DISCLOSURE FORM FOR PROVIDER ENTITIES

Directions: Use this form if you are trying to get a new TennCare/Medicaid ID number for a **Provider Entity**, or if you are re-credentialing or re-contracting a **Provider Entity**, or if there have been significant changes to the information required on this form, for example an ownership change, the addition of a new managing employee or the change of your business location. A **Provider Entity** is a business entity. i.e. a partnership or corporation, that provides TennCare covered services to TennCare enrollees.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return this form to the address on the application packet. Please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***. The SSN must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing Social Security Numbers (SSN).

I. IDENTIFYING INFORMATION

Name of person Completing form	Phone number of person completing form

Provider Entity Name	Provider Entity DBA Name (if different from Provider Entity name)	Provider Entity Federal Tax Id number

Provider Entity NPI number (If you have one, if not indicate if applied for.)	Provider Entity TennCare/Medicaid ID number (If you have one, if not indicate if applied for.)	Provider Entity telephone Number

Provider Entity Address- Must include at least one street address. (attach a separate sheet if needed).List all Practice locations	City	State	Zip

II. OWNER OR CONTROL INFORMATION

Directions: An **"Owner"** is a person or business entity which owns 5% or more of the assets, stock or profits of the **Provider Entity**. This 5% may be **Direct** ownership or **Indirect** ownership i.e, an individual might own 50% of a company that owns the actual **Provider Entity** meaning their indirect ownership is 50%. 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 **Provider Entity**.

A person with **"Control Interest**" is someone who directs the **Provider Entity** and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the **Provider Entity** is a non-profit entity, respond **N/A** in the column for % of ownership.

A **"Managing Employee"** is someone who makes the day to day decisions for the **Provider Entity**. These individuals include office or billing managers for smaller providers, and for larger **Provider Entities** the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

An **"Agent"** is an individual who has the legal ability to bind the **Provider Entity,** i.e., the **Provider Entity** may use an **Agent** to obtain contracts for it.

Please provide the following information for **Owners**, persons with **Control** interests, **Agents** and **Managing employees** of the **Provider Entity**. Attach a separate sheet if needed. If the company is a non-profit please put N/A in % ownership column.

A. Master List

Name	Address (For *individuals* use Home address. For *business entities* that might have Ownership/Control interest use all street addresses (if more than one location), and P.O. Box address if any.)	City	ST	ZIP	DOB	**SSN** for individuals or Tax ID for business entities	% own er-ship.	Title

B. Specific Questions

1) Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling?
   Yes ☐ No ☐. If yes, please provide the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**?

Yes ☐ No ☐. If "yes", please provide the following information about the other **Provider Entity** the person on the **Master List** has an interest in.

Name of other Provider entity	Address	City	State	Zip	Tax I.D.

3) Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Tricare or the CHIP services program since the inception of those programs? Yes ☐ No ☐. If yes, please provide the information requested below:

Name on Court records	SSN /TIN	Matter of the Offense	Date of the Conviction	Exclusion Period of the Offense if you were excluded by the Federal Office of the Inspector General(OIG)

4) Have any of the individuals or entities on the **Master List** ever been **Debarred** from participation in Federal Government contracts? **"Debarred"** means an individual 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:

When you were debarred	Length of Debarment	Reason for Debarment

5) Has any person or entity on the **Master List** 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 healthcare program.

Yes ☐ No ☐ If "Yes" please supply the following information:

Name of Individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

6) Has any person or entity on the **Master List** ever been **Terminated** from a State's Medicaid or CHIP programs 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 CHIP programs for a cause related to fraud or abuse.

Yes ☐ No ☐ If "Yes", please supply the following information:

State where practicing when terminated	Reason for termination	Date of termination

7) Has any person or entity on the **Master List** 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 healthcare program.

Yes ☐ No ☐ If "Yes" please supply the following information:

Name Of Individual	State where practicing when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

8) Did anyone on the **Master List** obtain their **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from

participation in a federal healthcare Program.: And 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's H**ousehold**, at the time of the transfer of ownership? [**Immediate Family**] is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Membe**r **of Household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.]

Yes ☐ No ☐ If "Yes" please supply the following information:

Name of original **Owner**	SSN or TAX ID of original **Owner**	Place of Transfer	Date of Transfer

9a) List any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Name of Subcontractor	Address	City	State	Zip	Tax I.D.

9b) For each **Subcontractor(s)** listed in 8a above please provide the following information for the individuals with an Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

Name	Address (for individuals use Home address, for business entities that might have a Direct or Indirect Ownership or Control **Interest** use business street address, and P.O. Box address if any.)	City	ST	Zip	DOB	SSN for individuals or Tax ID for business entities	% of own er-ship	Title

9c) Is anybody in the list in 9b list related to any person in the **Master List** above?

Yes ☐ No ☐ If yes, please supply the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

III. BUSINESS TRANSACTIONS

1) Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.8a. in which you have an **Direct or Indirect Ownership interest**. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** business functions, i.e., billing agent, or to provide medical services, i.e., a medical lab.

Name	Address	City	State	Zip

2) Does the **Provider Entity** *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **Provider Entity** *purchases goods and services* used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

Yes ☐ No ☐. If yes, supply the following information about the **Supplier:**

Name	Address	City	State	Zip	NPI	TIN

IV. SIGNATURE

The State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider 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 **Provider Entity**;

Name of Person (Printed)	Signature of Person	Title	Date