BlueCross BlueShield of New Mexico

PARTICIPATING PROVIDER INTEREST FORM
PROFESSIONAL PROVIDERS

The attached packet contains the forms required in order to be considered for network participation with Blue Cross Blue Shield of New Mexico (BCBSNM). Please complete all applicable sections of the packet and return to NM Network Services by fax (preferred method) or by mail as indicated below.

The completed packet will be reviewed, and if accepted, the legal entity will receive a Medical Services Entity Agreement (MSEA) for signature, in the mail. Once a signed agreement is received, the credentialing process will be initiated. Upon approved credentialing status, provider(s) will be added as a participating with the applicable lines of business and will be effective the date the provider is entered into the system. A fully executed copy of the agreement will then be sent to the legal entity.

If a provider is not accepted, a letter is sent to inform the provider they will not be added at this time, based on BCBSNM business needs.

Note: This is NOT the CAQH credentialing application. Please refer to the CAQH website for credentialing application information at http://www.caqh.org

Billing Information: Social Security Number and Federal Tax Identification Number must be completed in its entirety; the name that will appear on any reimbursement or Form 1099 will be that of the party to which payment is made. We will only make provider payments to the individual that rendered the service(s) and supplied a Tax Identification Number belonging to the named individual. To receive a Provider Record and/or join the BCBSNM network, please complete the Provider Record/Contracting form below and the W-9 Form.

Credentialing/Correspondence Address: BCBSNM will mail credentialing documentation/correspondence to the primary location listed in the CAQH application.

Please Note: Your assigned BCBSNM internal provider record does NOT mean that your organization is participating or that a contract will be offered. Until your organization is credentialed and contract is executed with an effective date, all claims will be processed as out-of–network.

Please complete this packet and provide a copy of the following:

- Current State Medical license
- SS4 Form is required (Solo). W-9 will only be accepted if SS4 is not available
- 147C (Corporation) Letter is required.W-9 will only be accepted if 147C is not available.
- Hospital Coverage Letter
- Federal DEA License and State Controlled Substance registration
- Medicare and/or Medicaid certification letters
- Malpractice Liability Insurance and amounts
- Call Coverage Form
- Behavioral Health Areas of Expertise
- Clinical Laboratory Improvement Amendments (CLIA) if applicable
- Medicaid Provider Disclosure of Ownership and Control Interest Form **(Legal Entity only)**

Complete packet and return to:
FAX: 1-866-290-7718 (toll-free) or 505-816-2688 (local)
MAIL: Blue Cross Blue Shield of New Mexico
Attention: Network Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630
PHONE: Network Services at 1-800-567-8540 or 505-837-8800
WEBSITE: Additional forms and information can be found on our website at bcbsnm.com.

We look forward to assisting you in the future.

BlueCross BlueShield of New Mexico

PARTICIPATING PROVIDER INTEREST FORM
PROFESSIONAL PROVIDERS

Applying for:	**Applying as:**	**Requested Networks:**
☐ Provider Record only	☐ Primary Care	☐ Commercial (HMO, PPO, POS, PAR, FEP)
☐ Provider Record and Participation in the BCBSNM Network(s)	☐ Specialist	☐ Medicaid
☐ Participation in an additional BCBSNM Network only	☐ Other Healthcare Professional Providers	☐ Medicare Advantage ☐ Blue Preferred ☐ Blue Advantage HMO Network℠ ☐ Blue Community HMO Network℠

Individual Specialty Information:

Board Certified Agency: _____

If not Board Certified please provide date of Graduation/Residence (Circle one) ___/___/ _____

Primary Specialty: _____ Secondary Specialty: _____

Tertiary Specialty: _____

Are you associated with:

☐ IPA (Independent Physician Association) Name: _____
☐ PHO (Physician Hospital Organization) Name:

☐ Health System Name: _____ Employed by Health System Yes ☐ No ☐

☐ Federally Qualified Health Center (FQHC) ☐ Community Mental Health Center (CMHC)

☐ Rural Mental Health Clinic (RHC) ☐ Indian Health Services Facility ☐ Core Service Agency (CSA)

GROUP INFORMATION (Solo providers skip this section)

