Disclosure of Ownership Form Individual

This form is to be used when applying for network participation as an individual provider or at the time of re-credentialing if contracted on an individual basis with Avēsis. If the addition of an individual provider to an existing entity will change the ownership or control structure of such entity, then a new disclosure form for the entity must be completed to reflect the new ownership or control structure. For example, the new individual provider will be an owner or high-ranking employee of the existing entity.

Please answer all questions as they pertain to the date the form is being completed. If additional space is needed, please note on the form the answer is being continued on a separate attachment and reference the item number on the attachment being continued. Please return the original document to Avēsis and retain a copy for your files. Respond to all applicable questions and respond N/A to any question not applicable. NO QUESTIONS CAN BE LEFT BLANK.

Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement. 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's Full Name: _____ SSN: _____ Date of Birth (DOB): _____

National Provider Identifier (NPI): _____ Medicaid Identification Number: _____

Provider's Home Address: _____

City: _____ State: _____ Zip Code: _____

Entity Name (List the individual provider's employer. If the individual provider is sole proprietor, list that provider's name.):

_____

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

Entity Federal Tax Identification Number: _____

Entity NPI	**Medicaid Identification Number**	**Entity Address** (If more than one practice location, list all locations)

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 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)): _____

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 healthcare area.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Date Debarred: _____ Length of Debarment: _____

Reason for Debarment: _____

C) Have you ever been excluded from participation in federal healthcare 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 is checked, provide the following information:

Date Excluded: _____ Date of Reinstatement: _____

Reason for Exclusion: _____

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 is checked, provide the following information:

State Issuing Termination: _____ Date of Termination: _____

Reason for 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 healthcare program.

☐ Yes ☐ No

If Yes is checked, provide the following information:

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

Reason for 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.

Managing Employee or Agent Name: _____ SSN: _____

DOB: _____ Complete Home Address: _____

City: _____ State: _____ Zip Code: _____

B) Has any person listed in question 3A ever 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 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:

Managing Employee or Agent's Full Name: _____

Date Convicted: _____ Sanction Period Issued by Office of Inspector General: _____

Explanation of Offense: _____

C) Has anyone on the list in question 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 healthcare area.

☐ Yes ☐ No

If Yes is checked, supply the following information:

Managing Employee or Agent's Full Name: _____

Date of Debarment: _____ Length of Debarment: _____

Reason for Debarment: _____

D) Has any person on the list in question 3A ever been excluded from participation in federal healthcare programs (Medicare, Medicaid, CHIP or TRICARE) in the past?

☐ Yes ☐ No

If Yes is checked, supply the following information:

Managing Employee or Agent's Full Name: _____

Date Excluded: _____ Date of Reinstatement: _____

Reason for Exclusion: _____

E) Has anyone on the list in question 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 is checked, supply the following information:

Managing Employee or Agent's Full Name: _____

State Issuing Termination: _____ Date of Termination: _____

Reason for Termination: _____

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

☐ Yes ☐ No

If Yes is checked, supply the following information:

Managing Employee or Agent's Full Name: _____

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

Reason for CMP: _____

IV. Signature

Avēsis 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.

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