



# Provider Relief Fund (PRF)



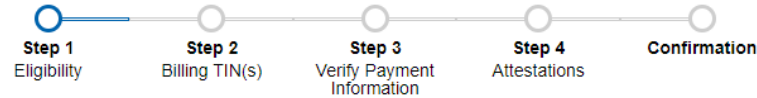
# PRF and ARPA-R Attestation Portal

**Vision: Healthy Communities, Healthy People**



# CARES

## PROVIDER RELIEF FUND



## 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 30 days of 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](https://hhs.gov/providerrelief) or call the provider support line at (866) 569-3522; for TTY dial 711.





## Privacy Act Statement

The following statement serves to inform you of the purpose for collecting personal information required by the [covid19.linkhealth.com](https://www.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/2015/03/04/2015-07900/privacy-act-of-1974-system-of-records-notice>

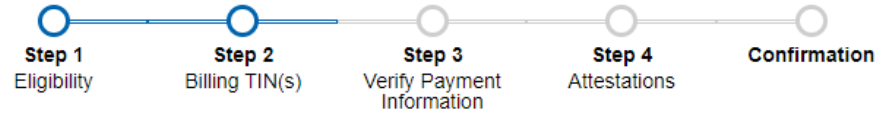
DISCLOSURE: Voluntary. If you choose not to provide your information, absence of the requested information may result in administration delays or the inability to process payments to you under the CARES Act.

Continue



# CARES

PROVIDER RELIEF FUND



## Step 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.

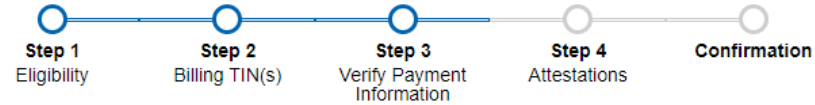
Billing TIN(s)

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

Continue



## PRF and ARPA-R attestation portal: Attest ACH Payment



### Step 3 Verify Payment Information



#### Verify Payment Information

Relief fund payments are made to your billing entity account via Optum Bank with "HHSPAYMENT" as the payment description. Please confirm the account number and payment(s) you received for each TIN. If you have not yet received payment, please call the toll-free CARES Provider Relief line at (866) 569-3522.

#### Automated Clearing House(ACH) Deposit

Billing TIN(s)	Last Six Digits of Deposit Account Number	Relief Fund Payment	Remove TIN
***877665	<input type="text"/>	<input type="text"/>	

Continue





## Step 4 Attestations

### Attestations

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

#### Automated Clearing House (ACH) Deposit

Billing TIN: ***877665	
Last Six Digits of Account Number 975301	Relief Fund Payment XXXXXX
<input type="button" value="Review and Accept"/>	



# 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 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.

- I acknowledge receipt of **\$100.10** from the Public Health and Social Services Emergency Fund ("Relief Fund"), and accept the [Terms & Conditions](#). I have 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





- 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\*

Columbia


State\*

Maryland

Zip Code\*

21033

I have read and agree to the [Optim Pay Enrollment Agreement Terms and Conditions](#).

I'm not a robot   
reCAPTCHA  
Privacy - Terms

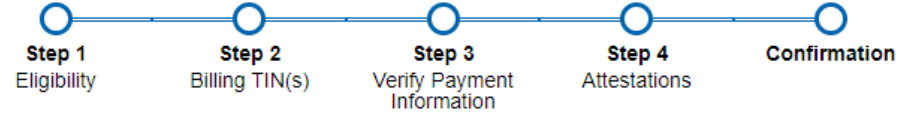
I Accept Payment

I Reject Payment



# CARES

PROVIDER RELIEF FUND



## 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**

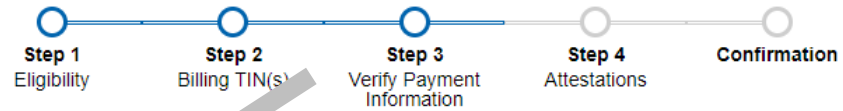
Last Six Digits of Account Number	Relief Fund Payment
<b>975301</b>	<b>\$100.10</b>

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

**Funds Accepted**



## PRF and ARPA-R attestation portal: Attest CHK Payment



### Step 3 Verify Payment Information

#### Verify Payment Information

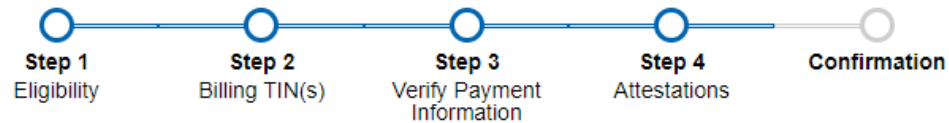
Relief fund payments are made to your billing entity account via Optum Bank with "HHSPAYMENT" as the payment description. Please confirm the account number and payment(s) you received for each TIN. If you have not yet received payment, please call the toll-free CARES Provider Relief line at (866) 569-3522.

