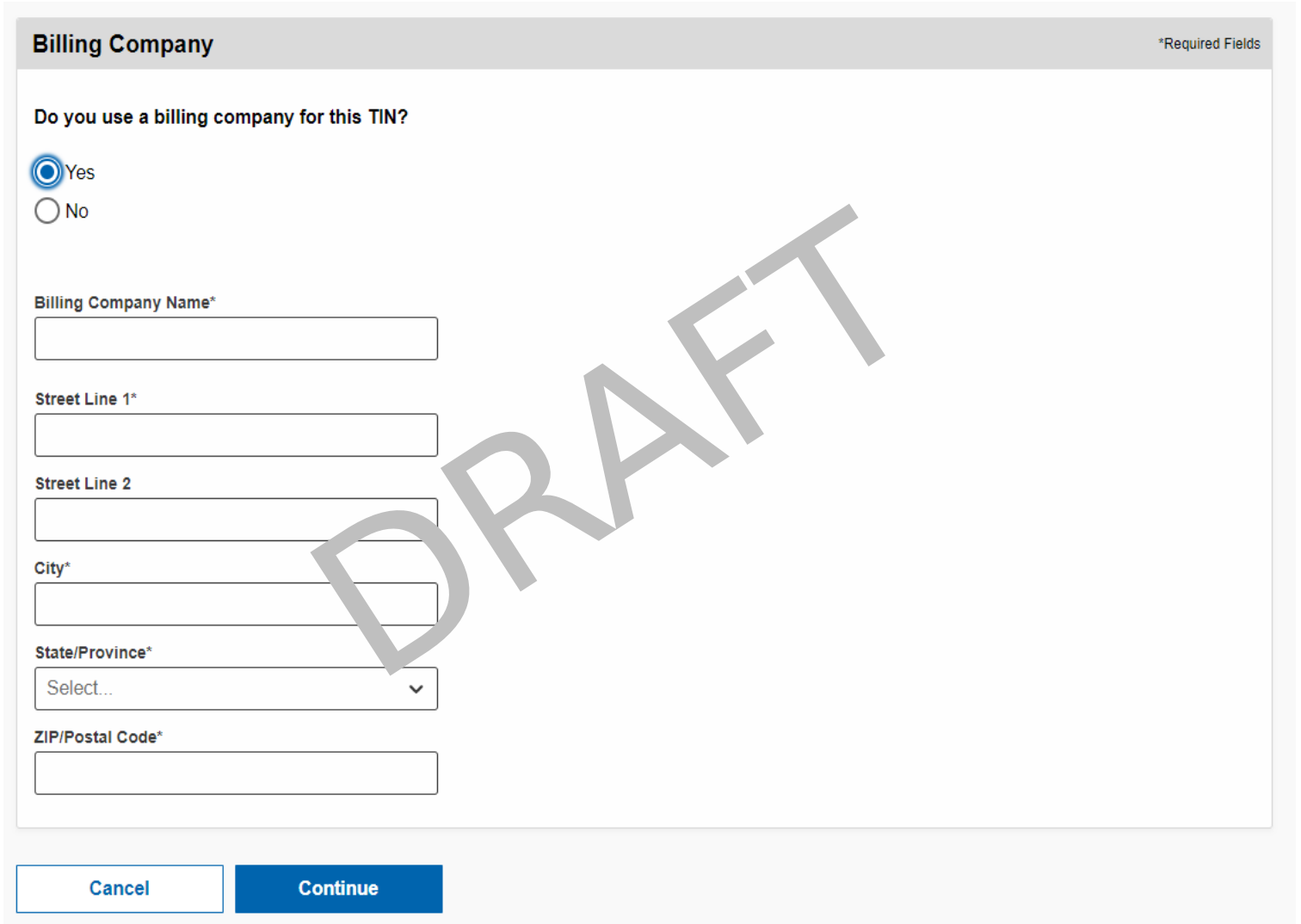
Billing Company

*Required Fields

Do you use a billing company for this TIN?

- Yes
- No

Cancel | Continue



Practice Detail

Practice Information

*Required Fields

Primary Servicing Location

Street Line 1*

Street Line 2

City*

State*

Select...

ZIP Code*

Phone Number*

Extension

Submitter Information

Submitter Name

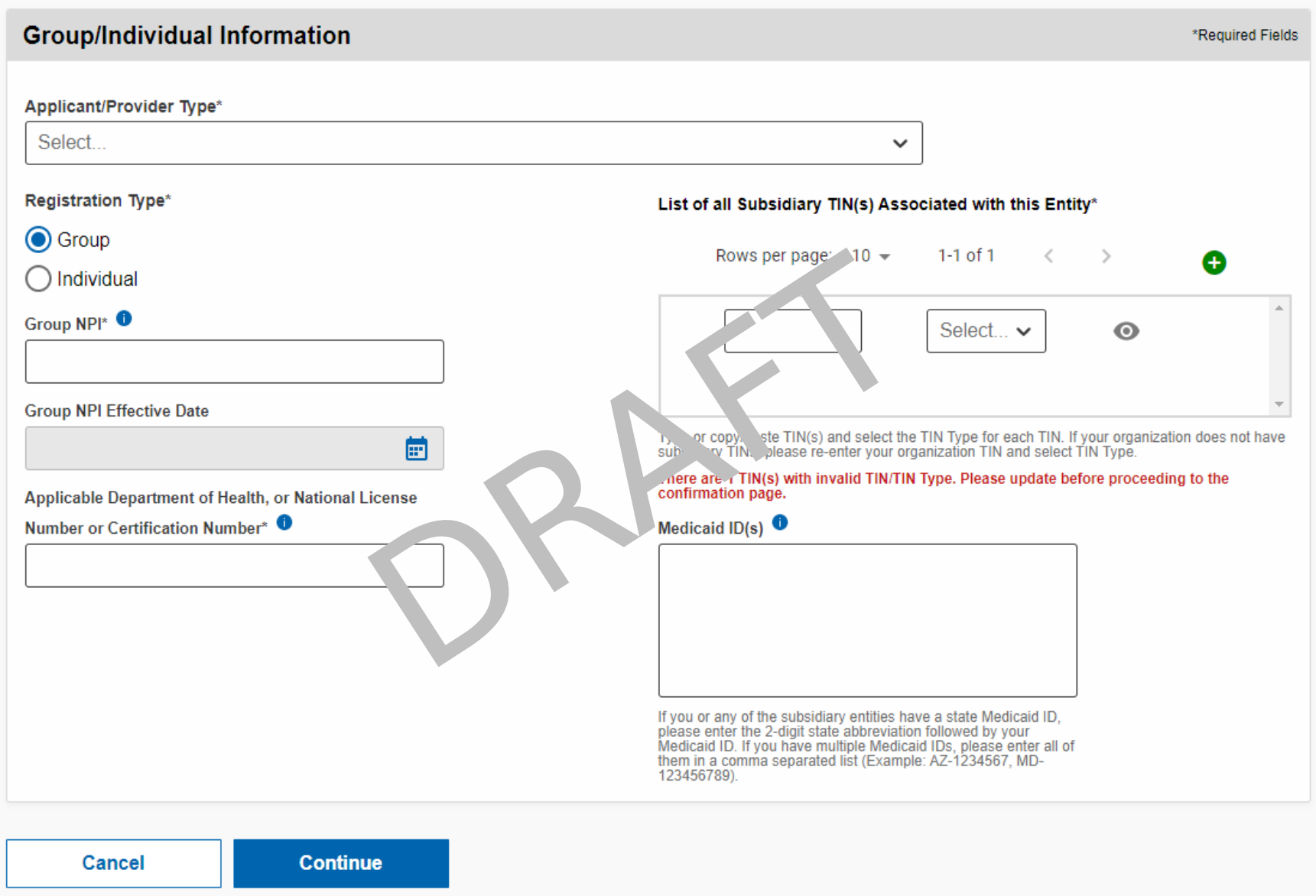
Submitter Email Address*

laluru@optumservetech.com

Submitter Phone Number

Extension

All data displayed here is sample data for example purposes only.



