State of Illinois
Department of Healthcare and Family Services

PROVIDER ENROLLMENT APPLICATION
ILLINOIS MEDICAL ASSISTANCE PROGRAM

(Must be Typed or Printed Legible and Do Not Use Highlighter On Any Documents.)
All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type or print NONE.

SECTION A: PROVIDER

1. New Enrollment [✓] Re-Enrollment [ ] Name Change [ ] Reinstatement Request [ ] 2. Provider Type: 010
3. Provider Name: Tara Kumaraswami MD
4. Primary Office Address: 820 S Wood MC 808
5. City: Chicago 6. County: Cook
7. State: IL 8. Zip Code: 60612-7313 9. Telephone: (312) 413-8779 10. Fax:
11. E-mail Address (3):
12. National Provider Identification # - NPI: 1144373184 **Report Additional NPI's In Section D** 13. FEIN: 376000511
14. SSN: [redacted] 15. License/Certification: 036-125298 16. DEA: [redacted]
17. Medicare Part A#: 18. Organization Type: 19. Control of Facility: 1 20. Fiscal Year:
21. CLIA #:

SECTION B: SERVICE/SPECIALTY

22. Category of Service: 001 | 006 | 017 | 030 | 045
23. Provider Specialty: Primary Specialty: OB Secondary Specialties:
24. Physician UPIN No.: 25. OBRA Qualifications (Physicians Only):
26. Hospital Admitting Privilege: (Physicians Only)
Hospital Name: University of Illinois at Chicago Medical Center Address: 1740 W Taylor St - Chicago, IL 60612
Hospital Name: Address:
27. Pharmacy Location: 28. Pharmacist In Charge: 29. License #:
30. Electronic Billing? Yes [✓] No [ ] 31. If Yes, Pharmacy Software Vendor Name: 32. Pharmacy NCPDP#:
33. Transportation: Taxi Base/Meter/Flag Rate: 34. Taxi Mileage Rate: 35. Medicar: Hydraulic Manual Lift or Ramp Yes [ ] No [ ]
36. Long Term Care Medical Bed Capacity: 37. Long Term Care Medicare Fiscal Intermediary:
38. Long Term Care Building ID Code:

SECTION C: FORMER PARTICIPATION

39. Change of Ownership Yes ☐ No ☐ Effective Date

40. Former Provider Number Former Provider Name

SECTION D: ADDITIONAL NPI - National Provider Identification #

41. NPI NPI NPI

NPI NPI NPI

SECTION E: PAYEE INFORMATION

42. Name University of Illinois at Chicago Medical Center 43. Telephone: (866) 213-3600

44. DBA University of Illinois Department of Medicine

45. Street Address 135 S LaSalle St - Dept 3463

46. City Chicago 47. State IL 48. Zip Code 60674-3463 49. TIN Type Code

50. SSN/FEIN [redacted] 51. Billing Provider/Pay To NPI # 1154541936

52. Medicare Part B# 936980 53. PIN 54. DMERC#

Name Telephone:

DBA

Street Address

City State Zip Code TIN Type Code

SSN/FEIN Billing Provider/Pay To NPI #

Medicare Part B# PIN DMERC#

SECTION F: CERTIFICATION/SIGNATURE

I understand that knowingly falsifying or willfully withholding information may be cause for the denial or termination of participation in the Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws..

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services, to verify the information provided on this application with other state and federal agencies. I further certify that I will review and comply with the Department's policies, rules and regulations including but not limited to those found at the following websites:

Illinois HFS website address: http://www.hfs.illinois.gov/
Illinois HFS Handbook updates are available: http://www.hfs.illinois.gov/handbooks
Illinois HFS Laws and Rule Regulations: http://www.hfs.illinois.gov/lawsrules/index.html

Check this box if you want a provider handbook mailed ☐

Signature: [redacted] Date 9/7/2010

Printed name of person signing above Tara Kumaraswami MD

State of Illinois
Department of Healthcare and Family Services

AGREEMENT FOR PARTICIPATION
ILLINOIS MEDICAL ASSISTANCE PROGRAM

WHEREAS, Tara Kumaraswami MD

Full Legal as well as an Assumed (d.b.a.) name.

_____(HFS Provider Number, if applicable)

hereinafter referred to as ("the Provider") is enrolled with the Illinois Department of Healthcare and Family Services hereinafter referred to as ("the Department") as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Healthcare and Family Services clients;

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program policy and billing provisions as set forth in the applicable Healthcare and Family Services Medical Assistance Program rules and handbooks.

2. The Provider agrees, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations. Hospitals are further required to be certified for participation in the Medicare Program (Title XVIII) or, if not eligible for or subject to Medicare certification, must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

3. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX and XXI of the Social Security Act and with all other applicable Federal and State laws and regulations.

