Disclosure of Ownership and Controlling Interest Statement

Once completed, please return via secure fax at: 1-800-676-6285

Part I – Identifying Information (Please print or type)			
Legal Name of Entity**:**			
Address:			
City:	State	ZIP Code:	Telephone:
Tax ID Number**:**			
Part II – Ownership Information (Please print or type)			

- For profit, list names, addresses for organization, Social Security numbers and dates of birth for individual owners, partners, board members, managing employees, subcontractors, employees, officers, and/or shareholders possessing a voting share in the entity, have direct or indirect ownership or controlling interest in the applying provider, another disclosing entity, or any subcontractor. Names and addresses may be listed on a separate sheet and attached to this statement.
- Not-for-profit corporations, please provide a list of the board of directors including, Social Security numbers and birth dates of the board members. Corporate entities must include primary business location, all business locations and P.O. addresses.
- Please also disclose any other disclosing entities in which an owner of the provider has an ownership or controlling interest.
- Please also indicate below whether a person, who has an ownership or controlling interest in the provider above, is related to another person with ownership or control interest in the provider above as a spouse, parent, child or sibling.
- If the provider above has an ownership or controlling interest in any subcontractor, please disclose whether any person with an ownership or controlling interest in the subcontractor is related to another person with ownership or controlling interest in the provider as a spouse, parent, child or sibling.

Title - select one:	Name:	DOB:
❐ Owner	Address:	Percentage Ownership:
❐ Board Member	City, ST, ZIP:	SSN (Individual):
❐ Managing Employee	Familial Relationship:	
Title - select one:	Name:	DOB:
❐ Owner	Address:	Percentage Ownership:
❐ Board Member	City, ST, ZIP:	SSN (Individual):
❐ Managing Employee	Familial Relationship:	
Title - select one:	Name:	DOB:
❐ Owner	Address:	Percentage Ownership:
❐ Board Member	City, ST, ZIP:	SSN (Individual):
❐ Managing Employee	Familial Relationship:	
Title - select one:	Name:	DOB:
❐ Owner	Address:	Percentage Ownership:
❐ Board Member	City, ST, ZIP:	SSN (Individual):
❐ Managing Employee	Familial Relationship:	

If more space is needed, please attach additional sheets.

Part III – Declaration

A. Please respond to these questions on behalf of yourself **and** managing employees, managing agent, or any individuals or organization having a direct or indirect ownership or controlling interest in the applying provider.

1. Have you or an entity in which you had an ownership interest ever been terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by the Medicaid program in New York or any other state of the United States, Medicare or any other governmental or private medical insurance program? ❒ **Yes** ❒ **No**

2. Have you ever been convicted of a crime relating to Medicare, Medicaid or any government health program or the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals? ❒ **Yes** ❒ **No**

3. Has your business or professional license or certification or the license of an entity in which you had an ownership interest ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any state? ❒ **Yes** ❒ **No**

4. Is there currently pending any proceedings that could result in the above stated sanctions? ❒ **Yes** ❒ **No**

5. Type of entity: ❒ Sole proprietorship ❒ Unincorporated association ❒ Corporation ❒ Governmental
❒ Partnership ❒ Other (specify) _____

6. Has there been a change of ownership or control within the last 12 months? ❒ **Yes** ❒ **No**
If "Yes," provide both: _____/_____/_____ Medicaid Number or National Provider Identifier (NPI)_____
MM DD YY

7. Do you anticipate a change of ownership within the next 12 months? ❒ **Yes** ❒ **No**
If "Yes," give a date: _____/_____/_____
MM DD YY

8. Is this provider operated by a management company, or leased in whole or in part by another organization? ❒ **Yes** ❒ **No**
If "Yes," give a date: _____/_____/_____
MM DD YY

As a Medicaid provider, you agree to comply with the rules, regulations and official directives of the New York State Department of Health, including but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, http://health.ny.gov. In addition, pursuant to 42 CFR §455.105, you agree to and may be requested to provide the following information within 35 days upon request by the Department or the Secretary of Health and Human Services:

1. The ownership of any subcontractor with whom you have had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2. Any significant business transactions or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of your total operating expenses between you and any wholly owned supplier, or between you and any subcontractor, during the five-year period ending on the date of the request.

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

Owner/Board Member Name (Print) Signature (No stamps) Date

Disclosure of Ownership and Controlling Interest Statement
Frequently Asked Questions

The Disclosure of Ownership and Control Interest Statement form is a federal regulation requirement under 42 CFR Part 455, applicable to all providers that participate in state-based health care programs (such as Medicaid and Child Health Plus) and provide services pursuant to a contract between a Medicaid Managed Care Organization and a state Medicaid agency.

To learn more, visit www.ecfr.gov. Also, refer to the Medicaid Tool Kit at: www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-ownership-control.pdf

Question	Answer
What is the Disclosure of Ownership and Control Interest Statement form and why is it needed?	As part of state and federal requirements, all providers are required to complete the form as part of their participation in government programs.
What happens if the Disclosure of Ownership and Control Interest Statement form is not completed and returned?	Excellus BlueCross BlueShield is required to report the non-compliance to the New York State Department of Health who will then report it to the Centers for Medicare & Medicaid Services (CMS). Failure to submit the requested information may result in termination of your contract. In addition, claims payments will be suspended if the form is not completed and returned timely.
Who should complete the Disclosure of Ownership and Control Interest Statement form?	Each provider entity (facility, all other entities) is required to complete the form answering the questions for the entity as a whole.
When should the Disclosure of Ownership and Control Interest Statement form be completed?	The form should be completed and returned by the date indicated in the bulletin.
What sections of the Disclosure of Ownership and Control Interest Statement form are required to be completed?	Facilities and other entities must complete the entire form. If a section is left blank, the form will be considered incomplete.
Who should sign the Disclosure of Ownership and Control Interest Statement form?	Since the form is being completed for a provider entity (facility, all other entities), it MUST be signed and dated by an individual with legal authority to bind the provider entity, and this person MUST be listed on the Master List in Part II. Signature stamps are not acceptable.
May I send an attachment if I have additional information to share?	You can submit an attachment or an addendum to the form if needed.
Do I have to submit the Social Security numbers (SSN) of the owners, managing employees, and board of directors?	Yes. Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.
My completed Disclosure of Ownership and Control Interest Statement form was sent to the state agency or another managed care organization. Can I send the already completed form as well?	Yes. You may send a copy of the same disclosure as long as it is accurate and less than three years old.
Who can I contact for more information about the Disclosure of Ownership and Control Interest Statement form?	If you have questions, please contact Customer Care at 1-800-920-8889, or contact your Provider Relations representative.

Definitions

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

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

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.

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

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs and HIOs.

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.

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.

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:
(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.

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).