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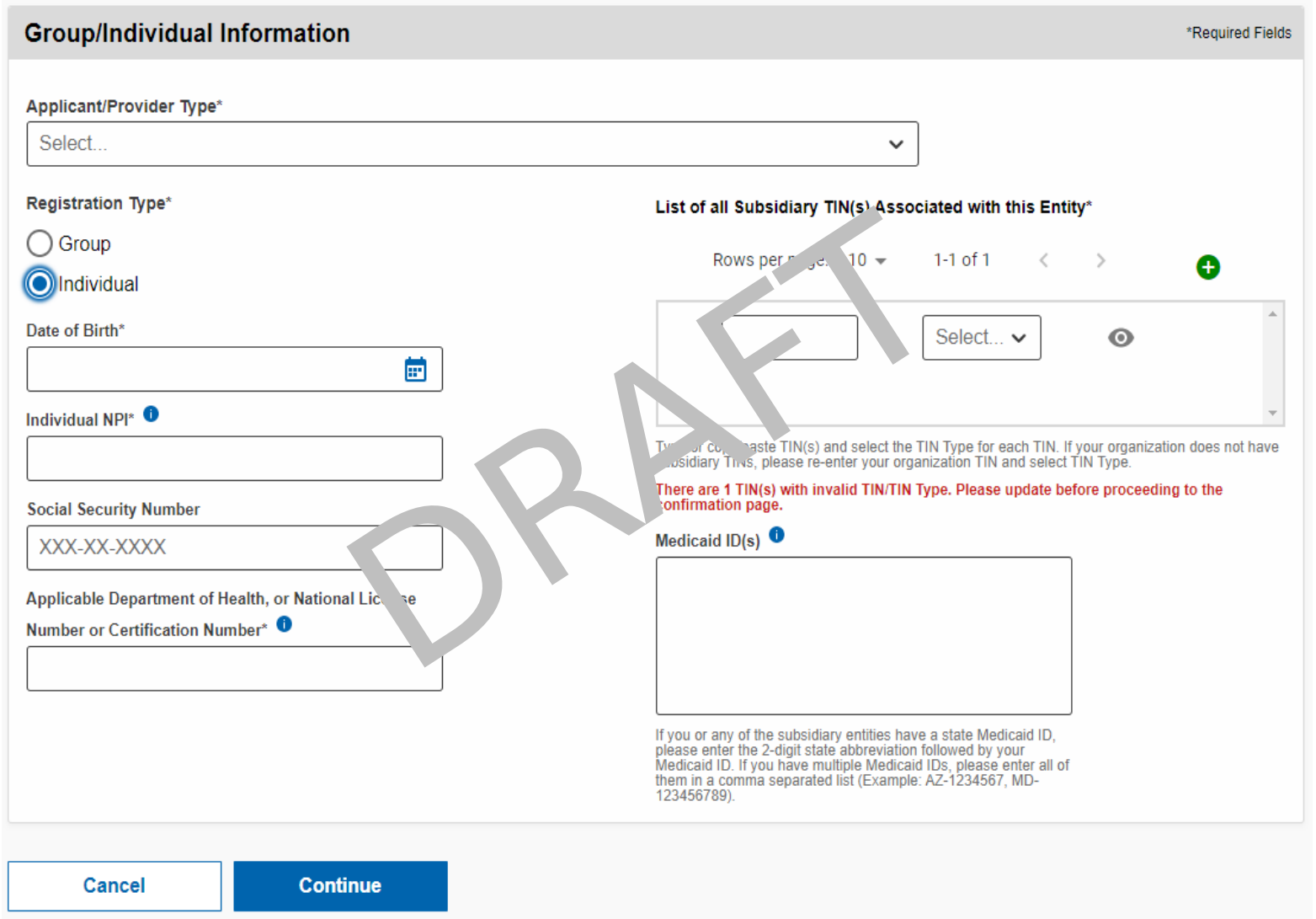

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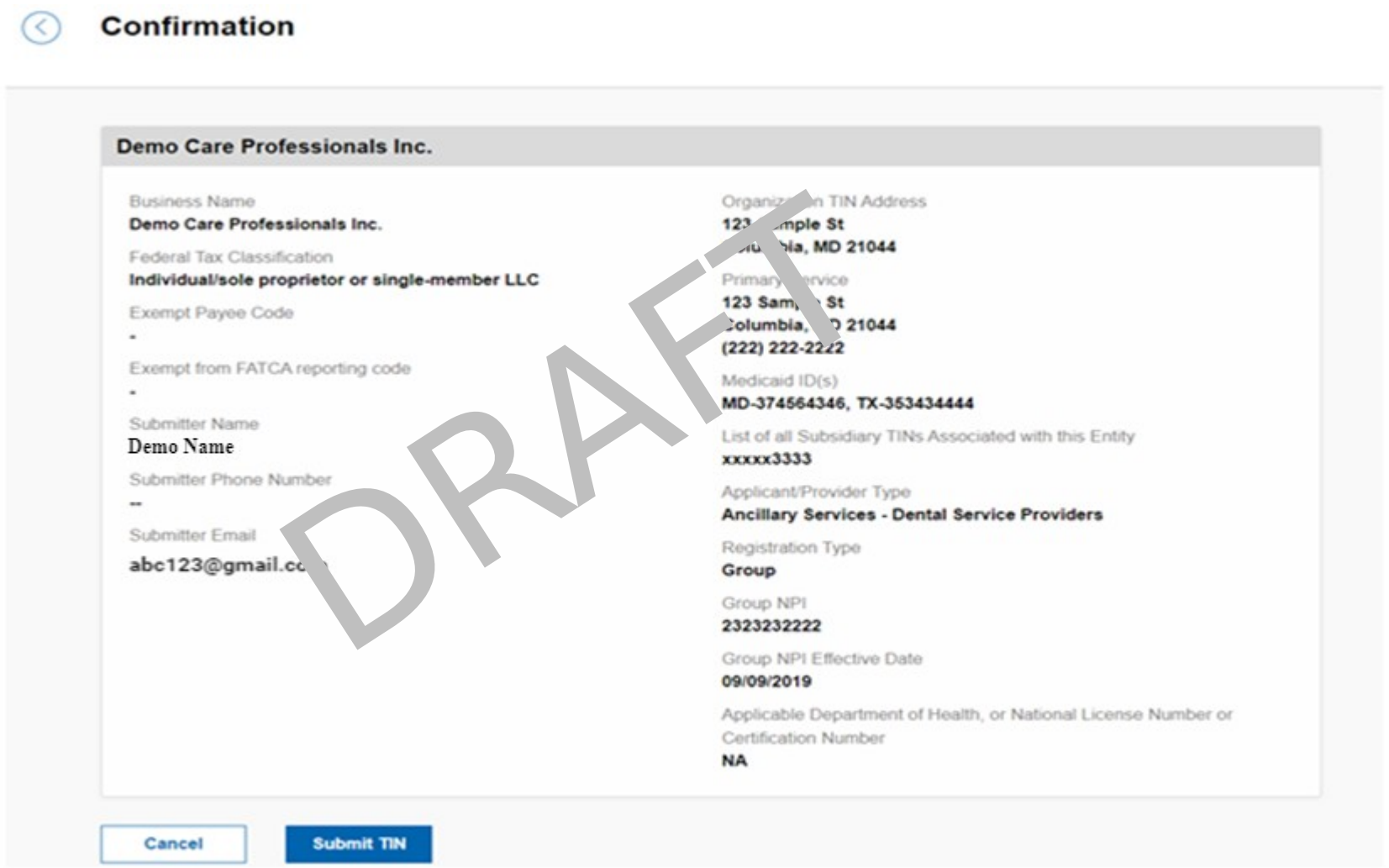
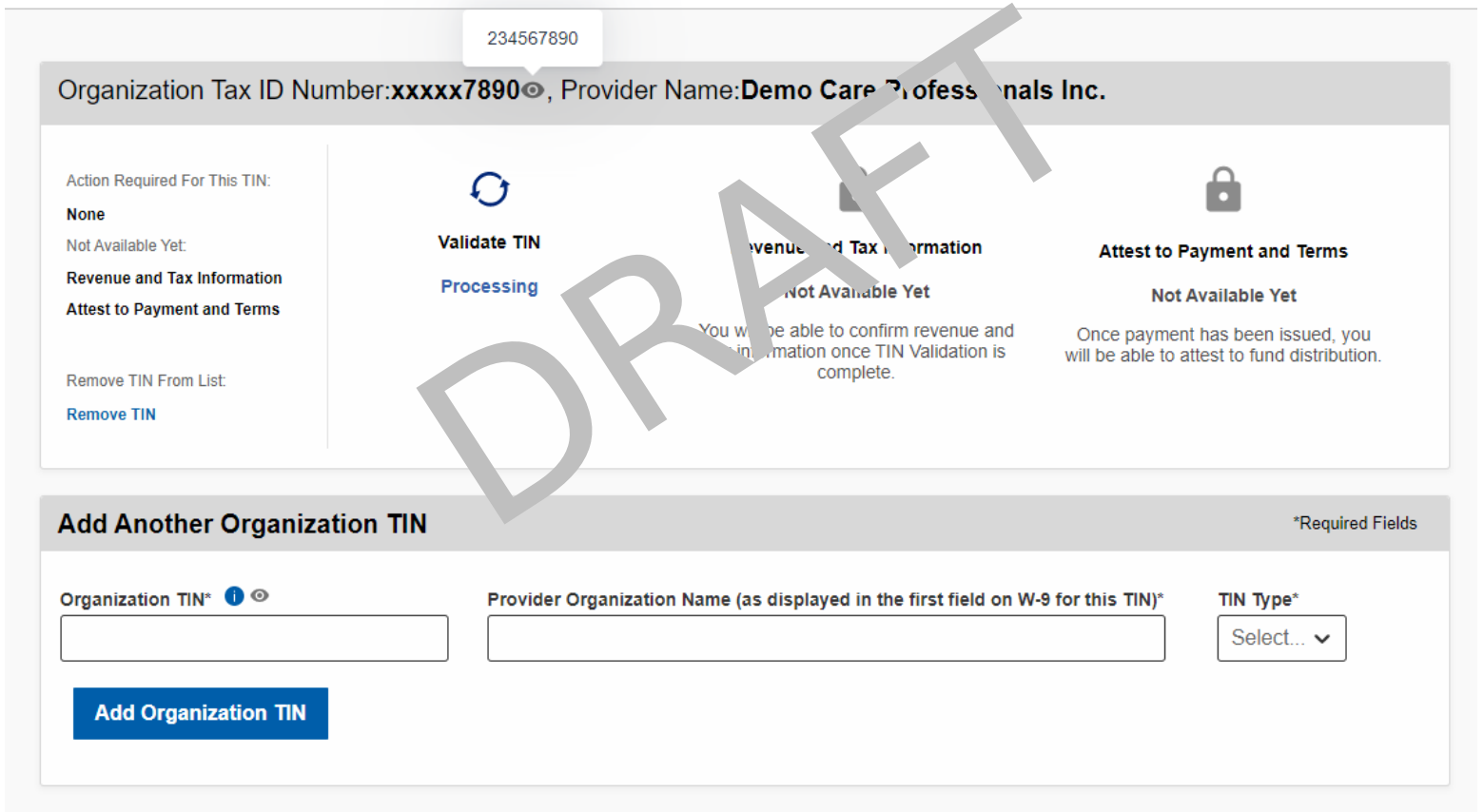