Group/Company Name: _____

Specialty or type of Group/Company: _____

Type 2 NPI: _____ Tax Identification Number (TIN): _____

Employer Identification Number (EIN): _____

Is this your personal taxpayer number? Yes ☐ No ☐

Does it belong to a Corporation, partnership, etc.? Yes ☐ No ☐

Physical Location:

(Attach a separate sheet for any additional addresses **with phone numbers, office hours and services performed**)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Scheduling Phone No: _____ Fax No: _____

Email address: _____

Contact name: _____ Phone No: _____

Services performed at this location: _____

Office Hours:

Mon___ to ___ | Tue ___ to ___ | Wed ___to___| Thu ___ to___| Fri___ to___| Sat___ to___ | Sun ___to ___|

Group Administrative Contact Information (correspondence):

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone No: _____ Fax No: _____

Email address: _____

Contact name: _____ Phone No: _____

Billing Address (for payments, checks):

Address: _____

City: _____ State: _____ Zip: _____ County:_____

Phone No: _____ Fax No: _____

Email address: _____

Contact name: _____ Phone No: _____

Practice Information
Are you currently a Medicaid provider? Yes ☐ No ☐ If yes, in what state: _____ Medicaid number:
Does this facility have wheelchair access? Yes ☐ No ☐
Does the physical location provide screening mammography services? Yes ☐ No ☐ Scheduling Phone Number:
Do you render laboratory services? Yes ☐ No ☐ If yes, please provide your CLIA number: _____ Describe testing methodology performed: _____
Do you render Telemedicine Services? Yes ☐ No ☐ Are you physically located in New Mexico at the time services are rendered? Yes ☐ No ☐ If No, please explain: _____ _____ _____
List any practice limitations (gyn only, etc.):
List any limitations to weekly practice hours:
Place of Service (POS) codes billed (office-POS 11, hospital-POS 21, surgery center-POS 24, etc.):
Do you provide lactation counseling services? Yes ☐ No ☐
Comments or additional information you would like to provide:

BlueCross BlueShield of New Mexico

Practitioner Information

(Please complete for each practitioner in the group)

Provider Name (First, Middle, Last, Title/Degree): _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Ethnicity (optional): _____ Race (optional): _____

NM State License #: _____ Type 1 NPI: _____

CAQH Provider ID: _____ Date Practice Started: _____

AANA Certification # (CRNAs only): _____ Effective Date: _____

Supervising Physician, if applicable: Name: _____ Alt: _____

Billing Information:

Social Security Number: _____ Tax Identification Number (TIN): _____

Taxonomy Code(s): _____

Physical Address

(Attach a separate sheet for any additional addresses **with phone numbers, office hours and services performed**)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Scheduling Phone No: _____ Fax No: _____

Email address: _____

Contact name: _____ Phone # _____

Office Hours:

Mon___ to ___ | Tue ___ to ___ | Wed ___to___| Thu ___ to___| Fri___ to___| Sat___ to___ | Sun ___to ___|

Services performed at this location: _____

Billing Address (for payment, checks):

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone No: _____ Fax No: _____

Email address: _____

Contact name: _____ Phone No: _____

Practice Information

Have you ever been a BCBSNM participating provider before? Yes ☐ No ☐

Are you currently a Medicare provider? Yes ☐ No ☐ If yes, in what state_____
Medicare PTAN:

Are you currently a Medicaid provider? Yes ☐ No ☐ If yes, in what state_____
Medicaid number:

Does this facility have wheelchair access? Yes ☐ No ☐

Does the physical location provide screening mammography services? Yes ☐ No ☐

Scheduling Phone Number:

Do you render laboratory services? Yes ☐ No ☐ If yes, please provide your CLIA number: _____

Describe the testing methodology: _____

Do you render Telemedicine Services? Yes ☐ No ☐

Are you physically located in New Mexico at the time services are rendered? Yes ☐ No ☐ If No, please explain:

_____
_____
_____

List any languages spoken:

List any practice limitations (Gyn only, etc.):

List any limitations to weekly practice hours (please list open days and hours of business):

List admitting hospital privileges (if applicable):

Place of Service (POS) codes billed (office-POS11, hospital-POS 21, surgery center-POS 24, etc.):