##### Paper Check Deposit

Billing TIN(s)	Check Number <sup>1</sup>	Relief Fund Payment	Remove TIN
***877665	<input type="text"/>	<input type="text"/>	

Continue





## 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  
0000001013

Relief Fund Payment  
\$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.

- 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 withhold 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 have been 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.

#### Current Request

Billing TIN  
\*\*\*877665

Check Number  
0000001013

Relief Fund Payment  
\$100.10



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\*

DRAFT



### Rendering/Service Address

Address 1\*

123 Sample St

Address 2 (optional)

City\*


Sample

State\*

Maryland

Zip Code\*

20000

 I'm not a robot



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  
**000001013**

Relief Fund Payment  
**\$100.10**

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

**Funds Accepted**

DRAFT





# PRF Phase 4/ARPA-R Application Portal

**Vision: Healthy Communities, Healthy People**



# 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.



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 portal, [start registration here](#) to begin.

### 2. If you have an One Healthcare ID already

You can access the portal at the top right of the webpage to sign in or [sign in with One Healthcare ID here](#).

The screenshot shows a web form titled "Create One Healthcare ID". At the top, it states: "One Healthcare ID separately tracks your account so that you can use one One Healthcare ID and password to sign in to all integrated applications." Below this is a green button with an information icon and the text "Already have One Healthcare ID? Sign in now".

The form is divided into two main sections:

- Profile Information:** Includes input fields for "First name", "Last name", and "Year of birth" (with a calendar icon).
- Sign In Information:** Includes a "Your email address" field, a "Create One Healthcare ID" field (with a refresh icon), and a "Your One Healthcare ID instructions" section. The instructions list: "6 to 90 characters", "At least one letter", "No spaces", "No letters with accents", and "None of these Symbols: @, #, %, &, \*, (, ), {, }, <, >, /, |, ~, =". Below the instructions is a "Create password" field (with a strength indicator icon).

At the bottom of the form is a blue "Sign in" button.



## What You Need

### 1. Validate Taxpayer Identification Number (TIN)

This should be the organization TIN ("Filing TIN") you will use in applying for relief of 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 for 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 within 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.



[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, as well as service and 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 Relief Program as simple and accessible as possible. We are also monitoring your inquiries and working hard to answer your questions. Let us know how we're doing, and we'll update our resources based on your input.

[Submit Feedback](#)

### Important Information

[CARES Act Provider Relief Fund](#)

### Support

[Contact Us](#)

[Feedback](#)

### Accessibility

[Accessibility Statement](#)

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# CARES

## PROVIDER RELIEF FUND

### Welcome

Welcome to the CARES Act Provider Relief Fund Payment Attestation Portal. This portal allows eligible providers to attest to relief fund payments made for healthcare-related expenses or lost revenue attributable to COVID-19.



#### Sign Up for Updates

We'll contact you with updates and requests for additional information. Your email address will only be used for CARES Act and the Paycheck Protection Program and Health Care Enhancement Act.

Email Address (required)\*



Sign Up

### New to this site?

To get started, please add an Organization Taxpayer Identification Number (TIN). You will be guided through each step.

### Add 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



## Program Administrator Attestation

### Program Administrator Attestation for Organization TIN xxxxx-55

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

- I attest that I am submitting on my own behalf and I am the 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.
- I certify that all information provided as part of this process is true, accurate and complete, to the best of my knowledge.
- I understand that any person who knowingly and with intent to defraud the Government or the Company, files information containing materially false information, or commits fraud for the purpose of misleading the company commits a fraudulent insurance act.
- I understand that only one 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



