# AMERIGROUP DISCLOSURE FORM FOR PROVIDER ENTITIES

**Directions:** Use this form if you are applying for network participation as a **Provider Entity**, or if you are recredentialing or recontracting the **Provider Entity**, or if there have been significant changes to the information required on this form, for example an ownership change, the addition of a new managing employee or the change of your business location. A **Provider Entity** is a business entity (i.e., a partnership or corporation that provides covered services to Amerigroup* members.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued and attach a sheet referencing the item number that is being continued. Please return the original to Amerigroup and retain a copy for your files. Completely answer the applicable questions. If a question is not applicable, please respond **N/A** for that question.
***NO QUESTIONS SHOULD BE LEFT BLANK***.

***Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).***

**I. Identifying Information**

| Provider Entity Name | Provider DBA Name (if different from Provider Entity name) | Provider Federal Tax ID Number | |
|---|---|---|---|
| | | | |
| Provider NPI number | Medicaid ID number | Provider Telephone Number | |
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| Provider Address - must include at least one street address (attach a separate sheet if needed). List all Practice locations | City | State | ZIP Code |
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**In Louisiana, Amerigroup Louisiana, Inc. In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.*

**II. OWNER OR CONTROL INFORMATION**

**Directions**: An **Owner** is a person or business entity that owns 5 percent or more of the assets, stock or profits of the **Provider Entity**. This 5 percent may be **Direct** ownership or **Indirect** ownership (i.e., an individual might own 50 percent of a company that owns the actual **Provider Entity**, meaning the indirect ownership is 50percent. In addition to ownership of stock, an **Owner** is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the **Provider Entity**.

A person with **Control** is someone who directs the **Provider Entity** and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the **Provider Entity** is a nonprofit entity, respond **N/A** in the column for % of ownership.

A **Managing Employee** is someone who makes the day-to-day decisions for the **Provider Entity**. These individuals include office or billing managers for smaller providers, and for larger **Provider Entities** ,the heads of the major operating groups of the provider like Head of Accounting or Director of Same-Day Services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

An **Agent** is an individual who has the legal ability to bind the **Provider Entity (**i.e., the **Provider Entity** may use an **Agent** to obtain contracts for it).

Please provide the following information for **Owners**, persons with **Control** interests, **Agents** and **Managing Employees** of the **Provider Entity**. Attach a separate sheet if needed.

**A. Master List**

| Full Name | (For *individuals,* use Home address. For *business entities* that might have ownership interest, use all street addresses (if more than one location) and P.O. Box address (if any).<br>Address | City | ST | ZIP | DOB | SSN for individuals or Tax ID for business entities | Percent of Ownership | Title |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| Full Name | (For *individuals,* use Home address. For *business entities* that might have ownership interest, use all street addresses (if more than one location) and P.O. Box address (if any).<br>Address | City | ST | ZIP | DOB | SSN for individuals or Tax ID for business entities | Percent of Ownership | Title |
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**B. Specific Questions**

1) Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent child or sibling?
Yes ☐ No ☐. **If yes, please provide the following information about the related persons:**

| Full Name of First-related Person | Full Name of Second-related Person | Type of Relation |
|---|---|---|
| | | |

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**?

Yes ☐ No ☐. If yes, please provide the following information about the other **Provider Entity** the person on the **Master List** has an interest in.

| Name of Other Provider Entity | Address | City | State | Zip | Tax I.D. |
|---|---|---|---|---|---|
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3) Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, TRICARE or the CHIP services program since the inception of those programs?
Yes ☐ No ☐. **If yes, please provide the information requested below:**

| Name on Court Records | SSN /DOB | Matter of the Offense | Date of the Conviction | Exclusion Period of the Offense, if excluded by the federal Office of the Inspector General(OIG) |
|---|---|---|---|---|
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4) Have any of the individuals or entities on the **Master List** ever been **Debarred** from participation in federal government contracts? **Debarred** means an individual is not allowed to participate in Contracts paid for by the federal government, whether or not those contracts are in the health care area.

Yes ☐ No☐ **If yes is checked, provide the following information:**

| Date of Debarment | Length of Debarment | Reason for Debarment |
|---|---|---|
| | | |

5) Has any person or entity on the **Master List** ever been **Excluded** from participation in federal health care programs ( Medicare, Medicaid, CHIP or TRICARE) in the past. Excluded means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded health care program.