4. The Provider agrees that any rights, benefits and duties existing as a result of participation in the Medical Assistance Program shall not be assignable without the written consent of the Department.

5. The Provider shall receive payment based on the Department's reimbursement rate, which shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from charges sent to the Department.

6. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to the Department for payment. Provider acknowledges that it understands the laws and handbook provisions regarding services and certifies that the services will be provided in compliance with such laws and handbook provisions. Provider further acknowledges that compliance with such laws and handbook provisions is a condition of payment for all claims submitted. Any submittal of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.

7. The Provider agrees to furnish to the Department or its designee upon demand all records associated with submitted claims necessary to disclose fully the nature and extent of services provided to individuals under the Medical Assistance Program and maintain said records for not less than three (3) years from the date of service to which it relates or for the time period required by applicable Federal and State laws, whichever is longer. The latest twelve months of records must be maintained on site. If a Department audit is initiated, the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.

8. The Provider, if a medical transportation provider, agrees that vehicle operators(s) shall have an appropriate Drivers License and vehicle(s) shall be properly registered.

9. The Provider, if not a practitioner, agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.

10. The Provider agrees to exhaust all other sources of reimbursement prior to seeking reimbursement from the Department.

11. The Provider agrees to be fully liable to the Department for any overpayments, which may result from the Provider's submittal of billings to the Department. The Provider shall be responsible for promptly notifying the Department of any overpayments of which the Provider becomes aware. The Department shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the Department.

12. The Provider (if a hospital, nursing facility, hospice or provider of home health care or personal care services) agrees to comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.

13. The Provider certifies that there has not been a prohibited transfer of ownership interest to or in the provider by a person who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12-4.25.

14. The Provider agrees to furnish to the Department or the U.S. Department of Health and Human Services (HHS) on request, information related to business transactions in accordance with 42 CFR 455.105 paragraph (b). The Provider agrees to submit, within 35 days of the date of the request by the Department or HHS, full and complete information about:- (1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

15. The Provider certifies the following owners/stock holders own 5% or more of the stock/shares. If additional space is needed for names, please use separate page. If there is no information to disclose, write NONE on PRINT NAME line. This section MUST be completed for enrollment purposes and an entry is required.

PRINT NAME	SOCIAL SECURITY NUMBER	% OF OWNERSHIP
PRINT NAME	SOCIAL SECURITY NUMBER	% OF OWNERSHIP

16. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws.

17. Requested effective date 07/01/2010 The Provider certifies that all services rendered on or after such date were rendered in compliance with and subject to the terms and conditions of this agreement.

Under penalties of perjury, the undersigned declares and certifies that the information provided in this Agreement for Participation is true, correct and complete.

by: [redacted]
(Pr[redacted]

Tara Kumaraswami MD
(Print Name of Signature above)

Date

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

by: [redacted]
D[redacted]

Date

[redacted] Date: 9/24/10

HFS 1413 (R-6-09)

ATTEST [redacted] Date: 9-24-10

Michele M. Thompson Secretary

Illinois Department of Healthcare and Family Services

HOSPITAL, PROFESSIONAL SCHOOL OR PRACTITIONER OWNED GROUP PRACTICE AS ALTERNATE PAYEE

1) The practitioner certifies that he or she is: a) an employee of the hospital or professional school or practitioner owned group practice and must, as a condition of his or her employment, turn over his or her fee for care or service to Healthcare and Family Services recipients to the hospital, school, or group practice; OR, b) an independent contractor under contract with the hospital and under the terms of that contract, the hospital submits the claims to the Department.

2) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice that, all owners, directors, members or practitioners of the group practice are licensed and eligible to participate, and at this time of application are in good standing in the Medical Assistance Program of Healthcare and Family Services.

3) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice, that the group practice shares facilities, equipment and personnel and maintains central patient records.

4) If this form is used for a hospital or school, no bills submitted by the practitioner are for services for which reimbursement has been made to the hospital or school or for which reimbursement will be sought by submission of a cost report, invoice or otherwise.

5) Bills submitted will only be for direct patient care rendered or supervised by that practitioner; e.g., services for which the practitioner assumes full responsibility as specified in Provider Handbooks.

6) The hospital, school or group practice shall be responsible for maintaining and making available to the Department all business and professional records sufficient to fully and accurately document the nature, scope, detail and receipt of services provided to Healthcare and Family Services recipients by the provider for whom this form has been submitted. The hospital, school or group practice shall be responsible for retaining such records for the period required under 89 Illinois Administrative Code 140.28, even if practitioner leaves the employ or otherwise terminates his or her relationship with the hospital, school or group practice.