I Do Not Accept

I Accept



⏪ **Tax Validation**

### Tax Validation \*Required Fields

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

Federal Tax Classification\*

**Exempt Payee Code** ⓘ

<input type="radio"/> 1 - An organization exempt from tax under section 501(c)(3), any IRA, or a custodial account under section 403(a)(7) if the account satisfies the requirements of section 401(f)	<input type="radio"/> 7 - A futures commission merchant registered with the Commodity Futures Trading Commission
<input type="radio"/> 2 - The United States or any of its agencies or instrumentalities	<input type="radio"/> 8 - A real estate investment trust
<input type="radio"/> 3 - A state, the District of Columbia, a U.S commonwealth or possession, or any of their political subdivisions, agencies, or instrumentalities	<input type="radio"/> 9 - An entity registered at all times during the tax year under the investment Company Act of 1940
<input type="radio"/> 4 - A foreign government or any of its political subdivisions, agencies, or instrumentalities	<input type="radio"/> 10 - A common trust fund operated by a bank under section 58(a)
<input type="radio"/> 5 - A corporation	<input type="radio"/> 11 - A financial institution
<input type="radio"/> 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	<input type="radio"/> 12 - A middleman known in the investment community as a nominee or custodian
	<input type="radio"/> 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 expanded affiliated group as a corporation described in Regulation section 1.472-1(c)(1)(i)
- F - A dealer in securities, commodities and derivative financial instruments (including notional principal contracts, futures, forwards and options) that is registered as such under the laws of the United States or any state
- G - A real estate investment trust
- H - A regulated investment company as defined in section 851 or any entity registered at all times during the tax year under the investment company act of 1940
- I - A common trust fund as defined in section 584(a)
- J - A bank defined in section 581
- K - A broker
- L - A trust 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\*

ZIP Code\*

### Billing Company \*Required Fields

Do you use a billing company for this TIN?

Yes

No



### Billing Company \*Required Fields

Do you use a billing company for this TIN?

Yes  
 No

Billing Company Name\*

Street Line 1\*

Street Line 2

City\*

State/Province\*

ZIP/Postal Code\*



⏪ Practice Detail

### Practice Information \*Required Fields

<b>Primary Servicing Location</b>	<b>Submitter Information</b>
Street Line 1* <input type="text"/>	Submitter Title <input type="text"/>
Street Line 2 <input type="text"/>	Submitter Name <input type="text"/>
City* <input type="text"/>	Lawson Aluru <input type="text"/>
State* <input type="text" value="Select..."/>	Submitter Email Address* <input type="text" value="laluru@optumserve.tech.com"/>
ZIP Code* <input type="text"/>	Submitter Phone Number <input type="text"/>
Phone Number* <input type="text"/>	Extension <input type="text"/>
Extension <input type="text"/>	



## Group/Individual Information

\*Required Fields

Applicant/Provider Type\*

Select...


Registration Type\*

Group

Individual

Group NPI\* <sup>i</sup>

Group NPI Effective Date

Applicable Department of Health, or National License

Number or Certification Number\* <sup>i</sup>

List of all Subsidiary TIN(s) Associated with this Entity\*

Rows per page: 10

1-1 of 1



TIN	TIN Type	Visibility
<input type="text"/>	Select... <sup>v</sup>	

Type or copy/paste TIN(s) and select the TIN Type for each TIN. If your organization does not have subsidiary TIN(s), please re-enter your organization TIN and select TIN Type.

**There are 1 TIN(s) with invalid TIN/TIN Type. Please update before proceeding to the confirmation page.**

Medicaid ID(s) <sup>i</sup>

If you or any of the subsidiary entities have a state Medicaid ID, please enter the 2-digit state abbreviation followed by your Medicaid ID. If you have multiple Medicaid IDs, please enter all of them in a comma separated list (Example: AZ-1234567, MD-123456789).

Cancel


Continue



### Group/Individual Information \*Required Fields

**Applicant/Provider Type\***  
Select... ▾


**Registration Type\***  
 Group  
 Individual


**Date of Birth\***  


**Individual NPI\*** ⓘ

**Social Security Number**

**Applicable Department of Health, or National License Number or Certification Number\*** ⓘ

**List of all Subsidiary TIN(s) Associated with this Entity\***  
Rows per page: 10 ▾ 1-1 of 1 < > 

TIN	TIN Type
<input type="text"/>	Select... ▾ 

TIN or Composite TIN(s) and select the TIN Type for each TIN. If your organization does not have subsidiary TINs, please re-enter your organization TIN and select TIN Type.

