# Disclosure of Ownership Form Business Entity

Use this form when applying for network participation as a business entity or at the time of recredentialing if you are already contracted with Avēsis as a business entity. A business entity is a partnership or corporation that provides covered services to Avēsis members or clients who seek services from an Avēsis-contracted business entity. Please update the form to reflect any significant changes to your information. Examples include but are not limited to change of ownership, addition of a new managing employee, or change of business location.

Please answer all questions as they pertain to the date of the form's completion. If you need additional space, please note on this form that the answer is continued on a separate attachment; on that attachment, please refer to the item number from this form.

Respond to all applicable questions; write N/A to questions that are not applicable. No questions may be left blank. Once the form is complete, return it to Avēsis and retain a copy for your files.

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

Business Entity Name: _____

Business Entity D.B.A Name (Only complete if different from Entity Name): _____

Business Entity Federal Tax Identification Number: _____

| Business Entity NPI | Medicaid Identification Number | Business Entity Telephone | Business Entity Address (If more than one practice location, list all locations) |
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## II. OWNER OR CONTROLLING INTEREST INFORMATION

**Definitions:** An **Owner** is a person or company that owns 5 percent or more of the assets, stock, or profits of the Business Entity. Ownership can be direct or indirect; example of indirect ownership is an individual who may own 50 percent of a company that owns the actual Business Entity. 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 Business Entity. A person with **Controlling Interest** is someone who directs the Business Entity; examples include Directors, Trustees, and Officers of Corporations and Partners in a Partnership. A **Managing Employee** makes the day-to-day decisions for the Business Entity; examples include office managers, billing managers, finance manager, or any individual who has responsibility for key operational areas of the Business Entity and would be typically listed below the corporate officers on an organizational chart. An **Agent** is an individual who has the legal ability to bind or enter into contracts on behalf of the Business Entity.

**IF A BUSINESS ENTITY IS A NONPROFIT ENTITY, RESPOND N/A IN THE COLUMN FOR % OF OWNERSHIP.**

Please provide the following information for Owners, persons with Controlling Interests, Agents, and Managing Employees of the Business Entity.

**Ownership & Controlling Interest Listing:**

| **Full Legal Name and Title** | **Complete Address** Home address for Individual(s)/All street and PO Boxes for Company(s) | **Date of Birth** | **SSN for Individual(s) FEIN for Company(s)** | **% of Ownership** |
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A) Is any person on the Ownership and Controlling Interest listing related to another person listed on the Ownership and Controlling Interest list as a spouse, parent, child, or sibling?

☐ Yes ☐ No

If Yes is checked, provide the following information:

Full Legal Name of First Person: _____

Related By: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other _____

Full Legal Name of Person Related To: _____

B) Does any person or entity on the Ownership and Controlling Interest Listing have an ownership or controlling interest in any other Business Entity?

☐ Yes ☐ No

If Yes is checked, provide the following information about the other Business Entity:

Business Entity Name: _____

Business Entity Full Address: _____

Business Entity Tax Identification Number: _____

C) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **convicted** of a criminal offense related to that person's or company's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs? Convicted means having been found guilty by a jury or judge, or having pled guilty, nolo contendre, best interest plea, pretrial diversion, or suspended sentence.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Name on Court Record: _____ SSN: _____

Description of Offense: _____ Date of Conviction:

Sanction Period (If Sanctioned by Office of the Inspector General (OIG)): _____

D) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **debarred** from participation in federal government contracts? **Debarred** means individual or company is not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the healthcare area.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Date Debarred: _____ Length of Debarment: _____

Reason for Debarment: _____

E) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **excluded** from participation in federal healthcare 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 healthcare program.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Date Excluded: _____ Date of Reinstatement: _____

Reason for Exclusion: _____

F) Have any of the individuals or companies on the Ownership and Controlling Interest Listing 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 SCHIP program for a cause related to fraud or abuse.

