

Please complete if W9 is not on file.

FAX



TO: **Valley Preferred ACE Program**
Attn: Christl Fritsch, Coordinator
GLVIPA
Attn: Andrea Ziolk, Coordinator

FROM: _____
Name (Please print)

Practice Name

DATE: _____

FAX: 610-969-0439

RE: W9 for ACE Payments

Pages including cover sheet: 2

- ☐ Completed W9 attached
- ☐ I would like more information about the Achieving Clinical Excellence® (ACE) Program. Please contact me.

PLEASE NOTE: LVPHO/Valley Preferred communications will be sent to your LVHN (hospital) email *only*.