

FACILITY DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104 (If additional space is needed, copy form; all entries must be on the form)



SECTION 1:

Disclosing Entity / Applicant

Entity Name	
FEIN	NPI (if exempt, leave blank)

Ownership in Applicant (per 42 CFR, Part 455.104(b)(1)(i) – (Entities and/or Individuals)

Copy this page to report additional owners.

Name of Individual or Entity		Title (if individual)		Date of Birth (if individual) (MM/DD/YYYY)	
Address (Home Address if individual; Primary Address if corporation) - Street				City, State & Zip Code (9 digit)	
SSN (if individual)	FEIN (if entity)	% of Ownership (if none, put 0%)	NPI or NY Medicaid ID (if none, write None)		
<p>For Individuals Only: If you are related* to another person with an ownership or controls interest in the Applicant, complete the following:</p> <p>Name of other Owner: _____ Relationship to other Owner (parent, child, sibling, spouse): _____</p> <p>_____</p> <p>_____</p> <p>_____</p>					
<p>For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):</p> <p>1) _____ 2) _____ 3) _____</p> <p>_____</p> <p>_____</p>					

Name of Individual or Entity		Title (if individual)		Date of Birth (if individual) (MM/DD/YYYY)	
Address (Home Address if individual; Primary Address if corporation) - Street				City, State & Zip Code (9 digit)	
SSN (if individual)	FEIN (if entity)	% of Ownership (if none, put 0%)	NPI or NY Medicaid ID (if none, write None)		
<p>For Individuals Only: If you are related* to another person with an ownership or controls interest in the Applicant, complete the following:</p> <p>Name of other Owner: _____ Relationship to other Owner (parent, child, sibling, spouse): _____</p> <p>_____</p> <p>_____</p> <p>_____</p>					
<p>For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):</p> <p>1) _____ 2) _____ 3) _____</p> <p>_____</p> <p>_____</p>					

SECTION 2:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104(b)(3)) - (Complete if any identified in Section 1 has an ownership or control interest in ODE.)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE

SECTION 3:

Ownership in Subcontractors If the Applicant has an ownership or controls interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4.

Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number

SECTION 4:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a *familial relationship with a person with ownership or control interest in one of the subcontractors identified in Section 3).
*parent, child, sibling, spouse

Owner's Name	Subcontractor's Name	Name & Familial Relationship
Owner's Name	Subcontractor's Name	Name & Familial Relationship

SECTION 5:

Managing Employees & Those with Interest – Including, but not necessarily limited to, the following: Facility Administrator, all Members of the Board of Directors, Managing Employees, Compliance Officer, Laboratory Director, and Supervising Pharmacist. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any.

Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

{If additional space is needed, copy form; all entries must be on the form}

Managing Employees & Those with Interest – (continued)

Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

SECTION 6:

Respond to these questions on behalf of:

1. The Applicant
2. All individuals and entities identified in Sections 1 and 5
3. Any entity in which the Applicant has a 5% or more ownership

1. Have any of the individuals/entities (1,2, and 3) been terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by the Medicaid Program in New York or any other state, Medicare, or any other governmental or private medical insurance program?
 Yes No
2. Have any of the individual/entities (1,2, and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any state?
 Yes No
3. Have any of the individuals/entities (1,2,and 3) ever had their business or professional license or certification of an entity for which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any state?
 Yes No
4. Are there currently any pending proceedings that could result in the above stated sanctions for the individuals/entities (1, 2, or 3)?
 Yes No

NOTE: If you answered “Yes” to any of the questions above, you must complete and submit the “Disclosure History Form” available at bcbswny.com/provider.

5. Has there been a change of ownership or control within the last 12 months to any of the entities (1, 2, and 3)?
 Yes No

If “Yes”, provide:

NPI
Date of Ownership Change (MM/DD/YYYY)

6. Do you anticipate a change of ownership within the next 12 months to any of the above entities (1, 2, and 3)?
 Yes No

If “Yes”, when do you anticipate the ownership change will occur: (MM/DD/YYYY)

SIGNATURE AND AFFIRMATION

By signing this Disclosure form, the Applicant/Provider understands and agrees to the following:

- As a Provider, you agree to comply with the rules, regulations, and official directives of the Department of Health (DOH) including, but not limited to Part 504 of 18NYCRR, which can be found at the Department of Health’s website, health.ny.gov.
- In addition, pursuant to 42 CFR, Part 455.105, you agree to disclose the following regarding business transactions within the next 35 days upon request of the DOH or the Secretary of Health and Human Services.
 - (1) Information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request, and
 - (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five-year period ending on the date of the request.

- As a Provider you agree to abide by all applicable federal and state laws as well as the rules and regulations of other New York state agencies
- As a Provider you agree to notify us immediately of any changes in practice including impending ownership changes.

As a Provider you maintain a policy that outlines your process to monitor staff and employees against the stated exclusion list (List of Excluded Individuals and Entities and the Restricted, Terminated or Excluded Individuals or Entities List) and report any exclusions to **BlueCross BlueShield of Western New York** on a monthly basis.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR SECRETARY, AS APPROPRIATE.

Print or Type the Name of Person Signing Below

Title

If Applicant / Provider is a legal entity other than a person, the person signing this Disclosure document on behalf of the Applicant / Provider warrants that he/she has legal authority to bind the Applicant / Provider. (NOTE: for Changes of Ownership, New Owner or Representative must sign.)

Signature Provider/Entity or Authorized Representative

Date (MM/DD/YYYY)

Name and Telephone Number of Person who Prepared Disclosure Form

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