All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Organization TIN Dashboard

Please see status details and complete any actions required below.



HRSA
Health Resources & Services Administration

All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Organization TIN Dashboard

Please see status details and complete any actions required below.

Organization Tax ID Number:**xxxxx7890**, Provider Name:**Demo Car[illegible]rofes[illegible]onals Inc.**

Action Required For This TIN:
Revenue and Tax Information

Not Available Yet:
Attest to Payment and Terms

Update TIN Validation:
Update TIN

Validate TIN
Complete

Reve[illegible]and Ta[illegible]nformation
Ava[illegible]le Now
Get Started

[illegible] will receive an email confirmation from DocuSign when you complete your Revenue and Tax Information submission. The "Get Started" message above will be updated when your submission is processed and payment determination is made.

Attest to Payment and Terms
Not Available Yet
Once payment has been issued, you will be able to attest to fund distribution.

Add Another Organization TIN

*Required Fields

Organization TIN*

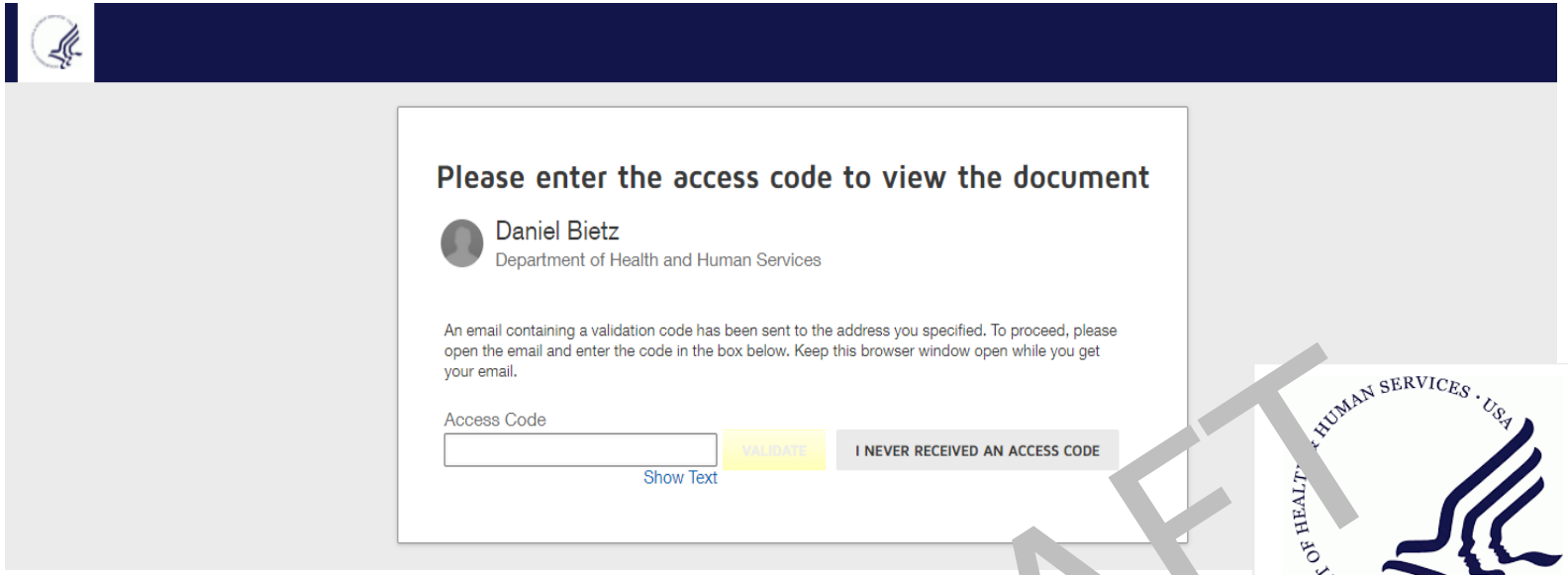
Provider Organization Name (as displayed in the first field on W-9 for this TIN)*

