NorthCare Network

Entity Disclosure of Ownership, Controlling Interest Statement
Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination

Prepaid Inpatient Health Plans (PIHPs) must comply with federal regulations (42 CFR 455) to collect disclosure of ownership, controlling interests, and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid and/or Medicare programs and the Children's Health Insurance Program (CHIP) by NorthCare Network the Pre-paid Inpatient Health Plan (PIHP) or by a delegate of NorthCare Network as a PIHP in Michigan. This requirement is pursuant to the PIHP Contract with the State Medicaid Agency and the federal regulations set forth in 42 CFR Part §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 convictions, sanctions, exclusions, debarment or termination information for the provider, owners or managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN) information for the provider, owners, board of directors and managing employees.

Completion and submission of this Disclosure Statement is a condition of participation as a credentialed or enrolled provider entity in the NorthCare Network managed care network for services to members under Medicaid, Medicare/Medicaid (MI Health Link) and CHIP benefits 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 any of the following times: upon the submission of an application; upon execution of an agreement; during re-credentialing or re-contracting (at least every two years); within 35 days after any change in ownership of the disclosing entity. 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: Provider Entity Information

Please choose appropriate category:	Name of Provider Entity:
☐ Corporation ☐ Government/Public Entity ☐ Limited Liability Corporation (LLC) ☐ Non-Profit ☐ Partnership ☐ Other:	Name of Person Completing this Form: Title: Phone Number: Fax: Email: In which state(s) do you participate in Medicaid?
Additional Addresses (list all Practice Locations) Attaching list? ☐ Yes ☐ No	

*SSN (if Individual): ☐ N/A *Federal Tax ID# (if Entity): ☐ N/A	☐ *Medicaid ID#: ☐ *Applied for Medicaid ID ☐ *Not applicable	☐ *Medicare ID#: ☐ *Applied for Medicare ID ☐ *Not applicable	☐ *NPI #: ☐ *Applied for NPI # ☐ *Not applicable

Section II: Provider Ownership Information

1. Are there any individuals with a Direct or Indirect Ownership Interest of 5% or more in your entity?
☐ 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 disclosing entity 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 Interest of 5% or greater. (42 CFR §455.104). Additional sheets are attached ☐ Yes ☐ No

Name and Title of Owner	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)			**SSN or TIN or both as applicable	% Interest
		Street:				
		C:	S:	Z:		
		Street:				
		C:	S:	Z:		
		Street:				
		C:	S:	Z:		

2. Are there any organizations with an ownership or control interest of 5% or more in your entity? ☐ Yes ☐ No
If yes, 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 Interest of 5% or greater. (42 CFR §455.104).
Additional sheets are attached ☐ Yes ☐ No

Name of Corporation	TIN	% Ownership	Primary Business Address	Every Business Address	P.O. Box Address(es)

***SSN and TIN required under §455.104; See Sect 4313 of the 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 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 Section II* also has an Ownership or Controlling Interest (42 CFR §455.104(b)(3)). Additional sheets are attached ☐ Yes ☐ No

Name of Owner (from Section II)	Name of Other Provider or Entity	Other Provider or Entity's SSN (indiv.) or TIN (entity)	% Ownership/ Interest

IV: Subcontractor Ownership

Does the Provider Entity, or any individuals listed in II or III, 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 *also have* 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	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. Has the Provider Entity 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:

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

VII: Business Transaction Information

1. **Business Transactions – Subcontractors:** Has the Provider Entity 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 Provider Entity 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 sheets 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 – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐ Yes ☐ No ☐ N/A **If yes,** list the information for any Wholly Owned Supplier with whom the Provider Entity 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:

3. **Significant Business Transactions – Subcontractors:** Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period? ☐ Yes ☐ No ☐ N/A **If yes,** list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past 5-year period (42 CFR §455.105(b)(2)).

Additional sheets 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:

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:** Does the Provider Entity 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 Provider Entity (CEO, CFO, CIO, 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:** Does the Provider Entity have any Agents? ☐ Yes ☐ *No* ☐ *N/A*
If yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, 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:** Does the Provider Entity 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 any employees or contractors providing services pursuant to a contract with NorthCare Network are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities on a monthly basis (https://oig.hhs.gov/exclusions/index/asp) and the System for Award Management (SAM) www.sam.gov and any applicable state, federal or other governmental exclusion or sanction database and 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 a claim and/or termination of the contract.

Signature_____ Title_____

Print Name_____ Date_____

_____ _____ _____

Phone Number Fax Number Email Address