Have you ever been convicted of a felony or fraud?	Yes ☐ No ☐
Has your license to practice medicine in any jurisdiction ever been suspended or revoked?	Yes ☐ No ☐
Does your physical/mental health limit you in any way from performing your duties as a physician?	Yes ☐ No ☐
While practicing medicine, have you ever been impaired by alcohol or other chemical substances?	Yes ☐ No ☐
Have your privileges at any hospital ever been restricted, revoked, or not renewed?	Yes ☐ No ☐
Have you ever been listed on an OIG or other government sanction list?	Yes ☐ No ☐
Have you ever been debarred by Medicare/Medicaid	Yes ☐ No ☐

If you answered *yes* to any of the above questions, please include a detailed letter of explanation.

Comments or additional information you would like to provide:

To the best of my knowledge, the information supplied on this document is accurate and complete.
Upon submission of this packet, provider hereby releases this information to Blue Cross and Blue Shield of New Mexico for the purpose of establishing a BCBSNM Provider Record.

I hereby represent and warrant that all information contained in this application is true, correct, and complete in all aspects. I understand and agree that any misrepresentation in this application by omission or affirmative statement shall be grounds for termination.

Print Name: _____ Title: _____

Signature: _____ Date: _____

BlueCross BlueShield of New Mexico

SOLO PROVIDER INFORMATION

Provider Name (First, Middle, Last, Title/Degree): _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Ethnicity (optional): _____ Race (optional): _____

NM State License #: _____ Type 1 NPI: _____

CAQH Provider ID: _____ Date Practice Started: _____

AANA Certification # (CRNAs only): _____ Effective Date: _____

Supervising Physician, if applicable: Name: _____ Alt: _____

Billing Information:

Social Security Number: _____ Tax Identification Number (TIN): _____

Taxonomy Code(s): _____

Physical Address
(Attach a separate sheet for any additional addresses **with phone numbers, office hours and services performed**)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Scheduling Phone No: _____ Fax No: _____

Email address: _____

Contact name: _____ Phone # _____

Office Hours:

Mon___ to ___ | Tue ___ to ___ | Wed ___to___| Thu ___ to___| Fri___ to___| Sat___ to___ | Sun ___to ___|

Services performed at this location: _____

Billing Address (for payment, checks):

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone No: _____ Fax No: _____

Email address: _____

Contact name: _____ Phone No: _____

Practice Information
Have you ever been a BCBSNM participating provider before? Yes ☐ No ☐
Are you currently a Medicare provider? Yes ☐ No ☐ If yes, in what state_____ Medicare PTAN:
Are you currently a Medicaid provider? Yes ☐ No ☐ If yes, in what state_____ Medicaid number:
Does this facility have wheelchair access? Yes ☐ No ☐
Does the physical location provide screening mammography services? Yes ☐ No ☐ Scheduling Phone Number:

Do you render laboratory services? Yes ☐ No ☐ If yes, please provide your CLIA number: _____

Describe the testing methodology: _____

Do you render Telemedicine Services? Yes ☐ No ☐

Are you physically located in New Mexico at the time services are rendered? Yes ☐ No ☐ If No, please explain:

_____

_____

_____

List any languages spoken:

List any practice limitations (Gyn only, etc.):

List any limitations to weekly practice hours (please list open days and hours of business):

List admitting hospital privileges (if applicable):

Place of Service (POS) codes billed (office-POS11, hospital-POS 21, surgery center-POS 24, etc.):

Have you ever been convicted of a felony or fraud?	Yes ☐ No ☐
Has your license to practice medicine in any jurisdiction ever been suspended or revoked?	Yes ☐ No ☐
Does your physical/mental health limit you in any way from performing your duties as a physician?	Yes ☐ No ☐
While practicing medicine, have you ever been impaired by alcohol or other chemical substances?	Yes ☐ No ☐
Have your privileges at any hospital ever been restricted, revoked, or not renewed?	Yes ☐ No ☐
Have you ever been listed on an OIG or other government sanction list?	Yes ☐ No ☐
Have you ever been debarred by Medicare/Medicaid	Yes ☐ No ☐

If you answered *yes* to any of the above questions, please include a detailed letter of explanation.