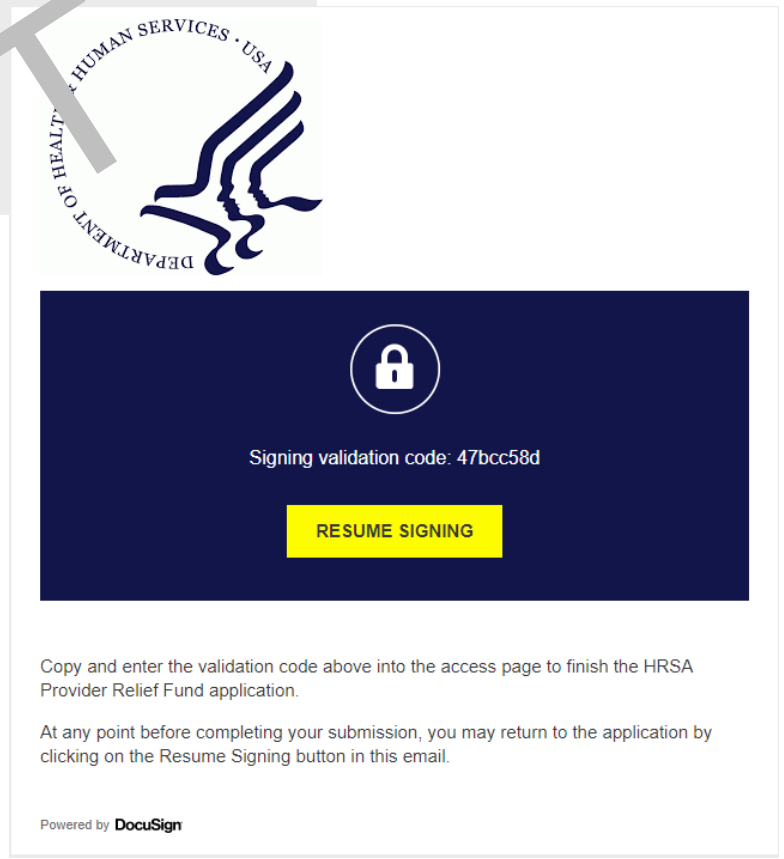
TIN Type*
Select...

Add Organization TIN

HRSA
Health Resources & Services Administration

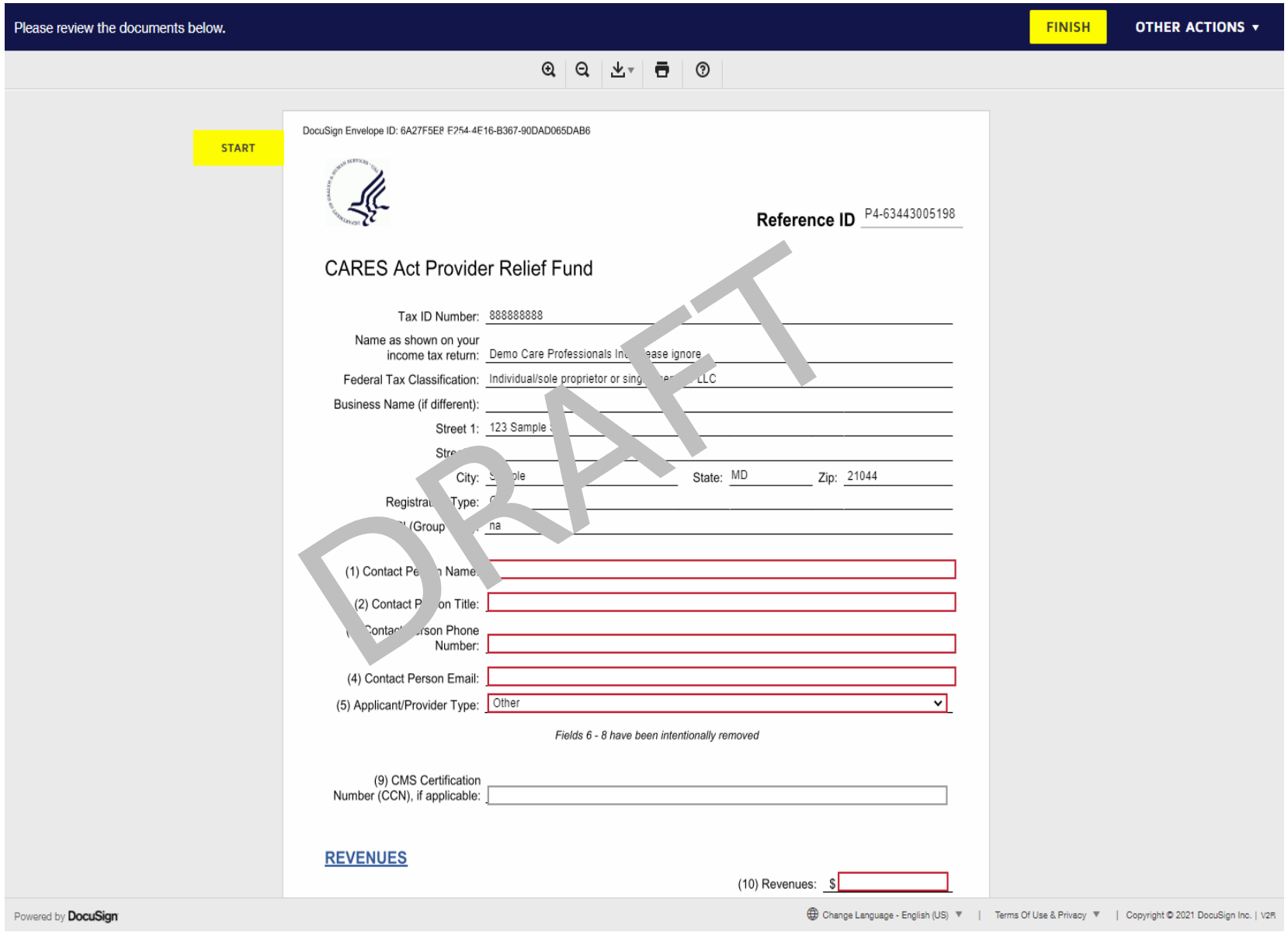
All data displayed here is sample data for example purposes only.



