



Provider Ownership Disclosure Statement Instructions & Definitions

The federal regulations set forth in the Code of Federal Regulations (CFR), specifically 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to managed care organizations the contract with Medicare/Medicaid Agency to: A) Identify all owners with a controlling interest of 5% or greater, B) Certain business transactions as described in 42 CFR 455.105 and, C) the identity of any excluded individual or entity with an ownership or controlling interest in the provider, the provider group, or disclosing entity who is an agent or managing employee of the provider group or entity. According to 42 CFR, part 455, sections 100-106, all providers enrolling with the Medicare/Medicaid Program must complete a Provider Disclosure Statement.

The definitions below are designed to clarify certain questions on the Disclosure form. If you cannot report all of the necessary information in a designated section of the form because of space limitations, please provide the information on a separate paper.

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicare/Medicaid Provider (other than an individual practitioner), or a fiscal agent.

Any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act means:

- a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- b. Any Medicare intermediary or carrier; and
- c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicare/Medicaid Agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Individual practitioner means a physician or other person licensed or certified under State law to practice his or her profession.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity as.

Person with an ownership or control interest means a person or corporation that—

- a. Has an ownership interest totaling 5 percent or more in disclosing entity;
- b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- e. An officer or director of a disclosing entity that is organized as a corporation; or
- f. Is a partner in a disclosing entity that is organized as a partnership.

The Provider must agree to keep information current at all times by informing the MCO in writing within 35 days of a change in ownership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means –



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- a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicare/Medicaid Agreement.

Convicted per 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicare/Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.



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Please **FAX** to (850) 487-1279

Attention: Provider Credentialing

Check one that most closely describes you: Individual Group Practice Disclosing Entity

Name of Applicant (Last, First).			
Name of Individual, Group Practice , or Disclosing Entity			
DBA Name			
<i>Address for Corporate Entities must include: primary business address, every business location, and P.O. Box address. (Please attach a separate sheet if necessary).</i>			
Address	City	State	ZIP Code:
Federal Tax Identification Number	Provider CAQH # This stands for the Council for Affordable Quality HealthCare. If your group is a member of this organization, please have Office Manager complete. If your group is not a member of this organization, please enter N/A		

Questions 1 – 3 to be answered by all providers.

1. Has the provider, or any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been suspended, excluded, or debarred related to that person's involvement in any program under Medicare, Medicaid or Title XX program or convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? If yes, list the name(s) of Person(s). (42 CFR 455.106) (Should be verified through appropriate HHS-EPLS-OIG Website).	Yes <input type="checkbox"/> No <input type="checkbox"/>
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NAME/TITLE	DOB	ADDRESS	SSN	EXCLUSION TYPE	BEGINNING DATE	ENDING DATE

2. Has the provider had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors? If yes, list the ownership of any subcontractor with whom this provider has had 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 5-year period. (Please attach a separate sheet if necessary). (42 CFR 455.105)	Yes <input type="checkbox"/> No <input type="checkbox"/>
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NAME SUPPLIER/SUBCONTRACTOR	ADDRESS	TRANSACTION AMOUNT

3. Please list all officers, directors, and managing employees. (Please attach a separate sheet if necessary). (42 CFR 455.104)					
NAME	ADDRESS	DOB	POSITION	SSN	

4. List the name, title, date of birth (DOB), address and Social Security Number (SSN if listing an Individual) of each person with an ownership or control interest in the provider/fiscal agent or in any subcontractor in which the provider/fiscal agent has direct or indirect ownership of 5% or more . List the name, Tax Identification Number (TIN), primary business address and all locations of each organization, corporation, or entity having an ownership or control interest of 5% or more . (Please attach a separate sheet if necessary). (42 CFR 455.104)			
NAME OF INDIVIDUAL OR ENTITY	DOB	ADDRESS	SSN (If listing an Individual)



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		TIN (If listing an Entity)
A.		
B.		
C.		
D.		
E.		
F.		
G.		

5. Is any person named in question #4 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). (42 CFR 455.104)
NOTE: Designate relationship to each person listed in question #4 by using A., B., C., etc.

Yes
 No

NAME	RELATIONSHIP

6. Does any person named in question #4 have an ownership or control interest in any other Medicaid provider or in any entity that does not participate in Medicare/Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act? If yes, give the name(s) of and address(es) of the Medicare/Medicaid provider or entity. (42 CFR 455.104)
NOTE: Designate relationship to each person listed in question #4 by using A., B., C., etc.

Yes
 No

NAME OF INDIVIDUAL OR ENTITY	DOB	ADDRESS	RELATIONSHIP	SSN (If listing an Individual) TIN (If listing an Entity)

7. Have you identified your status (under Provider Disclosure Statement Instructions & Definitions) as a Disclosing Entity? If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Yes
 No

NAME/TITLE	DOB	ADDRESS	SSN	% INTEREST

8. Any change in ownership within the last year or upcoming year? If yes, please explain.

Yes
 No

9. Are there any subcontractors that the **Disclosing Entity** has direct or indirect ownership of 5% or more? If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of **5% or more**. (42 CFR 455.104)

Yes
 No

NAME OF INDIVIDUAL OR ENTITY	DOB	ADDRESS	RELATIONSHIP	SSN (If listing an Individual) TIN (If listing an Entity)



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I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Name of Provider or Authorized Representative (Typed)

Title

Signature

Date

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly, and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.