Disclosure of Ownership Form
Business Entity

This form is to be used when applying for network participation as a business entity or at the time of re-credentialing if contracted as a business entity with Avesis. Business entity is defined as a partnership or corporation that provides covered services to Avesis members or members of Avesis' customers who seek services from an Avesis contracted business entity. This form must be updated to reflect any significant changes to the information previously provided. Examples of "significant changes" include, but not limited to, change of ownership, addition of a new managing employee or change of business location.

Please answer all questions as they pertain to the date the form is being completed. If additional space is needed, please note on the form the answer is being continued on a separate attachment and reference the item number on the attachment being continued. Please return the original document to Avesis and retain a copy for your files. Respond to all applicable questions and respond N/A to any question not applicable. NO QUESTIONS CAN BE LEFT BLANK.

Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).

I. IDENTIFYING INFORMATION

Business Entity Name			**Business Entity D.B.A Name** *(Only complete if different from Entity Name)*	**Business Entity Federal Tax Identification Number**
Business Entity NPI	**Medicaid Identification Number**	**Business Entity Telephone**	**Business Entity Address** *(If more than one (1) practice location, list all locations)*	

II. Owner or Controlling Interest Information

Definitions: An **Owner** is a person or company that owns 5 percent or more of the assets, stock or profits of the Business Entity. Ownership can be direct or indirect; example of indirect ownership is an individual who may own 50 percent of a company that owns the actual Business Entity. In addition to ownership of stock, an Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Business Entity. A person with **Controlling Interest** is someone who directs the Business Entity; examples include Directors, Trustees and Officers of Corporations and Partners in a Partnership. A **Managing Employee** makes the day-to-day decisions for the Business Entity; examples include office managers, billing managers, finance manager, or any individual who has responsibility for key operational areas of the Business Entity and would be typically listed below the corporate officers on an organizational chart. An **Agent** is an individual who has the legal ability to bind or entered into contracts on behalf of the Business Entity.

IF A BUSINESS ENTITY IS A NONPROFIT ENTITY, RESPOND N/A IN THE COLUMN FOR % OF OWNERSHIP.

Please provide the following information for Owners, persons with Controlling Interests, Agents and Managing Employees of the Business Entity.

Ownership & Controlling Interest Listing:

Full Legal Name and Title	**Complete Address** Home address for Individual(s) All street and PO Boxes for Company(s)	**Date of Birth**	**SSN for Individual(s) FEIN for Company(s)**	**% of Ownership**

A) Is any person on the Ownership and Controlling Interest listing related to another person listed on the Ownership and Controlling Interest list as a spouse, parent, child or sibling?

Yes ☐ **No** ☐

If Yes is checked, provide the following information about the related person:

Full Legal Name of First Person	**Full Legal Name of Person Related To**	**Related By** (Spouse, Parent, Child or Sibling)

B) Does any person or entity on the Ownership and Controlling Interest Listing have an ownership or controlling interest in any other Business Entity?

Yes ☐ **No** ☐

If Yes is checked, provide the following information about the other Business Entity:

Business Entity Name	Business Entity Full Address	Business Entity Tax Identification Number

C) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **convicted** of a criminal offense related to that person's or company's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services program since the inception of those programs? "Convicted" means been found guilty by a jury or judge, or pled guilty, nolo contendre, best interest plea or pretrial diversion or suspended sentence.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Name on Court Record	SSN	Description of Offense	Date of Conviction	Sanction Period *If Sanctioned by Office of the Inspector General (OIG)*

D) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **debarred** from participation in federal government contracts? **Debarred** means individual or company is not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the health care area.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Date Debarred	Length of Debarment	Reason for Debarment

E) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past? **Excluded** means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded health care program.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Date Excluded	Date of Reinstatement	Reason for Exclusion

F) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **terminated** from a state's Medicaid or CHIP program for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Provider lost the right to bill a state's Medicaid or SCHIP program for a cause related to fraud or abuse.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

State Issuing Termination	Date of Termination	Reason for Termination

G) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever had **Civil Monetary Penalties (CMPs)** assessed against them? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal health care program.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

State Assessing CMP	Date of CMP	Amount of CMP	Reason for CMP

H) Did any of the individuals or companies on the Ownership and Controlling Interest Listing obtain ownership interest as a result of (1) a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal health care program, or was excluded or terminated from participation in a federal health care program, and (2) where the original owner is or was a member of the current owner's immediate family or a member of the current owner's household at the time of the transfer of ownership?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Full Legal Name of Original Owner	SSN or Tax Identification Number	Place of Transfer	Date of Transfer

I) List and subcontractor whom the Business Entity has a direct or indirect ownership of 5% or greater. Examples of subcontractors include billing services/agents, laboratory, radiology center, etc.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Full Legal Name of Subcontractor	Subcontractor Full Address	Subcontractor Tax Identification Number

J) For each subcontractor listed in 2I, please provide the following information for the individuals with an ownership or controlling interest in the subcontractor(s).

Full Legal Name and Title	**Complete Address** Home address for Individual(s) All street and PO Boxes for Company(s)	**Date of Birth**	**SSN for Individual(s) FEIN for Company(s)**	**% of Ownership**

K) Is any individual listed above in J related to any individual listed on the Ownership and Controlling Interest Listing?

Full Legal Name of First Person	**Full Legal Name of Person Related To**	**Related By** (Spouse, Parent, Child or Sibling)

III. BUSINESS TRANSACTIONS

A) Has the disclosing Business Entity had any financial transaction with any subcontractor totaling more than $25,000 or any significant business transactions with any subcontractor in the previous 12-month period, and any significant business transactions between Business Entity and any wholly owned supplier, or between the Business Entity and any subcontractor during the past 5-year period?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Full Legal Name of Subcontractor	**Subcontractor Full Address**	**Subcontractor Tax Identification Number**

B) Does the Business Entity wholly own a supplier? A supplier means an individual, agency or organization from which the Business Entity purchases goods and/or services used in carrying out its responsibilities under Medicaid. Examples include commercial laundry, a manufacturer of hospital beds or a pharmacy.

Yes ☐ **No** ☐

If Yes is checked, supply the following information about the supplier:

Supplier Name	**Subcontractor Full Address**	**Subcontractor Tax Identification Number**	**Subcontractor NPI**

IV. SIGNATURES

Avesis and the state or federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider or if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106.

THE SIGNATURE BELOW MUST BE THE WRITTEN SIGNATURE OF AN INDIVIDUAL WHO CAN LEGALLY BIND THIS BUSINESS ENTITY.

In compliance with 42 CFR 455.104c, Provider shall provide a disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement at the time of re-credentialing/re-enrollment, and within 35-days after any change in ownership of the disclosing entity. In compliance with information outlined in section III, Business Transactions, above.

Name Individual Provider (printed)	Signature of Individual Provider STAMPED SIGNATURE NOT ACCEPTABLE	Date

Authorized Individual Completing Form (printed)	Title of Authorized Individual Completing Form
Phone Number of Authorized Individual	**Email of Authorized Individual**