**There are 1 TIN(s) with invalid TIN/TIN Type. Please update before proceeding to the confirmation page.**

**Medicaid ID(s)** ⓘ

If you or any of the subsidiary entities have a state Medicaid ID, please enter the 2-digit state abbreviation followed by your Medicaid ID. If you have multiple Medicaid IDs, please enter all of them in a comma separated list (Example: AZ-1234567, MD-123456789).



⏪ **Confirmation**

**Demo Care Professionals Inc.**

Business Name	Organization TIN Address
<b>Demo Care Professionals Inc.</b>	<b>123 Sample St</b>
Federal Tax Classification	<b>Columbia, MD 21044</b>
<b>Individual/sole proprietor or single-member LLC</b>	Primary Service
Exempt Payee Code	<b>123 Sample St</b>
-	<b>Columbia, MD 21044</b>
Exempt from FATCA reporting code	<b>(222) 222-2222</b>
-	Medicaid ID(s)
Submitter Name	<b>MD-374564346, TX-353434444</b>
<b>Demo Name</b>	List of all Subsidiary TINs Associated with this Entity
Submitter Phone Number	<b>xxxxx3333</b>
--	Applicant/Provider Type
Submitter Email	<b>Ancillary Services - Dental Service Providers</b>
<b>abc123@gmail.com</b>	Registration Type
	<b>Group</b>
	Group NPI
	<b>2323232222</b>
	Group NPI Effective Date
	<b>09/09/2019</b>
	Applicable Department of Health, or National License Number or Certification Number
	<b>NA</b>








## Organization TIN Dashboard

Please see status details and complete any actions required below.

234567890

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

<p>Action Required For This TIN:</p> <p><b>None</b></p> <p>Not Available Yet:</p> <p>Revenue and Tax Information</p> <p>Attest to Payment and Terms</p> <p>Remove TIN From List:</p> <p><a href="#">Remove TIN</a></p>	 <b>Validate TIN</b> <b>Processing</b>	 <b>Attest to Payment and Terms</b> <b>Not Available Yet</b>	 <b>Revenue and Tax Information</b> <b>Not Available Yet</b>
---	---	---	---

You will be able to confirm revenue and tax information once TIN Validation is complete.

Once payment has been issued, you will be able to attest to fund distribution.

**Add Another Organization TIN** \*Required Fields


<b>Organization TIN*</b> <span style="font-size: x-small;">i</span> <span style="font-size: x-small;">👁</span> <input style="width: 95%;" type="text"/>	<b>Provider Organization Name (as displayed in the first field on W-9 for this TIN)*</b> <input style="width: 95%;" type="text"/>	<b>TIN Type*</b> <input style="width: 95%;" type="text" value="Select..."/>
--	--	--





Add Organization TIN





## Organization TIN Dashboard

Please see status details and complete any actions required below.

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

<p>Action Required For This TIN:</p> <p>Revenue and Tax Information</p> <p>Not Available Yet:</p> <p>Attest to Payment and Terms</p> <p>Update TIN Validation:</p> <p><a href="#">Update TIN</a></p>	<p></p> <p><b>Validate TIN</b></p> <p>Complete</p>	<p></p> <p><b>Revenue and Tax Information</b></p> <p>Available Now</p> <p><a href="#">Get Started</a> </p> <p>You 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.</p>	<p></p> <p><b>Attest to Payment and Terms</b></p> <p>Not Available Yet</p> <p>Once payment has been issued, you will be able to attest to fund distribution.</p>
--	---	--	---

**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\*

[Add Organization TIN](#)





### Please enter the access code to view the document



**Daniel Bietz**

Department of Health and Human Services

An email containing a validation code has been sent to the address you specified. To proceed, please open the email and enter the code in the box below. Keep this browser window open while you get your email.

Access Code

VALIDATE

I NEVER RECEIVED AN ACCESS CODE

Show Text

DRAFT



Signing validation code: 47bcc58d

RESUME SIGNING

## Subsequent Process owned by DocuSign

Copy and enter the validation code above into the access page to finish the HRSA Provider Relief Fund application.

At any point before completing your submission, you may return to the application by clicking on the Resume Signing button in this email.