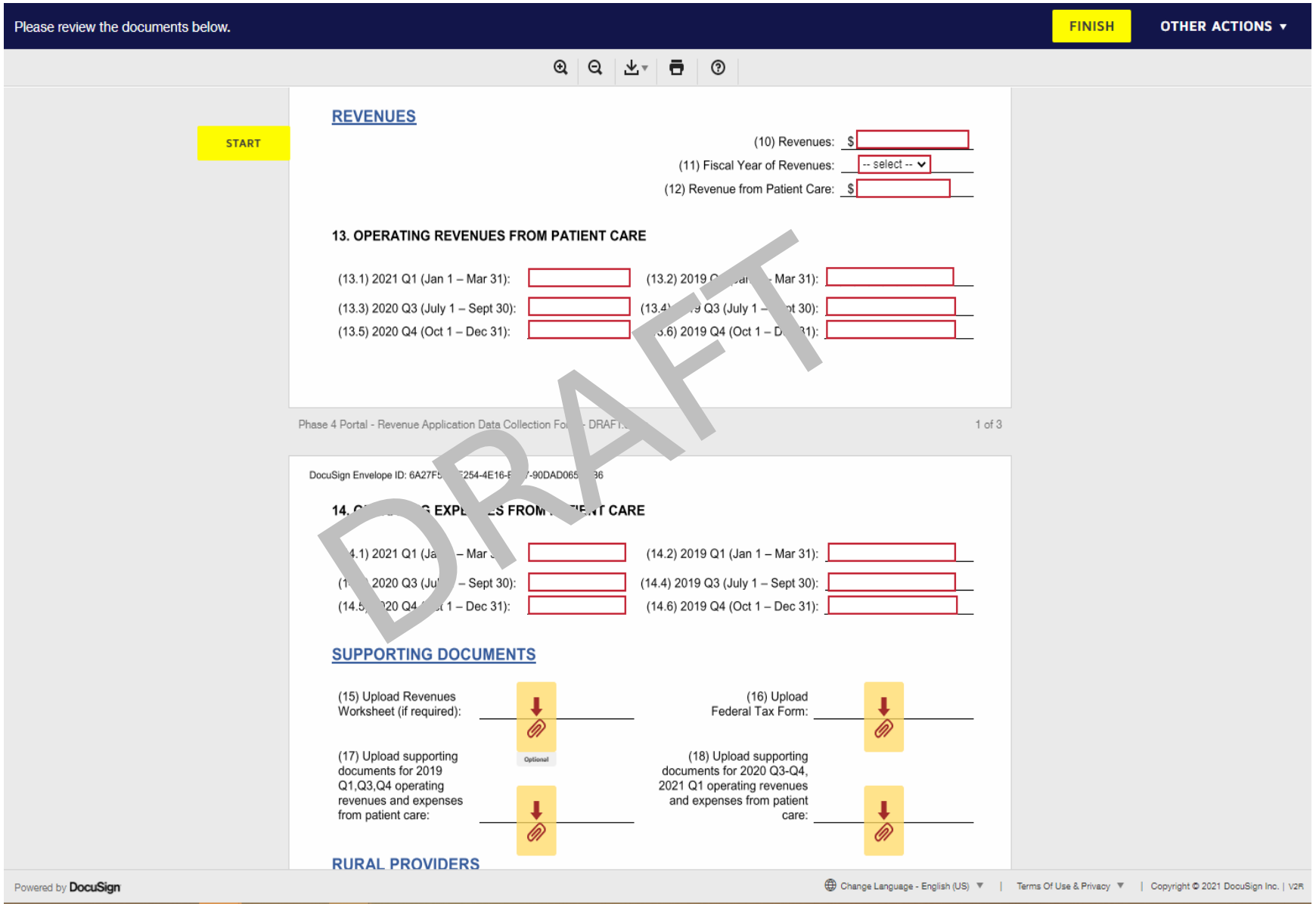


Subsequent Process owned by DocuSign

Process owned by DocuSign

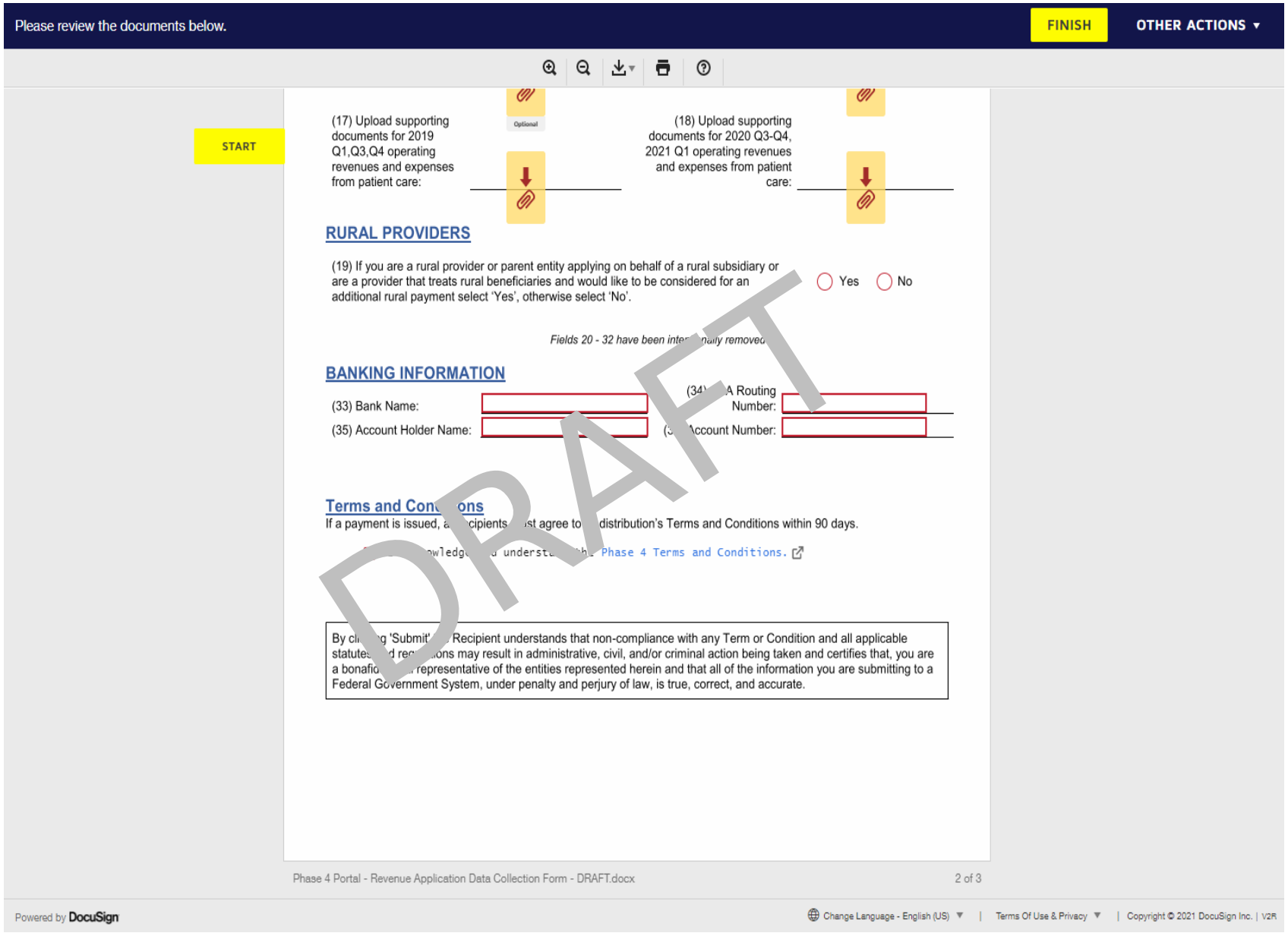


Process owned by DocuSign



All data displayed here is sample data for example purposes only.

Process owned by DocuSign



All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Organization TIN Dashboard

Please see status details and complete any actions required below.

Organization Tax ID Number:**xxxxx7890**, Provider Name:**Demo Car[illegible]rofes[illegible]onals Inc.**

Action Required For This TIN:
Revenue and Tax Information

Not Available Yet:
Attest to Payment and Terms

Update TIN Validation:
Update TIN

Validate TIN
Complete

Reve[illegible]and Ta[illegible]nformation
Ava[illegible]le Now
Get Started

[illegible] will receive an email confirmation from DocuSign when you complete your Revenue and Tax Information submission. The "Get Started" message above will be updated when your submission is processed and payment determination is made.

Attest to Payment and Terms
Not Available Yet
Once payment has been issued, you will be able to attest to fund distribution.