Comments or additional information you would like to provide:

To the best of my knowledge, the information supplied on this document is accurate and complete.
Upon submission of this application, provider hereby releases this information to Blue Cross and Blue Shield of New Mexico for the purpose of establishing a BCBSNM Provider Record.

I hereby represent and warrant that all information contained in this application is true, correct, and complete in all aspects. I understand and agree that any misrepresentation in this application by omission or affirmative statement shall be grounds for termination.

Print Name: _____ Title: _____

Signature: _____ Date: _____

BlueCross BlueShield of New Mexico

Behavioral Health Professional Areas of Expertise

Group Name:_____

Provider Name:_____

Provider Type (degree)_____

Individual NPI Number: _____

Language(s) Spoken (other than English):_____

Only complete the top 5					
Practice Description	**Ages 0-5**	**Ages 6-12**	**Ages 13-17**	**Ages 18-64**	**Ages 65+**
Abuse, Assault and Trauma (PTSD)					
Adoption Issues					
Affective Mood Disorders					
Anger Management					
Anxiety and Panic Disorders					
Applied Behavior Analysis (ABA)					
Attention Deficit Disorders					
Autism Spectrum Disorders					
Bariatric Assessment					
Behavior Modification					
Bipolar Disorders/Manic Depressive Illness					
Brief Solution Focused					
Chemical Dependency/Chemical Dependency Assessment					
Cognitive Behavior Therapy					
Compulsive Gambling					
Couples/Marriage Therapy					
Critical Incident Stress Debrief (CISD)					
Cultural/Ethnic Issues					
Depression					
Developmental Disorders					
Dialectical Behavior Therapy					
Divorce/Blended Family Issues					
Domestic Violence					
EAP General					
Eating Disorders (if yes, respond to the 4 questions below):					
Are you a Certified Eating Disorder Specialist (CEDS)?	○ Yes		○ No		
Do you have 3 years of experience in this area?	○ Yes		○ No		
Do you work closely with a dietician/nutritionist?	○ Yes		○ No		
Can you schedule an urgent appointment within 48 hrs?	○ Yes		○ No		
An Area of Expertise in Eating Disorders designation is available only to providers who answer "Yes" to all 4 of the above questions.					

Practice Description	Ages 0-5	Ages 6-12	Ages 13-17	Ages 18-64	Ages 65+
Electroconvulsive Therapy - Inpatient					
Electroconvulsive Therapy - Outpatient					
Eye Movement Desensitization & Reprocessing (EMDR)					
End of Life Issues					
Family Therapy					
Forensic					
Gay/Lesbian/Bisexual Issues					
Grief/Bereavement					
Group Therapy					
Hearing Impaired					
HIV/AIDS/ARC Related Issues					
Infertility					
Medical Illness/Disease Management					
Medication Management					
Men's Issues					
Multi-Systemic Therapy (MST)					
Neuropsychological Testing					
Obsessive Compulsive Disorder					
Organic Disorders					
Pain Management					
Pastoral Counseling					
Personality Disorders					
Phobias					
Police/Fire Fighter Issues					
Postpartum Issues					
Prenatal Issues					
Psychological Testing					
Schizophrenia and other Psychotic Disorders					
Sexual Dysfunction					
Sexual Offender Treatment					
Somatoform Disorders					
Suboxone Treatment					
Transgender Issues					
Women's Issues					
Public Transportation Access	○ Yes		○ No		
TDD Capacity	○ Yes		○ No		
Wheelchair Accessibility	○ Yes		○ No		
Accepting New Patients	○ Yes		○ No		

Completed by: _____ Date: _____

BlueCross BlueShield of New Mexico

HOSPITAL COVERAGE LETTER

To: Blue Cross and Blue Shield of New Mexico (BCBSNM)

Date: _____

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a participating network hospital (in the applicable BCBSNM provider network(s) in which I participate); with the exception of medical emergencies, my practice will be confined to outpatient care.

I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer BCBSNM subscriber/member care to a participating physician or hospitalist (in the applicable BCBSNM provider network) who has active admitting privileges at a participating network hospital (in the applicable BCBSNM provider network).

(Please print legibly or complete online)

Provider's Name: _____

Provider's NPI #: _____

Provider's Signature: _____

BCBSNM provider networks include:
1) Commercial: HMO/PPO 2) Medicaid 3) Medicare Advantage 4) Blue Preferred
5) Blue Advantage HMO Network℠

Note: *If you are unsure of the participation status of a specific BCBSNM provider network, for yourself, another physician, hospitalist, or hospital, please contact Network Services office by fax or phone*.

Telephone Numbers	FAX Numbers
505-837-8800/ 1-800-567-8540	505-816-2688/ 1-866-290-7718

BlueCross BlueShield of New Mexico

CALL COVERAGE DESIGNATION & CREDENTIALING CONTACT INFORMATION FORM

Requirements:

1. Physician agrees to provide coverage for Members twenty-four (24) hours per day, seven (7) days per week by a network Participating Provider
2. The Call Coverage Physician and Applying Physician must participate in the same networks, but if the Call Coverage Physician is participating in additional networks that is fine.
3. The Call Coverage Physician and the Applying Physician must be credentialed in the same specialty.
    a. Exception-if the Applying Physician is in a rural setting where there is not another physician in the same specialty, a physician in a similar specialty may be approved.
4. Call Coverage must be established prior to the credentialing approval of the Applying Physician.

Useful Tool:
It may be helpful to use our Provider Finder tool to assist in finding a Call Coverage Physician participating in the same networks and specialty. Go to www.bcbsnm.com and click the link on the Home page called "Find a Doctor". You can search providers in an area by specialty and view that provider's network participation.

Applying Physician's Name:_____
(please print name legibly)

Applying Physician's /Authorized Signature: _____

Designated Call Coverage Physician(s):_____
(please print name(s) legibly)

Do the Call Coverage and Applying Physician Specialties match? Yes ☐ No ☐

If no, why: _____

Is there a patient age restriction concern between the Applying and Call Coverage Physician?
If so, explain: _____

Admitting privileges Yes ☐ No ☐

Hospital(s): _____

Credentialing Contact Information

Credentialing Contact Name:_____

Phone No: _____ Email Address:_____

Address, City, State, Zip: _____

Disclosure of Ownership and Control Interest Form

Purpose: In compliance with 42 CFR 457.935, 42 CFR §455.104, §455.105, and §455.106, providers/*disclosing entities* are required to disclose including, but not limited to, information regarding (1) the identity of all *persons with an ownership or control interest* in the provider/*disclosing entity*, or in any *subcontractor* in which the provider/*disclosing entity* has a direct or *indirect ownership* of 5 percent or more including the identity of *managing employees*, and *other disclosing entities*; (2) certain business transactions and *significant business transactions* between the provider/*disclosing entity* and *subcontractors*/*wholly owned suppliers*; and (3) the identity of any *person with an ownership or control interest* in the provider/*disclosing entity* or who is an *agent*, or a *managing employee* of the provider/*disclosing entity* that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs. **Any authorized/designated representative of the provider/*disclosing entity* may complete and sign this form on behalf of the provider/*disclosing entity*.**

Instructions for Completing the Ownership & Control Interest Disclosure Form

1) Read all definitions and instructions outlined throughout the form and then reference the definitions and instructions while completing the form. Terms with corresponding regulatory definitions are italicized and underlined throughout this form. Please review the applicable definition before responding to the question.
2) Definitions for Disclosure of Ownership and Control Interest Form - See Appendix A
3) Completion and submission of this statement/disclosure is a condition of participation as a credentialed or enrolled provider in the New Mexico Centennial Medicaid Managed Care Network or the State Children's Health Insurance Program (CHIP) network for services to members under Medicaid and CHIP benefit plans.
4) Answer all questions as of the current date i.e. request date.
5) If there is no information to include, indicate "None" or "Not applicable" (N/A) in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. Incomplete Forms will be reported back to HSD.
6) If more space is needed, please attach additional sheets.
7) In any space requesting 'Name,' if it is the name of an individual, include First, Middle and Last.
8) Business & Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
9) Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.
10) This Statement/Disclosure should be submitted with your MCO application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A statement must also be provided within **35** calendar days of a request for this information.
11) Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

How to Determine Ownership or Control Percentages (42 CFR 455.102).

12) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
13) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Disclosure of Ownership and Control Interest Form

NAME OF PROVIDER/*DISCLOSING ENTITY* **BEING CONTRACTED:**

NAME OF GROUP WHERE MEMBERS WILL BE SEEN:
TAX ID # OF PROVIDER/*DISCLOSING ENTITY*:

Section 1 –Disclosure Regarding *Managing Employees* (42 CFR 455.104(b)(4))

1) Does the provider/*disclosing entity* have any *managing employees*? ☐ **Yes** ☐ **No**
If **Yes**, provide the following details for any *managing employee* of the provider/*disclosing entity.*
See the definition of *managing employee*

NAME	SSN	Birthdate	Complete Address (street/city/state/zip)	NPI	Position

Section 2 – Criminal Offense Disclosure (42 CFR 455.106)

2) Has the provider, or any *person (*(individual or entity) *who has ownership or controlling interest* in the provider/*disclosing entity*, or who is an *agent* or *managing employee* of the provider/*disclosing entity*, ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), or Title XX (Social Services Block Grants) since the inception of those programs? ☐ **Yes** ☐ **No** (verify exclusion through the applicable federal and state specific exclusion databases.)
If **Yes**, provide the following details and a description of offense(s). Use additional pages if necessary.

NAME	SSN/TIN	Birthdate	Description

Section 3 – Person(s) with Ownership or Control Interest Disclosure (42 CFR 455.104(b)(1))

3) Are there any *persons* (individual or entity) *with an ownership or control interest* in the provider/*disclosing entity*?
☐ **Yes** ☐ **No**
If **Yes**, provide the following details and include the title (for example, CEO, owner, board member etc).
* For corporations/entities that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address.
See the definition of *person with an ownership or control interest* and *disclosing entity*

NAME	**TIN or SSN, as applicable	Birthdate	Title	Address (street/city/state/zip)	% Ownership Interest

Section 4A – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b)(1))

Disclosure of Ownership and Control Interest Form

4A) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ **Yes** ☐ **No**
If **Yes**, provide the following details about the *subcontractor*.
See the definition of the following terms: *subcontractor* and *indirect ownership interest*

Name of Subcontractor	****TIN or SSN,** as applicable	**Birthdate**	**Address (street/city/state/zip)**	**% Ownership Interest**

Section 4B – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b)(1))

4B) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ Yes ☐ No
If Yes, provide the information below about any *person (individual or entity) with an ownership or control interest*, in any *subcontractor* in which the provider/ disclosing entity has a 5 percent or more direct or *indirect ownership or control interest*.
See the definition of the following terms: *subcontractor* and *indirect ownership interest*

Name of Subcontractor (from section 4A)	**Name of Person(s) with an ownership or control interest in the *subcontractor***	****TIN or SSN,** as applicable **of Person(s) with an ownership or control interest in the *subcontractor***	**Birthdate of Person(s) with an ownership or control interest in the *subcontractor***	**Address (street/city/state/zip)of Person(s) with an ownership or control interest in the *subcontractor***	**% Ownership Interest**

Section 5A – Relationships Disclosure (42 CFR 455.104(b)(2))

5A) Are any of the individuals disclosed in Section 3 above related to each other as a spouse, parent, child, or sibling?
☐ **Yes** ☐ **No** If **Yes**, provide the following details:

NAME(From Section 3)	**Nature of Relationship (e.g., spouse)**	**Related to Name(From Section 3)**

Disclosure of Ownership and Control Interest Form

Section 5B – Relationships Disclosure (42 CFR 455.104(b)(2))

5B) Are any of the individuals disclosed in **Section 3** above related to any of the individuals disclosed in **Section 4B** as a spouse, parent, child, or sibling? ☐ **Yes** ☐ **No** (spouse, parent, child, sibling? If yes, give the name(s) of person(s) and relationship(s). Use additional pages if necessary. If **Yes**, provide the following details:

NAME(From Section 3)	**Nature of Relationship (e.g., spouse)**	**Related to Name(From Section 4B)**

Section 6 – *Other Disclosing Entity* Disclosure (42 CFR 455.104(b)(3))