7) The hospital, school or group practice will keep and make available to Healthcare and Family Services such records regarding any payments claimed by the hospital, school or group practice for providing services to Healthcare and Family Services recipients as the Department may request.

8) The hospital, school or group practice will keep and make available all financial records that may be requested by Healthcare and Family Services, specifically including records that set forth the terms of the relationship between the hospital, school, or group practice and its practitioners.

9) The hospital, school or group practice shall have sole financial responsibility for any bills submitted in the name of the practitioner for which it is the alternate payee. However, if the practitioner owns, directly or indirectly, 5% or more of the shares of stock or other evidence of ownership in a corporate hospital, school or group practice, or is an investor, owner or partner of the hospital, school, or group practice, the practitioner and the hospital, school or group practice are jointly and severally liable and responsible. This responsibility includes liability to repay any overpayments made by the Department. By signing this form the hospital, school, or group practice expressly authorizes Healthcare and Family Services to withhold overpayments from payments made by the Department, either as direct payments to the hospital, school, or group practice or made based on the hospital, school, or group practice being an alternate payee.

10) In the event the alternate payee designated on this form is not a licensed hospital, professional school or practitioner owned group practice, both the practitioner and the alternate payee designated understand and acknowledge that they shall be personally liable and responsible, jointly and severally, for any bills submitted to Healthcare and Family Services even though such bills were prepared, signed and/or submitted solely by the alternate payee or the alternate payee's agent. Liability hereunder shall include any civil and/or criminal liability, including but not limited to liability under the theory of accountability and liability for repayment of any overpayment received by the designated alternate payee, plus any penalty provided by statute.

11) The practitioner shall be responsible for the accuracy and truthfulness of all bills submitted on behalf of the practitioner. Bills submitted in the practitioner's name will be signed by him or her personally or by an authorized agent pursuant to a power of attorney. This power of attorney must be executed on Form HFS 2306 which shall be submitted to the Department prior to submittal of any bills signed by the agent. Practitioner understands and acknowledges that it is his or her personal responsibility to review any and all billings before such billings are submitted to Healthcare and Family Services on practitioner's behalf and/or in his or her name.

12) The parties signing this document acknowledge and agree that payments will be directed to the alternate payee for all dates of service beginning 07/01/2010 and thereafter (insert date no earlier than sixty days prior to submission of this document to the Department).

Illinois Department of Healthcare and Family Services

CERTIFICATION

The parties to this agreement hereby certify under penalty of perjury that they are in compliance with 89 Illinois Administrative Code, Section 140.24 (d), in that: a) The medical practitioner has a contractual/salary arrangement, as a condition of employment with a hospital or professional school; b) The medical practitioner is part of a practitioner owned group practice consisting of three or more fulltime licensed practitioners or the equivalent thereof; c) The medical practitioner is employed by a practitioner who requires, as a condition of employment, that the fees be turned over to the employer; d) The medical practitioner has a contractual/salary arrangement or is employed by a governmental entity that requires, as a condition of employment that the fees be turned over to the governmental entity; e) The medical practitioner has a contractual/salary arrangement or is employed by a community mental health agency that is certified by the Department of Human Services under 59 Illinois Administrative Code, Ch. IV, Part 132 and is enrolled as a provider in the Illinois Medical Assistance Program; f) The medical practitioner has a contractual/salary arrangement or is employed by a Federally Qualified Health Clinic that is enrolled as a provider in the Illinois Medical Assistance Program. If at any time any of the conditions of this agreement are modified, the parties will immediately notify Healthcare and Family Services.

The parties acknowledge that false, inaccurate or incomplete information is grounds for cancellation of this alternate payee agreement or denial or termination of participation in the Medical Assistance Program and criminal and/or civil prosecution.

[redacted] Y PRACTITIONER

(Signature of Practit[redacted]) — (Date) 9/7/10 — 036-125298 (Provider #)

Tara KumaraswamiMD (Printed Name) — [redacted] (SSN) — (Individual Medicare #)

TO BE COMPLETED BY PAYEE

The payee certifies that the following owners/stock holders own 5% or more of the stock/shares in the payee's interest. If additional space is needed for names, please use separate page. If there is no information to disclose, write **NONE** on **PRINTED NAME** line. **This section MUST be completed for enrollment purposes and an entry is required.**

(PRINTED NAME) [redacted] — (SSN) — % OF OWNERSHIP

(SSN) — % OF OWNERSHIP

9/7/10 Date

(Print Name of Payee Representative)

936980 (Group Medicare #)

(Name of Hospital, Professional School, Practitioner Owned Group Practice, FQHC, Community Mental Health Agency or Government Entity)

(PIN - Practitioner ID number required when using a group Medicare number)

(CHECK ONE)

- ☐ Hospital
- ☑ Government Entity
- ☐ Practitioner Owned Group Practice
- ☐ Professional School
- ☐ FQHC (Provider Number _____)
- ☐ Community Mental Health Agency (Provider Number _____)

(DMERC #)

(Tax #) 376000511

(Telephone #)

(Doing Business As name, if applicable)
Department of OB/GYNE

135 S LaSalle St - Dept 3463

Chicago, IL 60674-3463

(Mailing address where payment is to be sent)

Use payee ID# [redacted]

Check Box If practitioner Office Address should be changed to the Payee Address shown above.