Add Another Organization TIN

*Required Fields

Organization TIN*

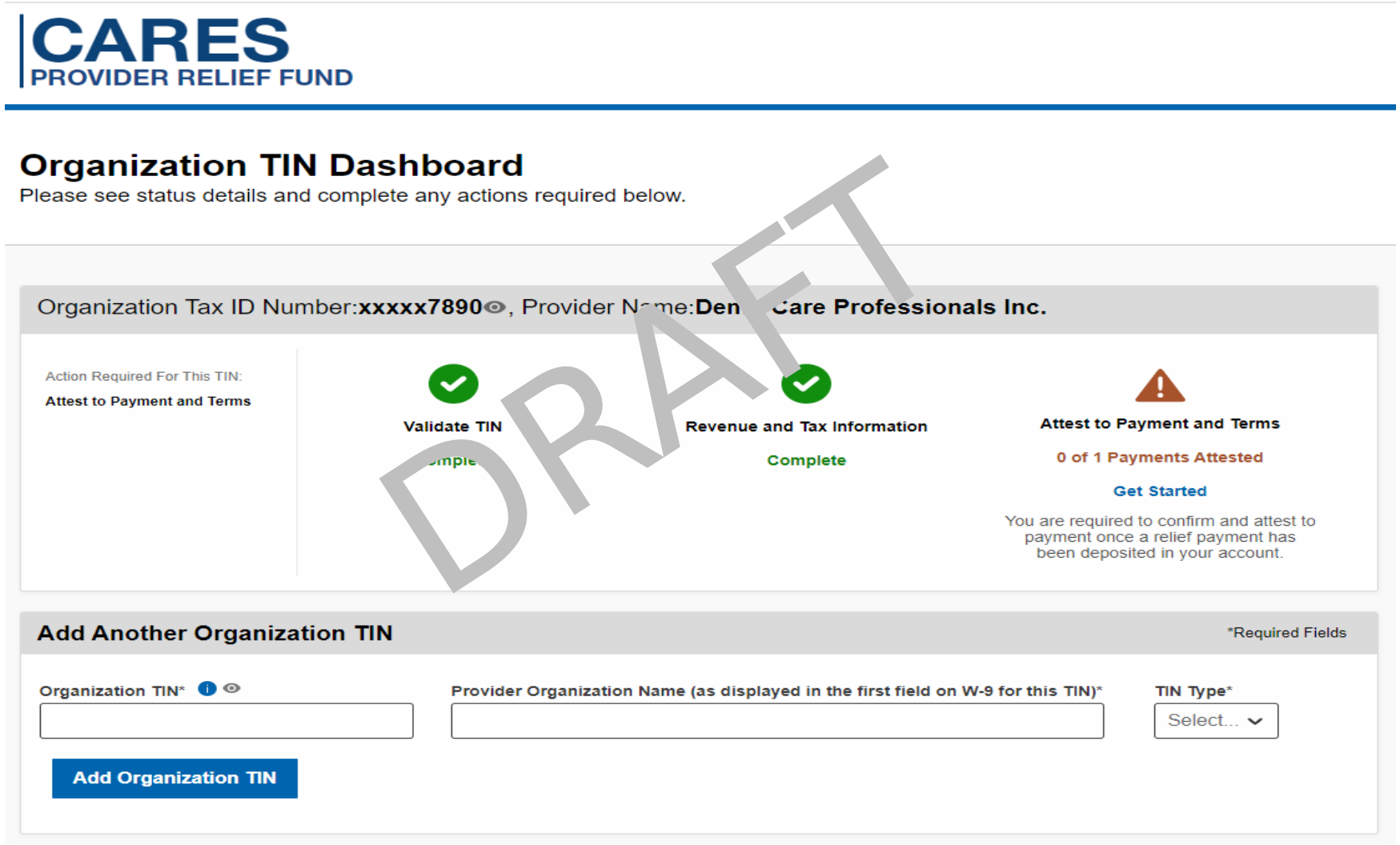
Provider Organization Name (as displayed in the first field on W-9 for this TIN)*

TIN Type*
Select...

Add Organization TIN

HRSA
Health Resources & Services Administration

CARES PRF Portal 2.0: Attest to Payments and Terms - Accept Payments



CARES
PROVIDER RELIEF FUND

Attest to Payment and Terms

Attestation of Payment

*Required Fields

Automated payments are sent via Optum Bank with "...GOV" in the payment description. All relief payments are made to provider billing organizations based on their Taxpayer Identification Numbers (TINs). please confirm the account number and payment you received for this TIN.

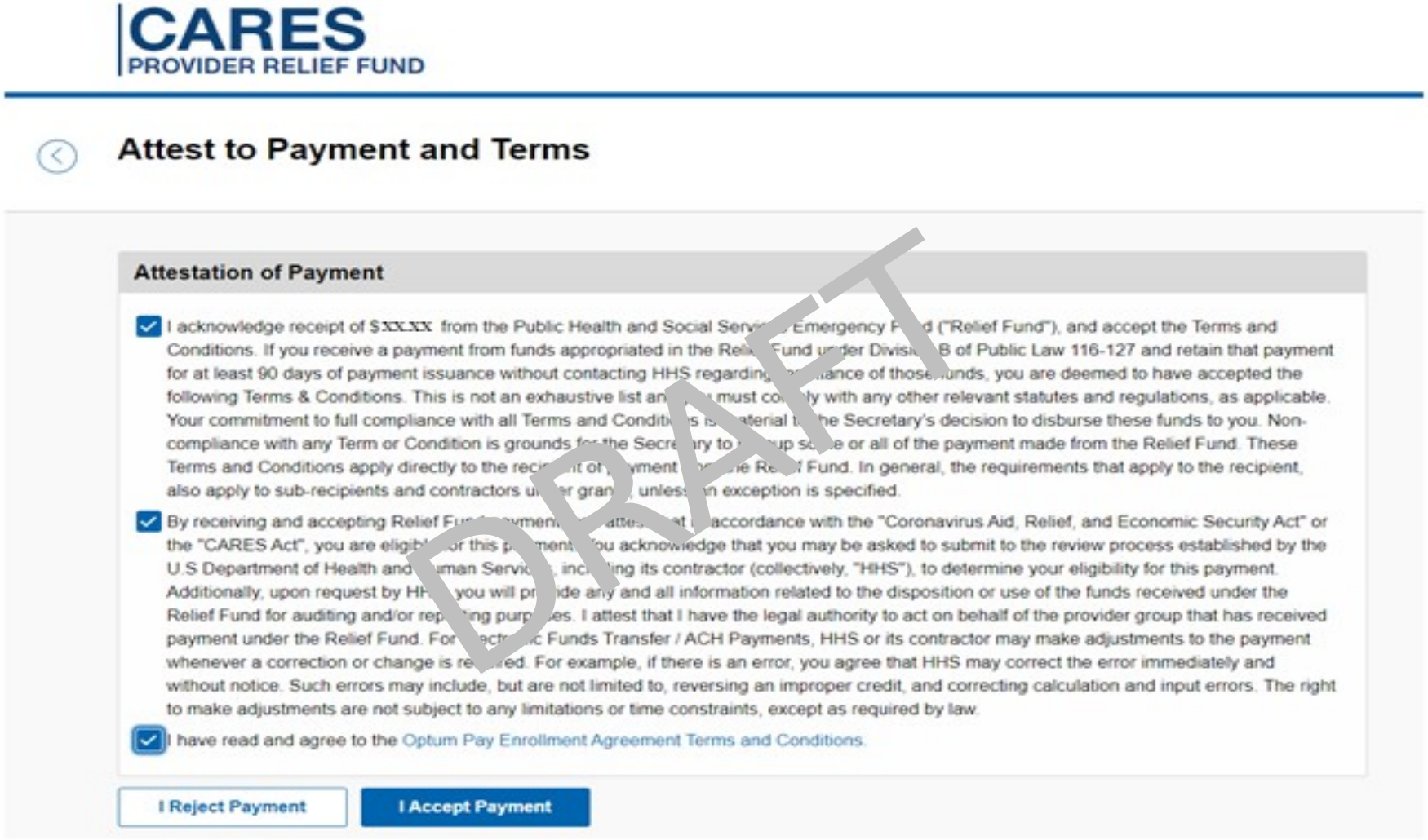
This form should only be filled out once you have received the deposit in your account

Last Six Digits of Bank Account Number*

Relief Fund Payment Amount*

Cancel | Continue

HRSA
Health Resources & Services Administration



All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Organization TIN Dashboard

Please see status details and complete any actions required below.