Powered by **DocuSign**



Process owned by DocuSign

Please review the documents below. **FINISH** OTHER ACTIONS ▾

DocuSign Envelope ID: 6A27F5E8 F254-4E16-B367-90DAD065DAB6

**Reference ID** P4-63443005198

### CARES Act Provider Relief Fund

Tax ID Number: 888888888

Name as shown on your income tax return: Demo Care Professionals Inc. Please ignore

Federal Tax Classification: Individual/sole proprietor or single member LLC

Business Name (if different):

Street 1: 123 Sample

Street 2:

City: Sample State: MD Zip: 21044

Registration Type:

Organization (Group) Name:

(1) Contact Person Name:

(2) Contact Person Title:

(3) Contact Person Phone Number:

(4) Contact Person Email:

(5) Applicant/Provider Type: Other

*Fields 6 - 8 have been intentionally removed*

(9) CMS Certification Number (CCN), if applicable:

**REVENUES**

(10) Revenues: \$

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Please review the documents below.

FINISH

OTHER ACTIONS ▾



START

### REVENUES

(10) Revenues: \$

(11) Fiscal Year of Revenues: -- select -- ▾

(12) Revenue from Patient Care: \$

### 13. OPERATING REVENUES FROM PATIENT CARE

(13.1) 2021 Q1 (Jan 1 – Mar 31):  (13.2) 2019 Q1 (Jan 1 – Mar 31):

(13.3) 2020 Q3 (July 1 – Sept 30):  (13.4) 2019 Q3 (July 1 – Sept 30):

(13.5) 2020 Q4 (Oct 1 – Dec 31):  (13.6) 2019 Q4 (Oct 1 – Dec 31):

Phase 4 Portal - Revenue Application Data Collection Form - DRAFT 1 of 3

DocuSign Envelope ID: 6A27F5...254-4E16-F...90DAD065...36

### 14. OPERATING EXPENSES FROM PATIENT CARE

(14.1) 2021 Q1 (Jan 1 – Mar 31):  (14.2) 2019 Q1 (Jan 1 – Mar 31):

(14.3) 2020 Q3 (July 1 – Sept 30):  (14.4) 2019 Q3 (July 1 – Sept 30):

(14.5) 2020 Q4 (Oct 1 – Dec 31):  (14.6) 2019 Q4 (Oct 1 – Dec 31):

### SUPPORTING DOCUMENTS

(15) Upload Revenues Worksheet (if required):



(16) Upload Federal Tax Form:



(17) Upload supporting documents for 2019 Q1, Q3, Q4 operating revenues and expenses from patient care:



(18) Upload supporting documents for 2020 Q3-Q4, 2021 Q1 operating revenues and expenses from patient care:



### RURAL PROVIDERS

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Process owned by DocuSign



Please review the documents below.

FINISH

OTHER ACTIONS ▾

Process owned by DocuSign

START

(17) Upload supporting documents for 2019 Q1, Q3, Q4 operating revenues and expenses from patient care:



(18) Upload supporting documents for 2020 Q3-Q4, 2021 Q1 operating revenues and expenses from patient care:



**RURAL PROVIDERS**

(19) If you are a rural provider or parent entity applying on behalf of a rural subsidiary or are a provider that treats rural beneficiaries and would like to be considered for an additional rural payment select 'Yes', otherwise select 'No'.  Yes  No

Fields 20 - 32 have been intentionally removed.

**BANKING INFORMATION**

(33) Bank Name:

(34) A Routing Number:

(35) Account Holder Name:

(36) Account Number:

**Terms and Conditions**

If a payment is issued, recipients must agree to distribution's Terms and Conditions within 90 days.


I acknowledge and understand the [Phase 4 Terms and Conditions](#).





By clicking "Submit" Recipient understands that non-compliance with any Term or Condition and all applicable statutes and regulations may result in administrative, civil, and/or criminal action being taken and certifies that, you are a bona fide representative of the entities represented herein and that all of the information you are submitting to a Federal Government System, under penalty and perjury of law, is true, correct, and accurate.





## Organization TIN Dashboard

Please see status details and complete any actions required below.

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

<p>Action Required For This TIN:</p> <p>Revenue and Tax Information</p> <p>Not Available Yet:</p> <p>Attest to Payment and Terms</p> <p>Update TIN Validation:</p> <p><a href="#">Update TIN</a></p>	<p></p> <p><b>Validate TIN</b></p> <p>Complete</p>	<p></p> <p><b>Revenue and Tax Information</b></p> <p>Available Now</p> <p><a href="#">Get Started</a> </p> <p>You 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.</p>	<p></p> <p><b>Attest to Payment and Terms</b></p> <p>Not Available Yet</p> <p>Once payment has been issued, you will be able to attest to fund distribution.</p>
--	---	--	---

**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\*

[Add Organization TIN](#)






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



## Organization TIN Dashboard

Please see status details and complete any actions required below.