This Alternate Payee Request is (Check One Box and Circle Affected Payee Number):

ADD CHANGE PAYEE 1 2 3 4 5 6 7 8 9

Illinois Department of Healthcare and Family Services

POWER OF ATTORNEY

I, Tara Kumaraswami MD, do hereby make and appoint
(Practitioner's Name)

Wolcott, Wood and Taylor Inc. as my true and lawful attorney
(Name of Agency)

in fact solely for the purpose of affixing my name to the HFS 1443, Provider Invoice, or HFS 2360, Health Insurance Claim Form, as appropriate. I understand and acknowledge that the person appointed must be a trusted employee over whom I have direct supervision on a daily basis or the person is employed by the hospital and must sign my name to the HFS 1443 or HFS 2360 along with his/her initials. I understand and acknowledge that said person will be acting on my behalf, and that I will be bound by the certification statement on each HFS 1443 or HFS 2360. I understand and acknowledge that this Power of Attorney in no way limits my rights, liabilities or duties relating to the provision of services under the Illinois Department of Healthcare and Family Services' Medical Assistance Program. I understand and acknowledge that I retain full responsibility for all claims submitted to the Department of Healthcare and Family Services under my name.

Tara Kumaraswami MD
Practitioner Name
(Printed)

Signature [redacted]

Date: 9/7/10

Wolcott, Wood and Taylor Inc.
Address
200 W Adams St - Suite 225

Chicago, IL 60606

Use payee ID#3760005116067428

Walter K Knorr
Agent Name

Signature [redacted]

Date: 9/24/10

[redacted]

Michele M. Thompson Secretary

Date: 9-24-10

Completion of this form or compliance with instructions is voluntary; however, failure to do so may affect this Department's action. Form approved by the Forms Management Center.

HFS 2306 (R-10-06)

IL478-1124

2010/10/05 09:43:08

State of Illinois
Department of Healthcare and Family Services

ENROLLMENT DISCLOSURE STATEMENT
ILLINOIS MEDICAL ASSISTANCE PROGRAM

1. Identifying Information

Provider Name / DBA Name	Provider No.	NPI
Tara Kumarswami MD University of Illinois Dept of OB/GYNE	036-125298	1144373184

Provider Office Street Address
820 S Wood MC 808

City, County, State	Zip Code	Telephone
Chicago,Cook, Illinois	60612-7313	(312) 413-8779

2. (a) List the name, address, and SSN/EIN of each person and/or entity with direct or indirect ownership or control interest in the disclosing entity or any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. List any additional names, addresses, and SSN/EIN under "Remarks" on page 2.

Name	Address	SSN/EIN
N/A		

(b) If any persons listed in 2(a) are related to each other as spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage, list that relationship (i.e. John Smith and Mary White are siblings).

(c) Check type of entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations

☑ Other, please specify Employee

List the name, address, and SSN of the Directors, Officers, Partners, and Managing Employees of the Disclosing Entity. List any additional names, addresses, and SSN under "Remarks" on page 2.

Name	Address	SSN
N/A		

(d) Are any of the individuals/entities listed in 2(a) also current or previous owners of other Medicare/Medicaid entities?

☐ Yes ☐ No If yes, for each affiliation list the individual/entity name from 2(a); the name, address, and provider number of the affiliated entity, along with the affiliation date. List any additional information as needed under "Remarks" on page 2.

Individual/Entity (2(a))	Name of Affiliated Entity	Affiliated Entity's Address	Affiliated Entity's Provider Number	Date of Affiliation
N/A				

ENROLLMENT DISCLOSURE STATEMENT

3. Has there been a change in ownership or control for the disclosing entity within the last year? ☐ Yes ☑ No

   If yes, give date and name of prior owner(s) _____

   If the prior owner is a relative of anyone listed in 2(a), state the individual from 2(a) and the relationship (spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage).

   _____

4. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been convicted of a criminal offense:

Name	Ownership Interest/Position	Criminal Offense	Date
N/A			

5. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been sanctioned (previously or currently) by any health care related program including, but not limited to, Medicare, Medicaid, or the Title XX services program since the inception of those Programs.

Name	Sanction	Date	State
N/A			

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT WITH THE DEPARTMENT.

