DISCLOSURE HISTORY FORM

Confidential Information

BlueCross BlueShield of Western New York

Please submit this form to our Corporate Provider Enrollment Department.
Fax: (716) 887-8886

ADDITIONAL QUESTIONS REGARDING PRIOR CONDUCT

All responses must be thorough and complete. If there is not sufficient space available for a response, you may attach additional sheets to this form. Failure to fully respond or to provide accurate and detailed information can result in a delay in the processing of your application, or can result in the denial of your request for enrollment or reinstatement.

Applicant Name: _____

New York Provider ID #:_____ NPI #_____

I. A. Prior Medicare History (Federal Program, Title XIX)

1. Have you ever been excluded, terminated, and/or suspended by Medicare?

   Yes_____ No_____

   If yes:

   (a) Date of exclusion, termination, or suspension. _____/_____/_____
   MM / DD / YY

   (b) Cause of exclusion, termination, or suspension (you must be specific and provide full details). _____

   _____

   (c) Were you reinstated? Yes_____ No_____

   If yes, provide a copy of your reinstatement letter.

   (d) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your exclusion, termination or suspension won't be repeated. (See reinstatement instructions with application for examples.)

2. Have you ever been restricted by agreement or sanctioned by Medicare for a reason that did not result in an exclusion, termination, or suspension?
   Yes_____ No_____

   (a) Identify date and type of action. _____

   _____

   (b) Identify reason for restriction or sanction. _____

(c) Are you currently participating in Medicare without any restrictions or sanctions?

Yes_____ No_____

(d) Date the restriction ended. _____/_____/_____
MM / DD / YY

B. Prior Medicaid History (State Program, Title XVIII)

1. Have you ever been excluded, terminated, and/or suspended by Medicaid in any state?
Yes_____ No_____

If yes:

(a) Date of exclusion, termination, or suspension. ____/_____/_____
MM / DD / YY

(b) Cause of exclusion, termination, or suspension (you must be specific and provide full details).

_____

_____

(c) Were you reinstated? Yes_____ No_____

If yes, provide a copy of your reinstatement letter.

(d) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your exclusion, termination, or suspension won't be repeated. (See reinstatement instructions with application for examples.)

2. Have you ever been denied enrollment by Medicaid in any state?
Yes_____ No_____

If yes:

(a) Identify state(s), date(s) of denial, and reason.

_____

_____

(b) Submit a copy of your denial letter.

3. Have you ever been restricted by agreement or sanctioned by Medicaid for a reason that did not result in an exclusion, termination, or suspension?

   Yes_____ No_____

   (a) Identify date and type of action.

   _____

   (b) Identify reason for restriction or sanction.

   _____

   _____

   (c) Are you currently participating in Medicare without any restrictions or sanctions?

   Yes_____ No_____

   (d) Date the restriction or sanction ended? _____/_____/_____
   MM / DD / YY

II. A.

1. Have you ever been convicted of stealing from any federally or state funded Medicaid/Medicare Program (Medicaid/Medicare Fraud)?

   Yes_____ No_____

   If yes:

   (a) What was the date and location of the conviction?

   _____

   (b) What were the causes that resulted in the conviction?

   _____

   _____

   (c) Provide a copy of your conviction papers.

   (d) Are you currently on probation?

   Yes_____ No_____
   If yes, provide a copy of your probation papers and a current status report.

   (e) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your conviction won't be repeated.

(See reinstatement instructions with application for examples.)

B.

1. Have you ever been convicted of public assistance or welfare fraud?
   Yes_____ No_____

   If yes:

   (a) Identify the state and date of the conviction.

   _____

   (b) What penalty was imposed as a result of the conviction? _____

   _____

C.

1. Have you ever been convicted of any crime related to furnishing or billing for medical care, services, or supplies (an offense involving fraud or theft) against a public administration, or public health and morals, other than previously listed on this form?
   Yes_____ No_____

   If yes:

   (a) Identify the state(s) and date(s) of the conviction.

   _____

   (b) What penalty was imposed as a result of the conviction? _____

   _____

III. A.

1. Has your medical license or registration ever been revoked and/or suspended in any state?

   Yes_____ No_____

   If yes:

   (a) Identify the state(s) and date(s) of the revocation and/or suspension.

   _____

   (b) Identify the causes of the revocation and/or suspension _____

   _____

(c) Has your license been restored?

Yes_____ No_____

(d) Date your license was restored. _____/_____/_____
MM / DD / YY

(e) Are you currently on probation?

Yes_____ No_____

(f) Date you expect probation to end. _____/_____/_____
MM / DD / YY

(g) Provide information and documentation of any corrective steps you have taken to demonstrate the cause that led to the revocation/termination or suspension of your medical license won't be repeated. (For examples, see reinstatement instructions with application.)

B.

1. Has your medical license or registration ever been surrendered in any state?

Yes_____ No_____

If yes:

(a) Identify the state(s) and date(s) your license was surrendered.

_____

(b) Identify the reason you surrendered your license. _____

_____

(c) Date your license was reissued. _____/_____/_____
MM / DD / YY

C.

1. Has your license and/or registration ever been placed on probation or have you entered into any type of agreement by any licensing authority in any state?

Yes_____ No_____

If yes:

(a) Identify state(s) and date(s) of action.

(b) Identify reason for the action. _____

_____

(c) List any restrictions placed on your license. _____

_____

(d) If on probation, attach a letter that indicates you are currently in compliance with all terms of your probation.

III. A.

1. Are there any pending proceedings that could result in a sanction in any state?
   Yes_____ No_____

   If yes:

   (a) Identify all sanctions that may result from the pending action:

Medicare:

Termination from Medicare _____

Denial of enrollment by Medicare _____

Suspension from Medicare _____

Restriction by agreement from Medicare _____

Conviction of Medicare fraud _____

Medicaid:

Termination from Medicaid _____

Denial of enrollment by Medicaid _____

Suspension from Medicaid _____

Restriction by agreement from Medicaid _____

Conviction of Medicaid fraud _____

Other:

Conviction for stealing _____

Conviction for welfare or public assistance fraud _____

License or registration revoked _____

License or registration suspended _____

License or registration surrendered _____

License or registration restricted by probation _____

License or registration restricted by agreement _____

B.

1. Expected date that a decision will be rendered. _____/_____/_____
   MM / DD / YY

I certify that the answers provided in this document are correct.

Full name (please print):_____
First Middle Last

_____
Provider Signature Date MM / DD / YY