NorthCare Network

Individual Providers
Disclosure of Ownership, Controlling Interest and Management Statement
Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination

Prepaid Inpatient Health Plans (PIHPs) must comply with federal regulations to collect disclosure of ownership, controlling interest and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid and/or Medicare and the Children's Health Insurance Program (CHIP) by NorthCare Network (PIHP) or by a delegate of NorthCare Network (PIHP), pursuant to a Medicaid contract with the MDCH and the federal regulations set forth in 42 CFR §455. Required information includes 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal conviction, sanction, exclusion, debarment or termination information for the provider, owners and managers. The information required includes, but it is not limited to name, address, date of birth, social security number (SSN) and tax identification (TIN).information for the provider, owners and managers. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of a Disclosure Statement is a condition of participation as a credentialed or enrolled provider in NorthCare Network (PIHP) managed care network for services to members under Medicaid, Medicare/Medicaid (MI Health Link) and CHIP benefit plans. Failure to submit the requested information may result in a refusal to enter into a provider contract, termination of existing contract, refusal of participation in the network or denial of a claim.

This Statement should be submitted at the time of credentialing, enrollment, or contracting and updated at least every two (2) years and at any time there is a revision to the information, or upon a request for updated information. A Statement must be provided to NorthCare Network (PIHP) within 35 days of a request for this information by the U.S. Department of Health and Human Services (HHS) or the State Agency. NorthCare Network maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions.

Detailed instructions *and a glossary of terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.*

Every field must be complete. The form will be returned for corrections/completeness if fields are left blank.

Section I: Individual Provider Information

Please choose appropriate category: ☐ Individual Contracted Practitioner ☐ Individual Member of a Medical Group ☐ Sole Proprietor ☐ Other: _____ Group Affiliation? ☐ Yes ☐ No If Affiliated with a Group, do you have a Private Practice as well? ☐ Yes ☐ No	**Name of Person Completing the Form** Title Phone Number Fax Email
Legal Name of Individual Provider:	Name of Group: ☐ N/A

Physical Address of Practice (Full address: Street, PO Box, City, State, Zip)			
Additional Addresses (list full addresses for all Practice locations – attach a separate sheet if necessary): Additional sheet(s) are attached ☐ Yes ☐ No			
SSN #:	*Medicaid ID #:	Medicare ID #:	*National Provider ID (NPI) #:
*If billing under an Entity: Federal Tax Identification #:		*If billing under an Entity: Billing Entity's Medicare ID#:	
*If billing under an Entity: Billing Entity's Medicaid ID#:		*If billing under an Entity: Billing Entity's NPI #:	

These fields cannot be left blank; "N/A" non-applicable and "applied for" are acceptable responses.
****Individual providers please use social security number: "N/A" non-applicable and "applied for" are acceptable responses***

Section II: Individual Provider Ownership Information

Are there any individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Individual Provider? ☐ Yes ☐ No If yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater. (42 CFR §455.104)

Additional sheet is attached ☐ Yes ☐ No

Name of Owner	**DOB (mm/dd/yyyy)**	**Complete Address (Street/City/State/Zip)**	**** SSN (individual) and/or TIN (entity)** *List both as applicable*	**% Interest**

***** SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22***

Section III: Ownership in Other Providers & Entities

Does the Owner *identified in* ***Section I*** have an Ownership or Controlling Interest in *any other provider or entity*?
Yes ☐ No If Yes, list the name and the SSN or TIN of the other provider or entity in which the Owner identified in tion II also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3))

Additional sheet is attached ☐ Yes ☐ No

Name of Owner from Section II	Name of *Other Provider or Entity*	Other Provider or Entity's SSN (individual) or TIN

IV: Subcontractor Ownership

Do you have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ☐ Yes ☐ *No*

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? ☐ Yes ☐ No

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *<u>also have</u>* Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104).

Additional sheets are attached ☐ Yes ☐ No

Name of Owner(s) (From Section II and III)	Legal Name of Subcontractor	Subcontractor Complete Address	SSN (Individual) and/or TIN (Entity)	% Ownership/ Interest

V: Familial Relationships of All Owners

Are any of the individuals identified in Sections II, III or IV related to each other? ☐ Yes ☐ No

If yes, list the individuals identified and the relationship to each other (e.g. spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2).

Additional sheets are attached ☐ Yes ☐ No

Name of Owner 1	Name of Owner 2	Relationship

VI: Criminal Convictions, Sanctions, Exclusions, Debarment, or Terminations

1. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been:

Additional sheets are attached ☐ Yes ☐ No

a. Indicted or Convicted of a Crime Related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program? ☐ Yes ☐ No **If yes,** list those persons and the required information below. (42 CFR §455.106)

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**State and Date of Conviction:**

b. Sanctioned, excluded, or debarred from any program under Medicaid, Medicare, CHIP or a Title XX program? ☐ Yes ☐ No **If yes,** list those persons and the required information below. (42 CFR §455.106)

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**List all States where currently excluded:**
Reason for Sanction, Exclusion, or Debarment:	
Date(s) of Sanctions, Exclusions, or Debarments:	**Date of Reinstatement:**

c. **Terminated from** any program under Medicaid, Medicare, CHIP or a Title XX program? ☐ Yes ☐ No **If yes,** list those persons and the required information below. (42 CFR §455.106)

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**Terminated from Medicare?** ☐ Yes ☐ No
Reason for Termination:	**Date of Termination:**
State that originated Termination:	**Date of Reinstatement:**

It is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations at any time during the Contract period. (See Fed. Register, Vol. 44, No. 138)

VII: Business Transaction Information

1. Have you, the Individual Provider, had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ☐ Yes ☐ No If yes, list the information for Subcontractors with whom the Individual Provider has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1))
   Additional sheet(s) are attached ☐ Yes ☐ No

Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

2. Significant Business Transactions : Have you, the Individual Provider, had any Significant Business Transactions with a Subcontractor and/or Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? Subcontractor ☐ Yes ☐ No Wholly Owned Supplier ☐ Yes ☐ No
   If yes, list the information for any Subcontractor and/or Wholly Owned Supplier with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (43 CFR §455.105(b)(2)). Additional sheets are attached ☐ Yes ☐ No

Name of Supplier:	**Suppliers SSN or TIN:**
Suppliers Address:	**City, State, Zip:**
Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

This information must be provided and/or updated within 35 days of a request. *Payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received.* (42 CFR §455.105)

VIII: Management and Control

1. **Managing Employees:** Do you, the Individual Provider have any Managing Employees? ☐ Yes ☐ No
   If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of your Individual Provider Practice (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104). Additional sheets are attached ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN	Title

2. **Agents:** Do you, the Individual Provider have any Agents? ☐ Yes ☐ No
   If yes, list all Agents that have been delegated the authority to obligate or act on behalf of Individual Provider, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104).
   Additional sheets are attached ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN

3. **Board of Directors:** Do you, the Individual Provider have a Board of Directors? ☐Yes ☐ *No*
If yes, list each Member of the Board of Directors or Governing Board, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104).
Additional sheets are attached ☐Yes ☐ No

Name	**DOB mm/dd/yyyy**	**Complete Address**	**SSN**

Through signature below, I hereby certify that the information provided herein, is true, accurate and complete. 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 and denial of claims.

Provider Name (Print):	Title:
Provider Signature:	Date:
Phone #:	Email: