providers.amerigroup.com

Amerigroup Disclosure Form for a Provider Person

Directions: Use this form if you are applying for network participation as a **provider person**. If the addition of the **provider person** will change the **ownership** or **control** structure of the **provider entity** that the **provider person** is joining (i.e., the new **provider person** will also be an owner or high-ranking employee of the **provider entity**), then you must also fill out a new disclosure form for the **provider entity** to reflect the new **ownership** or **control** arrangements.

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 document 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***. Website, and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

Social Security Numbers (SSN) must be provided for validation purposes.

I. Identifying information

Provider Person Full Name	Social Security Number	Date of Birth (DOB)	National Provider Identifier (NPI) Number	Medicaid Identification Number	
Provider Person Home Address			City	State	ZIP Code

Provider Entity Name (Provider entity is whom the provider person works for. If you are a sole proprietor, you would list yourself as the provider entity also.)	Provider Entity Doing Business As: (If different from provider Entity Name)	Provider Entity Address (If you have more than one practice location, list all locations)
Provider Entity Tax Identification Number	Provider NPI	Medicaid Identification Number

II. Criminal offense attestation

A) Have you ever been **convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, SCHIP or the Title XX services program since the inception of those programs? **"Convicted"** means been found guilty by a jury or judge, or pled guilty, nolo contendre , best interest plea or pretrial diversion or suspended sentence. **Yes** ☐ **No** ☐

If Yes is checked, provide the following information:

Name on court records	SSN	Matter of the offense	Date of the conviction	Sanction period of the offense if you were sanctioned by the Federal Office of the Inspector general (OIG)

B) Have you ever been **debarred** from participation in federal government contracts? **Debarred** means you are 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:

When you were debarred	Length of debarment	Reason for debarment

C) Have you ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, SCHIP 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 supply the following information:**

Start date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

D) Have you ever been **terminated** from a state's Medicaid or SCHIP 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 SCHIP program for a cause related to fraud or abuse.

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

State of practice when terminated	Reason for termination	Date of termination

E) Have you ever had **Civil Monetary Penalties (CMPs)** assessed against you? 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 supply the following information**:

State of practice when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

III. Questions for a sole proprietor

A) If you are a sole proprietor, please give the following information for your **managing employees and agents.** A **managing employee** is someone who makes day-to-day decisions on the running of your business such as an office manager or billing manager**.** An **agent** is someone besides yourself who can legally act for your business.

Name of managing employee or agent	SSN	DOB	Home address	City	State	ZIP code

B) Has any person listed in 3a been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? **Convicted** means been found guilty by a jury or judge, or pled guilty, nolo contendre , best interest plea or pretrial diversion or suspended sentence.

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

Name on court records	SSN	Matter of the offense	Date of the conviction	Sanction period of the offense if the person was sanctioned by the Federal Office of the Inspector General (OIG)

C) Has anyone on the list in 3a ever been **debarred** from participation in federal government contracts? **Debarred** means someone 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:

When the individual was debarred	Length of debarment	Reason for debarment

D) Has any person on the list in 3a ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past?

Yes ☐ No ☐ If Yes, please supply the following information:

Name of individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

E) Has anyone on the list in 3a ever been terminated from a state's Medicaid or SCHIP program for reasons having to do with Program Integrity(fraud or abuse)?

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

State of practice when terminated	Reason for termination	Date of termination

F) Has any person on the list in 3a ever had **Civil Monetary Penalties (CMPs)** assessed against them?

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

Name of individual	State of practice when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

IV. Signature

Amerigroup and 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. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of the Provider.

Name of provider person (printed)	Signature of provider person	Date

Name of person completing form (printed)	Phone number of person completing form