Tara Kumaraswami
Name of Authorized Representative (Typed)

MD
Title

S[redacted]

9/7/10
Date

Remarks:

HFS 1513 (N-6-09)

2010/10/05 09:43:10

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
036.125298

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

EXPIRES:
07/31/2011

LICENSED
PHYSICIAN AND SURGEON

TARA N KUMARASWANI MD

[redacted]

[redacted]
BRENT E. ADAMS
SECRETARY

[redacted]
DANIEL E. BLUTHARDT
DIRECTOR

The official status of this license can be verified at www.idfpr.com

5054341

State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO.
036.125298

LICENSED
PHYSICIAN AND SURGEON

TARA N KUMARASWANI MD

EXPIRES
07/31/2011

SIGN: [redacted]

[redacted]
BRENT E. ADAMS
SECRETARY

[redacted]
DANIEL E. BLUTHARDT
DIRECTOR

The official status of this license can be verified at www.idfpr.com

5054341

20100326 1/

CERTIFICATION

The parties to this agreement hereby certify under penalty of perjury that they are in compliance with 89 Illinois Administrative Code, Section 140.24 (d), in that: a) The medical practitioner has a contractual/salary arrangement, as a condition of employment with a hospital or professional school; b) The medical practitioner is part of a practitioner owned group practice consisting of three or more fulltime licensed practitioners or the equivalent thereof; c) The medical practitioner is employed by a practitioner who requires, as a condition of employment, that the fees be turned over to the employer; d) The medical practitioner has a contractual/salary arrangement or is employed by a governmental entity that requires, as a condition of employment that the fees be turned over to the governmental entity; e) The medical practitioner has a contractual/salary arrangement or is employed by a community mental health agency that is certified by the Department of Human Services under 59 Illinois Administrative Code, Ch. IV, Part 132 and is enrolled as a provider in the Illinois Medical Assistance Program; f) The medical practitioner has a contractual/salary arrangement or is employed by a Federally Qualified Health Clinic that is enrolled as a provider in the Illinois Medical Assistance Program. If at any time any of the conditions of this agreement are modified, the parties will immediately notify Healthcare and Family Services.

The parties acknowledge that false, inaccurate or incomplete information is grounds for cancellation of this alternate payee agreement or denial or termination of participation in the Medical Assistance Program and criminal and/or civil prosecution.

TO BE COMPLETED BY PRACTITIONER

[redacted]	9/13/11	036125298
	(Date)	(Provider #)
Tara Kumaraswami	[redacted]	1144373184
(Printed Name)	(SSN)	(Individual National Provider Identifier-NPI)

TO BE COMPLETED BY PAYEE

The payee certifies that the following owners/stock holders own 5% or more of the stock/shares in the payee's interest. If additional space is needed for names, please use separate page. If there is no information to disclose, write **NONE** on **PRINTED NAME** line. **This section MUST be completed for enrollment purposes and an entry is required.**

N/A		
(PRINTED NAME)	(SSN)	(% OF OWNERSHIP)
N/A		
(PRINTED NAME)	(SSN)	(% OF OWNERSHIP)

[redacted] 9/19/11

(Signature of Payee Representative) (Date)

MARC DEVAR [redacted]

(Print Name of Payee Representative) (DMERC #)

University of Illinois Hospital [redacted]

(Name of Hospital, Professional School, Practitioner Owned Group Practice, FQHC, Community Mental Health Agency or Government Entity)

Organization/Biller/Payee National Identifier - NPI

(CHECK ONE)

☒ Hospital ☐ Hospital Affiliated ☐ Professional School ☐ Partnership ☐ Government Entity

☐ Practitioner Owned Group Practice (List all Practitioners, Names and SSN regardless of percentage of ownership on separate page).

☐ FQHC Provider Number _____

☐ Community Mental Health Agency Provider Number _____

☐ Corporation registered with Secretary Of State whose shares of ownership are publicly traded in a recognized stock exchange within the USA.

University of Illinois Hospital — 376000511

(Doing Business As name, if applicable) (Tax #)

3460B RAUSPHERE CIRCLE

Chicago, IL 60674

(Mailing address where payment is to be sent) 312-996-7699 (Telephone)

☐ Check Box. **If practitioner Office Address should be changed to the Payee Address shown above.**

This Alternate Payee Request is (Check One Box and Circle Affected Payee Number): ☒ Add ☐ Change

PAYEE ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9

State of Illinois
Department of Healthcare and Family Services

HOSPITAL, PROFESSIONAL SCHOOL OR PRACTITIONER OWNED GROUP PRACTICE AS ALTERNATE PAYEE

1) The practitioner certifies that he or she is: a) an employee of the hospital or professional school or practitioner owned group practice and must, as a condition of his or her employment, turn over his or her fee for care or service to Healthcare and Family Services recipients to the hospital, school, or group practice; OR, b) an independent contractor under contract with the hospital and under the terms of that contract, the hospital submits the claims to the Department.

2) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice that, all owners, directors, members or practitioners of the group practice are licensed and eligible to participate, and at this time of application are in good standing in the Medical Assistance Program of Healthcare and Family Services.

3) The practitioner certifies that if the alternate payee designated is a practitioner owned group practice, that the group practice shares facilities, equipment and personnel and maintains central patient records.

4) If this form is used for a hospital or school, no bills submitted by the practitioner are for services for which reimbursement has been made to the hospital or school or for which reimbursement will be sought by submission of a cost report, invoice or otherwise.

5) Bills submitted will only be for direct patient care rendered or supervised by that practitioner; e.g., services for which the practitioner assumes full responsibility as specified in Provider Handbooks.

6) The hospital, school or group practice shall be responsible for maintaining and making available to the Department all business and professional records sufficient to fully and accurately document the nature, scope, detail and receipt of services provided to Healthcare and Family Services recipients by the provider for whom this form has been submitted. The hospital, school or group practice shall be responsible for retaining such records for the period required under 89 Illinois Administrative Code 140.28, even if practitioner leaves the employ or otherwise terminates his or her relationship with the hospital, school or group practice.

7) The hospital, school or group practice will keep and make available to Healthcare and Family Services such records regarding any payments claimed by the hospital, school or group practice for providing services to Healthcare and Family Services recipients as the Department may request.

8) The hospital, school or group practice will keep and make available all financial records that may be requested by Healthcare and Family Services, specifically including records that set forth the terms of the relationship between the hospital, school, or group practice and its practitioners.

9) The hospital, school or group practice shall have sole financial responsibility for any bills submitted in the name of the practitioner for which it is the alternate payee. However, if the practitioner owns, directly or indirectly, 5% or more of the shares of stock or other evidence of ownership in a corporate hospital, school or group practice, or is an investor, owner or partner of the hospital, school, or group practice, the practitioner and the hospital, school or group practice are jointly and severally liable and responsible. This responsibility includes liability to repay any overpayments made by the Department. By signing this form the hospital, school, or group practice expressly authorizes Healthcare and Family Services to withhold overpayments from payments made by the Department, either as direct payments to the hospital, school, or group practice or made based on the hospital, school, or group practice being an alternate payee.

10) In the event the alternate payee designated on this form is not a licensed hospital, professional school or practitioner owned group practice, both the practitioner and the alternate payee designated understand and acknowledge that they shall be personally liable and responsible, jointly and severally, for any bills submitted to Healthcare and Family Services even though such bills were prepared, signed and/or submitted solely by the alternate payee or the alternate payee's agent. Liability hereunder shall include any civil and/or criminal liability, including but not limited to liability under the theory of accountability and liability for repayment of any overpayment received by the designated alternate payee, plus any penalty provided by statute.

11) The practitioner shall be responsible for the accuracy and truthfulness of all bills submitted on behalf of the practitioner. Bills submitted in the practitioner's name will be signed by him or her personally or by an authorized agent pursuant to a power of attorney. This power of attorney must be executed on Form HFS 2306 which shall be submitted to the Department prior to submittal of any bills signed by the agent. Practitioner understands and acknowledges that it is his or her personal responsibility to review any and all billings before such billings are submitted to Healthcare and Family Services on practitioner's behalf and/or in his or her name.

12) The parties signing this document acknowledge and agree that payments will be directed to the alternate payee for all dates of service beginning 06/07/2010 and thereafter (insert date no earlier than sixty days prior to submission of this document to the Department).

(See Reverse Side)

2011/11/30 16:22:13

Illinois Department of Healthcare and Family Services

POWER OF ATTORNEY

I, Tara Kumaraswami, do hereby make and appoint
(Practitioner's Name)

University of Illinois Hospital as my true and lawful attorney
(Name of Agency)

in fact solely for the purpose of affixing my name to the HFS 1443, Provider Invoice, or HFS 2360, Health Insurance Claim Form, as appropriate. I understand and acknowledge that the person appointed must be a trusted employee over whom I have direct supervision on a daily basis or the person is employed by the hospital and must sign my name to the HFS 1443 or HFS 2360 along with his/her initials. I understand and acknowledge that said person will be acting on my behalf, and that I will be bound by the certification statement on each HFS 1443 or HFS 2360. I understand and acknowledge that this Power of Attorney in no way limits my rights, liabilities or duties relating to the provision of services under the Illinois Department of Healthcare and Family Services' Medical Assistance Program. I understand and acknowledge that I retain full responsibility for all claims submitted to the Department of Healthcare and Family Services under my name.