6.1) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any other Medicaid provider? ☐ Yes ☐ No ☐ N/A

6.2) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any *other disclosing 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 (Maternal and Child Health Services Block Grant), XVIII (Medicare), XX (Block Grants to States for Social Services) , or Title XXI (State Children's Health Insurance Program) of the Social Security Act? ☐ Yes ☐ No ☐ N/A

If Yes to Items 1 or 2 of this Section 6, provide the following details:

See the definition of the following terms: *other disclosing entity* and *ownership interest*

NAME (From Section 3)	**Name of *other disclosing entity or other Medicaid Provider***	**SSN and/or TIN**, as applicable **of the *other disclosing entity or other Medicaid Provider***

Section 7A – Business Transactions Disclosure (42 CFR 455.105)

7A) Business Transactions - Subcontractors: Has the provider/*disclosing entity* had any business transactions with a *Subcontractor* totaling more than $25,000 in the previous twelve (12) month period (12-month period ending as of the date on this request) ? ☐ **Yes** ☐ **No** If **Yes**, provide the following details:

**See the definition of *subcontractor* **

Name of *subcontractor*	****TIN or SSN,** as applicable of *subcontractor*	**Birthdate**	**Address (street/city/state/zip)**	**Transaction Amount**

Disclosure of Ownership and Control Interest Form

Section 7B – Significant Business Transactions Disclosure (42 CFR 455.105)

7B) Significant Business Transactions: Has the provider/*disclosing entity* had any *Significant Business Transactions* with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending as of the date on this request) ? ☐ **Yes** ☐ **No** If **Yes**, provide the following details:

See the definition of the following terms: *subcontractor, wholly-owned supplier,* and *significant business transactions*

Type of entity	Name	**TIN or SSN, as applicable	Birthdate	Address (street/city/state/zip)	Transaction Amount
☐ Wholly Owned Supplier ☐ Subcontractor					
☐ Wholly Owned Supplier ☐ Subcontractor					

Section 8 – Attestation

8) Through signature below, I hereby certify that persons with ownership and control interest in the provider/*disclosing entity* or in a *subcontractor*, *agents*, *subcontractors*, *managing employees*, and any employees providing healthcare services as part of this application are screened with the applicable background check including, but is not limited to, verification against the applicable state and federal exclusion databases . I hereby represent and warrant that all information contained in this form is true, correct, and complete in all aspects. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract. I further understand completion of this form does not guarantee participation with the Managed Care Organization.

Name:_____ **Title:**_____
(Print or Type: First/Middle/Last) **(Print or Type)**

Signature:_____ **Date (MM/DD/YYYY):**_____
(Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)

Disclosure of Ownership and Control Interest Form

APPENDIX A

DEFINITIONS

#	Term/Words	Definition
1	*Agent*	Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2	*Disclosing entity*	Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. * For purposes of completing the Medicaid Disclosure Form, solo practitioners and the group contracting entity are also treated as a "disclosing entity." **Group Providers - The contracting group entity should complete the Form on behalf of the group.
3	*Fiscal agent*	Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4	*Group of practitioners*	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).
5	*Health Insuring Organization (HIO)*	Health insuring organization (HIO) has the meaning specified in § 438.2.
6	*Indirect ownership interest*	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. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
7	*Managed care entity*	Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
8	*Managing employee*	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.

9	*Other disclosing entity*	Other disclosing entity means any other Medicaid disclosing entity and 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. This includes: 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.
10	*Ownership interest*	Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in: a. The capital, the stock or the profits of the entity, or b. Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
11	*Person with an ownership or control interest*	Person with an ownership or control interest means a person or corporation that: a) Has an ownership interest totaling 5 percent or more in a 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) Is 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.
12	*Prepaid ambulatory health plan (PAHP)*	Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.
13	*Prepaid inpatient health plan (PIHP)*	Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.
14	*Primary care case manager (PCCM)*	Primary care case manager (PCCM) has the meaning specified in § 438.2.
15	*Significant business transaction*	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.
16	*Subcontractor*	Subcontractor means: 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 Medicaid agreement.

17	*Supplier*	Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
18	*Termination*	Termination means – a) For a-- i. Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and ii. Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. b) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. c) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.
19	*Wholly owned supplier*	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.