Organization Tax ID Number:**xxxxx7890**, Provider Name:**Dem Care Professionals Inc.**

Validate TIN	Re ue a Tax Information	Attest to Payment and Terms
Complete	Complete	Complete
		1 of 1 Payments Attested
		Funds Accepted
		Reference Number: P4-68849651465 Accepted

Add Another Organization TIN

*Required Fields

Organization TIN*

Provider Organization Name (as displayed in the first field on W-9 for this TIN)*

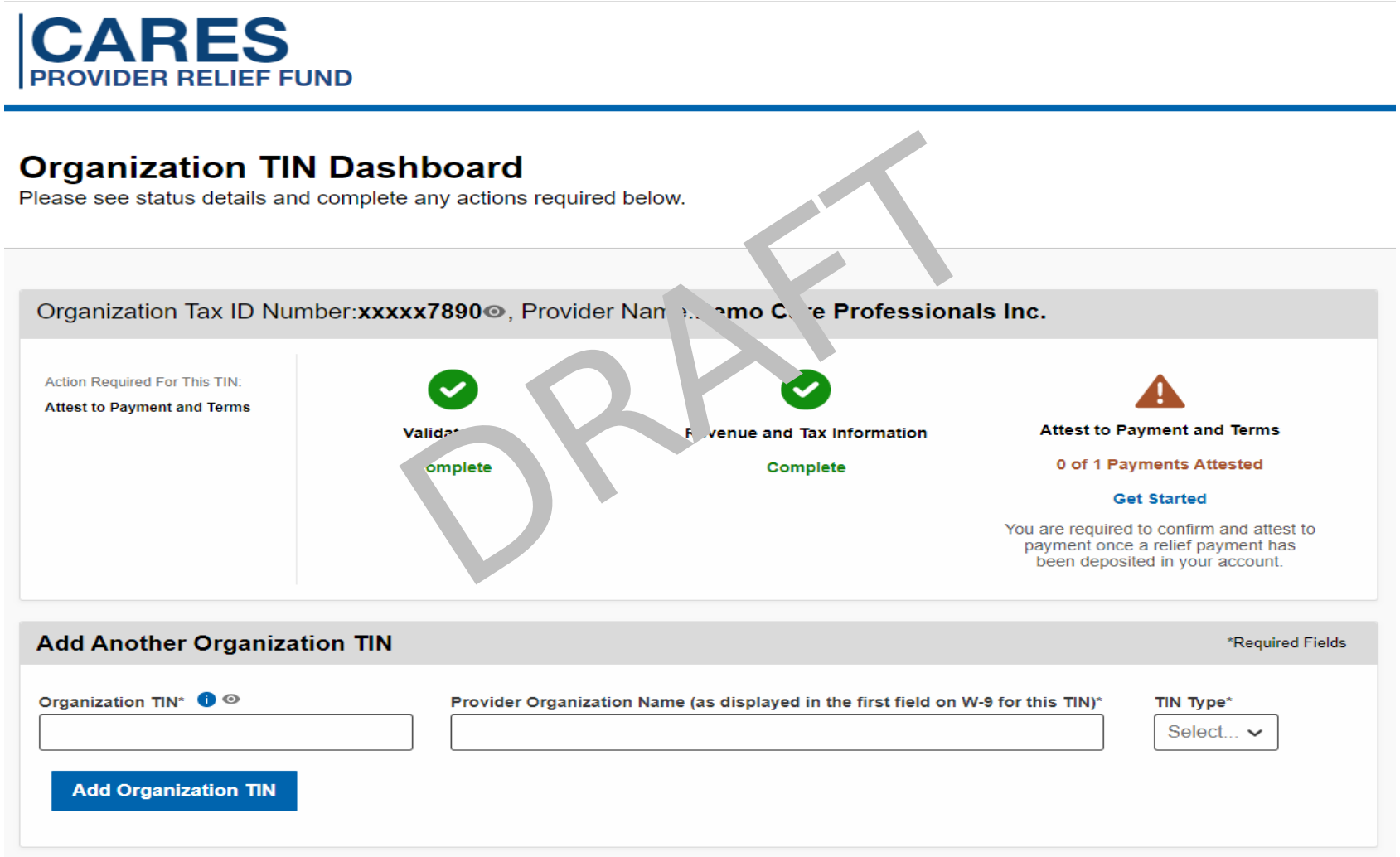
TIN Type*

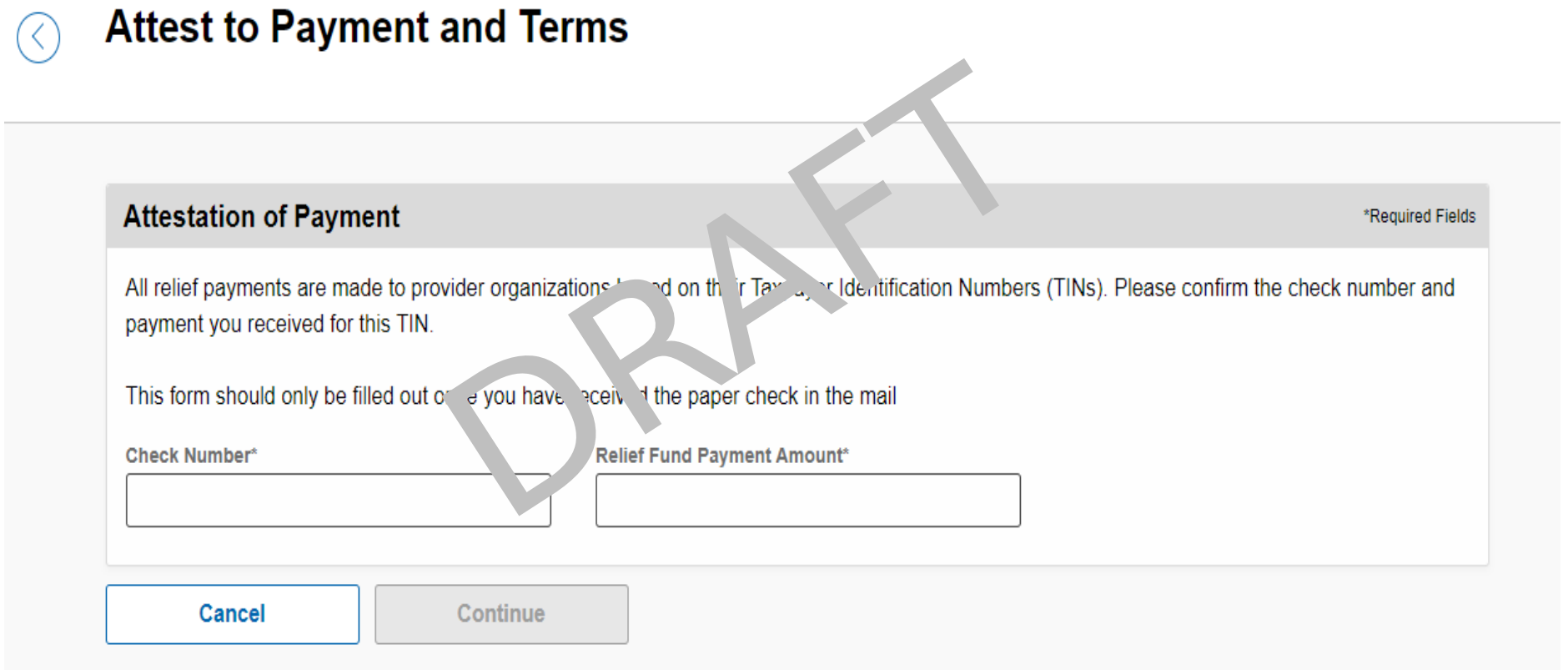
Select...