Tara Kumaraswami
Practitioner Name
(Printed)

Signature [redacted]

Date: 9/13/11

University of Illinois Hospital
Address
3440 PARKSPHERE CIRCLE

Chicago, IL 60674

Marc DeVar
Agent Name
(Printed)

Signature [redacted]

Date: 9/12/11

Completion of this form or compliance with instructions is voluntary; however, failure to do so may affect this Department's action. Form approved by the Forms Management Center.

Danny
17

2013/08/27 13:51:26

ILLINOIS MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PAYMENT (PIP) PROGRAM

Organization

ORG NAME: The Board of Trustees of the University of Illinois

ADDRESS: 820 South Wood St. (MC808)

CITY, STATE: Chicago, IL

STATE/ZIP: 60612

Contact

NAME: Karen Mitchum

PHONE #: 312-996-0533

EMAIL: mitchum@uic.edu

90 day Patient Volume Period

START: 10/3/2010

END: 12/31/2010

Group Patient Volume

Numerator: 5674

Denominator: 13515

Group ID (Submitted via Attestation): 1154541936

036125298
DT
8-27-12

Professional Information

Last Name	First Name	NPI	Check One Category for Each Professional: EP has Attested	EP has NOT Yet Attested	EP has not Yet Registered	Professional is NOT Eligible for Incentive
AHN	JENNIFER	1972673879	✓			
APP	MEGAN	1154334167	✓			
COWETT	ALLISON	1639282668	✓			
CRUZ	MEREDITH O	1154515849	✓			
ELAM	GLORIA	1043326671	✓			
GAMBALA	CECILIA	1386842490				
HARWOOD	BRYNA	1255304044	✓			
HIBBARD	JUDITH	1891734182	✓			
IRWIN	TRACY	1295786994	✓			
KILPATRICK	SARAH	1366455362				
KOBAK	WILLIAM	1023007887	✓			
KOMINIAREK	MICHELLE	1902822737	✓			
KUMARASWAMI	TARA N	1144373184	✓			
LOY	GARY	1851404073				
LUNDE	BRITT	1285893016				
MODY	VAISHALI R.	1639118920				
NORDSTROM	SHERRY	1770530503	✓			
ROTMENSCH	JACOB	1790746600				
SCOCCIA	HUMBERTO	1144336751	✓			
SWIATKOWSKI	VALERIE	1821005927	✓			
VAJARANANT	MARK	1962585059	✓			
WENCKUS	DALIA J	1992915623	✓			
WILKINS	ISABELLE	1497868434	✓			

HOLD

HOLD

HOLD

100 Hospital

question 5
"See scanned documents"

* If more space is needed for a large group, submit the information via Excel spreadsheet.

I certify that the above professionals practice with this group and that the practice used group proxy as the methodology for determining Medicaid patient volume for the EHR/PIP program.

[redacted]
Signature of Administrator

8/8/2012
Date

Karen Mitchum
Printed Name of Administrator

Minder, Susan

From: Mitchum, Karen [mitchum@UIC.EDU]
Sent: Thursday, August 09, 2012 11:06 AM
To: HFS.EHRIncentive
Cc: hyildi2@uic.edu
Subject: 1154541936 BOARD OF TRUSTEES UNIVERSITY OF ILFW: Group Proxy Form
Attachments: OB GYN Univ of IL Medicaid EHR PIP.pdf; Corrected File University of Illinois OB GYN.pdf

2012/08/27 13:51:27

Attached is the initial document sent for the Incentive Program. A second "Corrected File" is also attached as there was an excel error that did not include all the providers. The "Corrected File" is our submission.

The providers that do have a check box marked next to their calculations in any category, no longer work here.

Again, if you have any questions, feel free to call me.

Thank you,

Karen A. Mitchum, MSA, FACHE
Director of Administrative Operations
Department of Obstetrics and Gynecology (MC 808)
820 South Wood Street, 264 CSN
Chicago, IL 60612

Phone: (312) 996-0533
Fax: (312) 996-4238
Email: mitchum@uic.edu

From: Mitchum, Karen
Sent: Tuesday, August 07, 2012 4:27 PM
To: 'hfs.ehrincentive@illinois.gov'
Cc: hyildi2@uic.edu
Subject: Group Proxy Form

Attached is the Illinois Medicaid EHR PIP Group Report for our physicians. If you have any questions, feel free to call.
Thank you,

Karen A. Mitchum, MSA, FACHE
Director of Administrative Operations
Department of Obstetrics and Gynecology (MC 808)
820 South Wood Street, 264 CSN
Chicago, IL 60612

Phone: (312) 996-0533
Fax: (312) 996-4238
Email: mitchum@uic.edu

Susan,

The following groups have submitted group forms and by our calculation come within 15% of the patient volume allowable threshold. Please see the information below and if you come to the same conclusion. I think there is in excess of 40 providers.