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

<p>Action Required For This TIN: Attest to Payment and Terms</p>	<p> <b>Validate TIN</b> Complete</p>	<p> <b>Revenue and Tax Information</b> Complete</p>	<p> <b>Attest to Payment and Terms</b> 0 of 1 Payments Attested <a href="#">Get Started</a> You are required to confirm and attest to payment once a relief payment has been deposited in your account.</p>
--	---	--	--

**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](#)





# CARES

PROVIDER RELIEF FUND



## Attest to Payment and Terms

### Attestation of Payment

\*Required Fields

Automated payments are sent via Optum Bank with "U.S. 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



# CARES

PROVIDER RELIEF FUND

## Attest to Payment and Terms

### Attestation of Payment

- I acknowledge receipt of \$XXX.XX from the Public Health and Social Services Emergency Fund ("Relief Fund"), and accept the Terms and Conditions. If you receive 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 of payment issuance without contacting HHS regarding issuance 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 stop 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 grant, unless an exception is specified.
- By receiving and accepting Relief Fund payment, I 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.
- I have read and agree to the Optum Pay Enrollment Agreement Terms and Conditions.

I Reject Payment

I Accept Payment





## Organization TIN Dashboard

Please see status details and complete any actions required below.

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

<b>Validate TIN</b>	<b>Revenue and Tax Information</b>	<b>Attest to Payment and Terms</b>
<b>Complete</b>	<b>Complete</b>	<b>Complete</b>
		<b>1 of 1 Payments Attested</b>
		<b>Funds Accepted</b>
		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\*

**Add Organization TIN**



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



### Organization TIN Dashboard

Please see status details and complete any actions required below.

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

Action Required For This TIN:  
Attest to Payment and Terms



Validated  
complete



Revenue and Tax Information  
Complete



Attest to Payment and Terms

0 of 1 Payments Attested

[Get Started](#)

You are required to confirm and attest to payment once a relief payment has been deposited in your account.

#### 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\*

[Add Organization TIN](#)



## ⏪ Attest to Payment and Terms

### Attestation of Payment

\*Required Fields

All relief payments are made to provider organizations based on their Taxpayer Identification Numbers (TINs). Please confirm the check number and payment you received for this TIN.

This form should only be filled out once you have received the paper check in the mail

Check Number\*

Relief Fund Payment Amount\*

Cancel

Continue





## Attest to Payment and Terms

### Attestation of Payment

- I acknowledge receipt of \$ **XX.XX** from the Public Health and Social Services Emergency Fund ("Relief Fund"), and accept the Terms and Conditions. If you receive 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 of payment issuance 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 grant, unless an exception is specified.
- By receiving and accepting Relief Fund payment, you agree 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.

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.



## Rejected Payments Important Information



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.

### Can I return the money a different way than how it was received?

No, you must return the money using the same method the money was sent to you.

### Can I return a portion of the money?

No, you must return the full amount received.

### Contact us

For additional information, please contact our provider support line at (866) 569 3522; for TTY Dial 711.

Cancel

Reject Payment











## Organization TIN Dashboard

Please see status details and complete any actions required below.

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


 <b>Validate TIN</b> Complete	 <b>Provide and Tax Information</b> Complete	 <b>Attest to Payment and Terms</b> Complete <b>1 of 1 Payments Attested</b> <b>Rejected - 1</b> Reference Number: P4-68849651465 Rejected <a href="#">How to return funds</a>
--	---	--

**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**



## Multiple Payments

<a href="#">Hide Details ^</a>	xxxxx3455	Demo Care Inc.	
Action Required For This TIN: Attest to Payment and Terms	 <b>Validate TIN</b> Complete	 <b>Revenue and Tax Information</b> Complete	 <b>Attest to Payment and Terms</b> 1 of 2 Payments Attested <a href="#">Get Started</a> <p>You are required to confirm and attest to payment once a relief payment has been deposited in your account.</p>

<a href="#">Hide Details ^</a>	xxxxx3455	Demo Care Inc.	
	 <b>Validate TIN</b> Complete	 <b>Revenue and Tax Information</b> Complete	 <b>Attest to Payment and Terms</b> Complete 2 of 2 Payments Attested <b>Funds Accepted</b> Reference Number: P4-93581565481 Accepted



# Discussion

# Questions

