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Disclosure Form for Provider Entities

Please answer all questions. If you need additional space to respond to a question, add a separate sheet that includes your entity name and the question and header. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as required by *42 CFR 455.104 (b)(1)(ii)*.

I. Identifying information

(This information must match form *W9 – Request for Taxpayer Identification Number and Certification*.)

Entity/organization name	Business name (if different from name)	Empl Ident Num (EIN)
Entity/organization NPI numbers*	**Medicaid ID number**	**Telephone number**

Mailing address	City	State	ZIP

**Use individual NPI if no organization NPI.*

II. Ownership and control information

A. Master List of all controllers, owners, agents and managing employees (use additional pages if needed):

Full name	DOB	SSN	Title (see instructions)	Ownership %
Address		City	State	ZIP

Full name	DOB	SSN	Title (see instructions)	Ownership %
Address		City	State	ZIP

Full name	DOB	SSN	Title (see instructions)	Ownership %
Address		City	State	ZIP

B. Specific questions

1. Is any person listed in 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
Full name of first-related person	Full name of second-related person	Type of relation

2. Does any person or entity listed 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:**

Name of other provider entity		EIN	
Mailing address (number, street, and apt. or suite no.)	City	State	ZIP
Name of other provider entity		EIN	
Mailing address (number, street, and apt. or suite no.)	City	State	ZIP

3. Has any person or entity listed in the Master List been convicted of a criminal offense related to that person's or entity'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 following information:**

Name on court records	Date of conviction	Exclusion period
Matter of the offense		

*Exclusion period of the offense, if excluded by the federal Office of the Inspector General (OIG)

4. Has any person or entity listed in the Master List ever been **debarred** from participation in federal government contracts? Debarred means an individual is prohibited from participation in contracts paid for by the federal government, whether or not those contracts are in the health care area.

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

Full name of individual or entity	Date of debarment	Length of debarment
Reason for debarment		

5. Has any person or entity listed in the Master List ever been **excluded or terminated from participation in federal health care programs** (Medicare, Medicaid, CHIP or TRICARE) in the past? Excluded means a provider or entity has been notified by the Department of Health and Human Services, Office of the Inspector General (HHS OIG) that they are prohibited from participating as a provider in any federally funded health care program.
   Yes ☐ No ☐ **If Yes, please provide the following information.**

Full name of individual or entity	Beginning date	End date
Reason for exclusion or termination		

6. Has any person or entity listed in 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 and/or CHIP programs for a cause related to fraud or abuse?
   Yes ☐ No ☐ **If Yes, please provide the following information.**

Full name of individual or entity	State of termination	Date of termination
Reason for termination		

7. Has any person or entity listed in the Master List ever had civil monetary penalties (CMP) 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 CMP	Date of CMP	Amount of CMP
Reason for CMP			

8. Has any person or entity listed in the Master List obtained an ownership interest in a provider entity:
    a. 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?
    b. Where the original owner is or was a member of the current owner's immediate family or member of the current owner's household 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. Member of household means, 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 renter 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
Reason for CMP			

9. Does any person or entity listed in the Master List have a direct or indirect ownership interest of at least 5% in a subcontractor of the provider entity? A subcontractor is a person or company that the provider entity has contracted with to provide some of the provider entity's management functions (for example, billing agent or provide medical services — such as a medical lab).

    Yes ☐ No ☐ **If Yes, please list each Subcontractor and answer questions 9a and 9b. If No, skip to Section III.**

Full name of subcontractor		EIN	
Mailing address	City	State	ZIP
Full name of subcontractor		EIN	
Mailing address	City	State	ZIP

    a. For each subcontractor listed in item 9 above, please provide the following information about all individuals with an ownership or control interest in the subcontractor:

Full name	DOB	SSN	Title (see instructions)	Ownership %
Address		City	State	ZIP
Full name	DOB	SSN	Title (see instructions)	Ownership %
Address		City	State	ZIP

b. Is anyone listed in 9a related to any person in the Master List?
Yes☐ No☐ **If Yes, please provide the following information about the related persons.**

Full name of first-related person	Type of relation
Full name of second-related person	Type of relation

III. Business transactions

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, please provide the following information.**

Name (as shown on your income tax return)	Entity NPI number(s)	EIN	
Mailing address (number, street, and apt. or suite no.)	City	State	ZIP

Instructions for title: Controllers, owners, agents and managing employees are defined as follows:

- ***Controller*****:** All directors, trustees and officers of a corporation or partners in a partnership. If the entity is a non-profit or not-for-profit, list all controllers and N/A in the percentage of ownership column.
- ***Owner*****:** Any person or business entity that owns 5% or more of the assets, stock or profits of the provider entity either directly or indirectly.
- ***Agent*****:** Any person or entity that has the authority to obligate the provider to a contract, mortgage or loan that may or may not be secured by the entity's assets.
- ***Managing employee*****:** Any person that has the authority to make material business decisions on behalf of the provider entity.

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.

In compliance with *42 CFR 455.104(c)*, provider shall complete this disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement, at the time of recredentialing/re-enrollment, and within 35 days after any change in ownership by the provider. In compliance with *42 CFR 455.105(b)*, provider certifies that it will submit within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete subcontractor information as outlined in section III, Business Transactions, above.

Controller/owner/agent/managing employee (please print)	Signature	Title
Person completing form (please print)	Phone number	Date