Group ID	Org Name	Start Date	End Date	Attestation Numerator	NPI's	EDW TOTAL MEDICAID	PCT Difference
133620932903	Heartland Pediatrics	9/3/2011	12/1/2011	1272	1942369145	1433	-11.23517097
1194802835	Willow Oak Pediatrics	10/1/2010	12/29/2010	642	1235126236	712	-9.831460674
100398177001	Ahmad & Rana Pediatrics	10/3/2010	12/31/2010	3527	1700973229	3837	-8.079228564
1154541936	Board of Trustees	10/3/2010	12/31/2010	5674	1972673879	6006	-5.527805528
1720208135	Board of Trustees U of I	10/3/2010	12/31/2010	6104	1851598072	6012	1.530272788
1649255266	Family Care Associates of Effingham S.C	8/1/2010	10/29/2010	2623	1063497659	2513	4.377238361

Respectfully,

Andrew Garrett
Public Service Administrator
Health Information Technology Project Office
Healthcare and Family Services
Ph. 217.785.6288

University of Illinois Medical Center at Chicago

Physician Group
3293 Paysphere Circle
Chicago, IL 60674-3293

FAX COVER SHEET [redacted]

DATE: 1/12/12

TO: Provider Enrollment

COMPANY: Medicaid

FAX PHONE NUMBER: 217-557-8800

FROM: Salome Desir

FAX PHONE NUMBER: 312-704-2882

PAGES TO FOLLOW: 3

COMMENTS: Please update CHA information

HARD COPY TO FOLLOW: YES ☐ NO ☒

IF ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CONTACT SENDER AT 866/213-3600

University of Illinois Medical Center at Chicago

January 12, 2012

Illinois department of Healthcare and Family Services
Provider participation Unit
PO Box 19114
Springfield, Illinois 6279-9114

Re: CLIA # 14D0907359

Attached is the updated CLIA certificate for OB.GYNE, Please link all providers on attached list to aforementioned CLIA numbers

Should you have any questions please contact Sabine Desir 312-704-2882.

Thanks in advance for your assistance.

Please link provider to CLIA 14D0907359

Ahn	Jennifer	T.	MD	12/01/06	1972673879	036-106184
App	Megan	E.	MD	07/11/01	1154334167	036-100761
Cowett	Allison	A.	MD	7/21/04	1639282668	036-104263
Cruz	Meredith	O	MD	7/15/09	1154515849	036-123449
Elam	Gloria	L.	MD	10/23/90	1043326671	036-077332
Harwood	Bryna	J.	MD	9/11/06	1255304044	036-115591
Hibbard	Judith	U.	MD	12/27/04	1891734182	036-067741
Hirshfeld-Cytron	Jennifer	E	MD	11/6/11	1083932032	036-117352
Irwin	Tracy	E.	MD	2/6/07	1295786994	036-113414
Kobak	William	H.	MD	7/25/05	1023007887	036-091917
Kominiarek	Michelle	A	MD	10/4/08	1902822737	036-105885
Kumaraswami	Tara	N	MD	6/7/10	1144373184	036-125298
Loy	Gary	L.	MD	12/21/00	1851404073	036-065416
Lunde	Britt	M	MD	6/7/10	1285893016	036-124943
Mohammed	Humera		MD	1/11/11	1366621054	036-126822
Nordstrom	Sherry	K.	MD	9/01/01	1770530503	036-105195
Robinson	Nuriya	D	MD	7/7/11	1801037171	036-127563
Scoccia	Humberto		MD	4/19/90	1144336751	036-070337
Sprawka	Nicole	M	MD	5/10/11	1659534055	036-127135
Swiatkowski	Valerie		MD	12/01/06	1821005927	036-116516
Vajaranant	Mark		MD	10/24/91	1962585059	036-078309
Wenckus	Dalia	J	MD	7/9/10	1992915623	036-126006
Wilkins	Isabelle		MD	6/1/2004	1497868434	036-111165

not enrolled—

added/updated clia as needed 2/9/12

[redacted]

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES

LABORATORY NAME AND ADDRESS

CTR FOR WOMENS HLTH/UNIV OF IL CHICAGO
1801 W TAYLOR-SUITE 4C (M/C 650)
CHICAGO, IL 60612

CLIA ID NUMBER
14D0907359

EFFECTIVE DATE
10/13/2011

LABORATORY DIRECTOR
GLORIA ELAM, MD

EXPIRATION DATE
10/12/2013

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purpose of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

[redacted]

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

1026 Cert_091711

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.