☐ Yes ☐ No

If Yes is checked, provide the following information:

State Issuing Termination: _____ Date of Termination: _____

Reason for Termination: _____

G) Have any of the individuals or companies on the Ownership and Controlling Interest Listing 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 healthcare program.

☐ Yes ☐ No

If Yes is checked, provide the following information:

State Assessing CMP: _____ Date of CMP: _____ Amount of CMP: _____

Reason for CMP: _____

H) Did any of the individuals or companies on the Ownership and Controlling Interest Listing obtain ownership interest as a result of (1) a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal healthcare program, or was excluded or terminated from participation in a federal healthcare program, and (2) where the original owner is or was a member of the current owner's immediate family or a member of the current owner's household at the time of the transfer of ownership?

☐ Yes ☐ No

If Yes is checked, supply the following information:

Full Legal Name of Original Owner: _____ SSN or Tax Identification Number: _____

Place of Transfer: _____ Date of Transfer: _____

I) Are there any subcontractor(s) with whom the Business Entity has a direct or indirect ownership of 5% or greater. Examples of subcontractors include billing services/agents, laboratory, radiology center, etc.

☐ Yes ☐ No

If Yes is checked, supply the following information:

Full Legal Name of Subcontractor: _____

Subcontractor Tax Identification Number: _____

Subcontractor Full Address: _____

List any additional subcontractors.

Full Legal Name of additional Subcontractor: _____

Additional Subcontractor Tax Identification Number: _____

Additional Subcontractor Full Address: _____

Full Legal Name of additional Subcontractor: _____

Additional Subcontractor Tax Identification Number: _____

Additional Subcontractor Full Address: _____

J) For each subcontractor listed in 2I, please provide the following information for the individuals with an ownership or controlling interest in the subcontractor(s).

Full Legal Name and Title: _____

Date of Birth: _____ SSN for Individual(s) FEIN for Company(s): _____ % of Ownership: _____

Complete Address. Home address for Individual(s). All street and PO Boxes for Company(s):

_____

_____

K) Is any individual listed above in J related to any individual listed on the Ownership and Controlling Interest Listing?

Full Legal Name of First Person: _____

Related By: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other _____

Full Legal Name of Person Related To: _____

## III. BUSINESS TRANSACTIONS

A) Has the disclosing Business Entity had any financial transaction with any subcontractor totaling more than $25,000 or any significant business transactions with any subcontractor in the previous 12-month period, and any significant business transactions between Business Entity and any wholly owned supplier, or between the Business Entity and any subcontractor during the past 5-year period?

☐ Yes ☐ No

If Yes is checked, provide the following information:

Full Legal Name of Subcontractor: _____

Subcontractor Tax Identification Number: _____

Subcontractor Full Address: _____

B) Does the Business Entity wholly own a supplier? A supplier means an individual, agency, or organization from which the Business Entity purchases goods and/or services used in carrying out its responsibilities under Medicaid. Examples include commercial laundry, a manufacturer of hospital beds, or a pharmacy.

☐ Yes ☐ No

If Yes is checked, supply the following information about the supplier:

Supplier Name: _____ Subcontractor NPI: _____

Subcontractor Tax Identification Number: _____

Subcontractor Full Address: _____

## IV. Signature

Avēsis and the state or federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider or 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 AN INDIVIDUAL WHO CAN LEGALLY BIND THIS BUSINESS ENTITY.**

In compliance with 42 CFR 455.104c, 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 re-credentialing/re-enrollment, and within 35-days after any change in ownership of the disclosing entity. In compliance with information outlined in section III, Business Transactions, above.

_____ _____

Name of Individual Provider (printed) Date

_____

**Signature of Individual Provider (STAMPED SIGNATURE NOT ACCEPTABLE)**

_____ _____

Authorized Individual Completing Form (printed) Phone Number of Authorized Individual

_____ _____

Title of Authorized Individual Completing Form Email of Authorized Individual