Add Organization TIN

Health Resources & Services Administration

CARES PRF Portal 2.0: Attest to Payments and Terms - Reject Payments





Attest to Payment and Terms

Attestation of Payment

I acknowledge receipt of $ XX.XX from the Public Health and Social Services Emer[illegible] Fund ("Relief Fund"), and accept the Terms and Conditions. If you receive a payment from funds appropriated in the Relief Fun[illegible]nder Divis[illegible]n B of Public Law 116-127 and retain that payment for at least 90 days of payment issuance without contacting HHS regardi[illegible]emittance of thos[illegible]unds, you are deemed to have accepted the following Terms & Conditions. This is not an exhaustive list and you must c[illegible]ply [illegible]h any other [illegible]levant statutes and regulations, as applicable. Your commitment to full compliance with all Terms and Conditi[illegible]s material [illegible]the Secretary's decision to disburse these funds to you. Non-compliance with any Term or Condition is grounds for the Secre[illegible]ry t[illegible]ccoup s[illegible]e or all of the payment made from the Relief Fund. These Terms and Conditions apply directly to the recipient [illegible]ayment f[illegible]m the [illegible]ief Fu[illegible]d. In general, the requirements that apply to the recipient, also apply to sub-recipients and contractors u[illegible]r grant[illegible]unless [illegible]xception is specified.

By receiving and accepting Relief Fund payment[illegible]ou [illegible]that i[illegible]ccordance with the "Coronavirus Aid, Relief, and Economic Security Act" or the "CARES Act", you are eligible [illegible]r this p[illegible]ment.[illegible]u acknow[illegible]dge that you may be asked to submit to the review process established by the U.S Department of Health and [illegible]man Servic[illegible] inclu[illegible]ng its contractor (collectively, "HHS"), to determine your eligibility for this payment. Additionally, upon request by HH[illegible] you will pr[illegible]de any and all information related to the disposition or use of the funds received under the Relief Fund for auditing and/or repo[illegible]ng purp[illegible]es. I attest that I have the legal authority to act on behalf of the provider group that has received payment under the Relief Fund. For E[illegible]ctronic Funds Transfer / ACH Payments, HHS or its contractor may make adjustments to the payment whenever a correction or change is required. For example, if there is an error, you agree that HHS may correct the error immediately and without notice. Such errors may include, but are not limited to, reversing an improper credit, and correcting calculation and input errors. The right to make adjustments are not subject to any limitations or time constraints, except as required by law.

I Reject Payment | I Accept Payment

Rejected Payments Important Information

How do I return a direct deposit payment?

To return the money must contact your financial institution and ask them to refuse the received Automated Clearinghouse (ACH) credit by initiating ACH return using the ACH return code of "R23 - Credit Entry Refused by Receiver".

- You are not required to call back to confirm that the funds have been received by OptumBank.

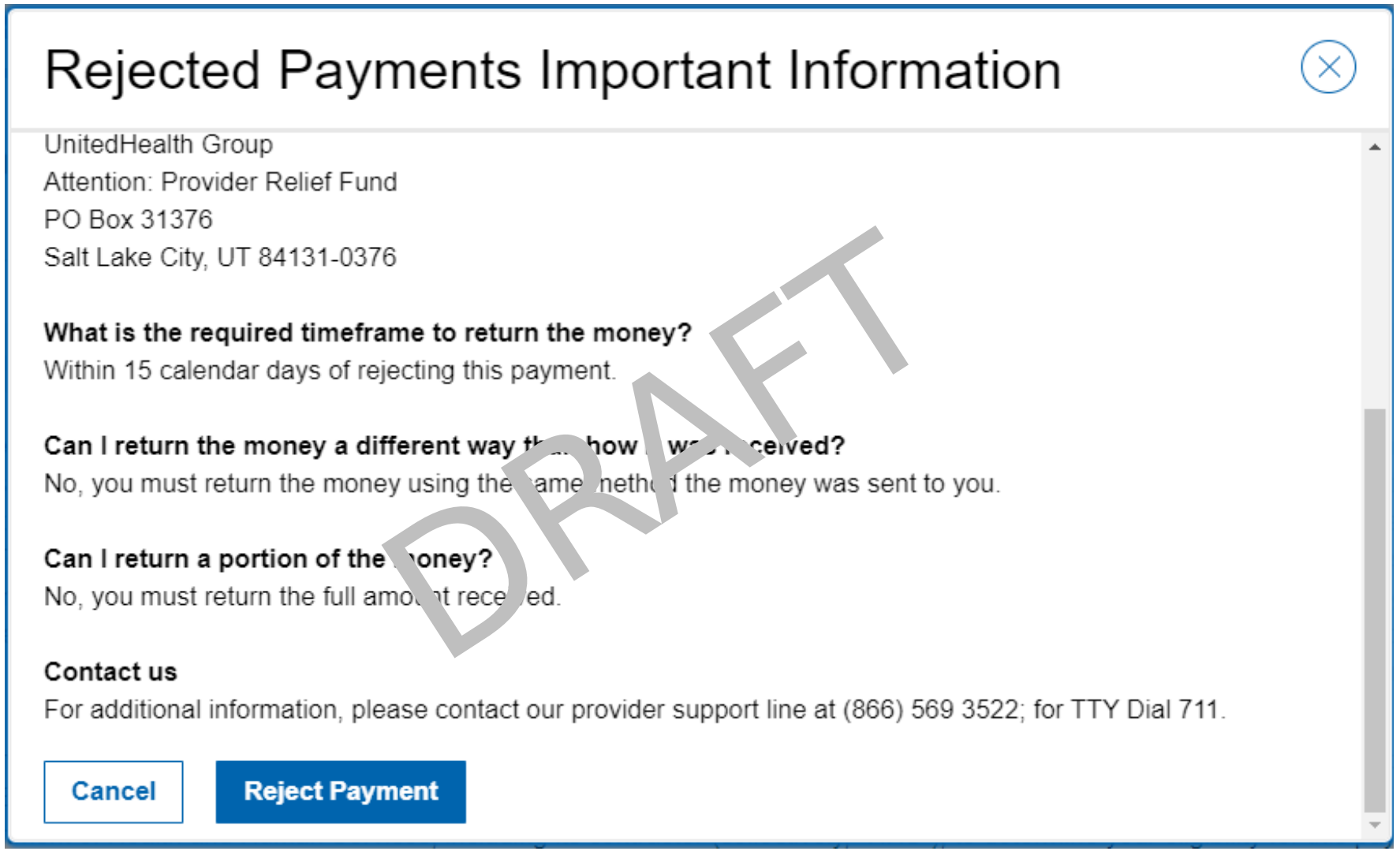
If payment was received via paper check:

Mail a refund check for the full amount payable to "UnitedHealth Group" to the address below via United States Postal Service (USPS); mailing services such as FedEx and UPS cannot be used with this PO box. List the check number from the original Provider Relief Fund check in the memo.

UnitedHealth Group
Attention: Provider Relief Fund
PO Box 31376
Salt Lake City, UT 84131-0376

What is the required timeframe to return the money?

Within 15 calendar days of rejecting this payment.



All data displayed here is sample data for example purposes only.

CARES
PROVIDER RELIEF FUND

Organization TIN Dashboard

Please see status details and complete any actions required below.

Organization Tax ID Number:**xxxxx7890**, Provider Name:**Dem[illegible] Care Pro[illegible]ssionals Inc.**

Validate TIN	[illegible]nd Tax Information	Attest to Payment and Terms
Complete	Complete	Complete
		1 of 1 Payments Attested
		Rejected - 1
		Reference Number: P4-68849651465 Rejected
		How to return funds

Add Another Organization TIN

*Required Fields

Organization TIN*

Provider Organization Name (as displayed in the first field on W-9 for this TIN)*

TIN Type*

Select...

Add Organization TIN

HRSA
Health Resources & Services Administration

Multiple Payments

Hide Details

xxxxx3455

Demo Care Inc.

Action Required For This TIN:
Attest to Payment and Terms

Validate TIN
Complete

Revenue and Tax Information
Complete

Attest to Payment and Terms
1 of 2 Payments Attested
Get Started
You are required to confirm and attest to payment once a relief payment has been deposited in your account.

Hide Details

xxxxx3455

Demo Care Inc.

Validate TIN
Complete

Revenue and Tax Information
Complete

Attest to Payment and Terms
Complete
2 of 2 Payments Attested
Funds Accepted
Reference Number: P4-93581565481
Accepted

Discussion

Questions