Yes ☐ No☐ **If Yes, please provide the following information:**

| Full Name of Individual or Entity | Beginning date of Exclusion or Termination | End Date of Exclusion or Termination | Reason for Exclusion or Termination |
|---|---|---|---|
| | | | |

6) Has any person or entity on the **Master List** ever been **Terminated** from a state's Medicaid or CHIP program for reasons having to do with program integrity(fraud or abuse) ? **Terminated** means the Provider lost the right to bill a state's Medicaid or CHIP programs for a cause related to fraud or abuse.

Yes ☐ No☐ **If Yes, please provide the following information:**

| Full Name of Provider | State of Practice When Terminated | Reason for Termination | Date of Termination |
|---|---|---|---|
| | | | |

7) Has any person or entity on the **Master List** ever had Civil Monetary Penalties (CMPs) assessed against them? A CMP is a type of fine assessed against a provider by a governmental agency that manages a federal health care program.

Yes ☐ No☐ **If Yes, please provide the following information:**

| Full Name Of Individual or Entity | State of Practice When CMP Assessed | Reason for CMP | Amount of CMP | Date of CMP |
|---|---|---|---|---|
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8) Did anyone on the **Master List** obtain **Ownership** interest: 1)As a result of a transfer of ownership from someone who was about to be Excluded or Terminated from participation in a federal health care program, or was in fact Excluded or Terminated from participation in a federal health care program, and 2), where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of the current owner's** H**ousehold** at the time of the transfer of ownership? [**Immediate Family** is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Membe**r **of Household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of the household.

Yes ☐ No ☐ **If Yes, please provide the following information:**

| Full Name of Original **Owner** | SSN or TAX ID of Original **Owner** | Place of Transfer | Date of Transfer |
|---|---|---|---|
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8a) List any **Subcontractor** in which this **Provider Entity** has a direct or indirect **Ownership** interest of at least 5percent. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions (i.e., billing agent, or provide medical services, i.e., a medical lab).

| Full Name of Subcontractor | Address | City | State | ZIP | Tax I.D. |
|---|---|---|---|---|---|
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8b) For each **Subcontractor(s)** listed in 8a above, please provide the following information for the individuals with an **Ownership** or **Control** interest in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

| Full Name | Address (for individuals, use home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any) | City | State | ZIP | DOB | SSN for individuals or Tax ID for business entities | % of owner-ship | Title |
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8c) Is anybody on the list in 8b related to any person in the **Master List** above?

Yes ☐ No☐ **If yes, please provide the following information about the related persons:**

| Full Name of First Related Person | Full Name of Second Related Person | Type of Relation |
|---|---|---|
| | | |

**III. Business transactions**

1) Has the **Disclosing Entity** had any financial transaction with any **Subcontractor** totaling more than $25,000 or any significant business transactions with any **Subcontractor**?
   Yes ☐ No ☐.
2) If yes, list the ownership of any **Subcontractor** with whom this provider has had one or more business transactions totaling more than $25,000 during the previous twelve-month period, and any significant business transactions between this **Provider** and any wholly owned supplier, or between the **Provider** and any **Subcontractor** during the past five-year period.

| Full Name | Address | City | State | ZIP |
|---|---|---|---|---|
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3) Does the **Provider Entity** *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **Provider Entity** *purchases goods and services* used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy).

   Yes ☐ No ☐. If yes, supply the following information about the **Supplier:**

| Name | Address | City | State | ZIP | NPI | TIN |
|---|---|---|---|---|---|---|
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**IV. Signature**

The State or Federal Medicaid agency may refuse to enter into, renew or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. The signature below **MUST** be the written signature of an individual who can legally bind this **Provider Entity**.

In Compliance with 42 CFR 455.104(c), Provider shall provide a disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement at the time of recredentialing/reenrollment, and within 35 days after any change in ownership of the disclosing entity. In compliance with 42 CFR 455.105(b), a provider must submit within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete ownership information outlined in section III, Business Transactions, above.

| Name of Person (Printed) | Signature of Person | Title | Date |
|---|---|---|---|
| | | | |

| Name of person Completing Form | Phone Number of Person Completing Form |
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| | **( )** |