PRACTITIONER 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 (Individual named on page 1 of CAQH Application)

Name	NPI	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	

Ownership in Applicant Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address.

Name of Individual or Entity		% of Ownership	Entity/Group NPI
Business Address (Home address if individual)		City & State	Zip Code (9 digit)
SSN (if individual)	FEIN (if entity)	Date of Birth (if individual) (MM/DD/YYYY)	Familial Relationship (if individual, if any)

SECTION 2:

Ownership in Other Disclosing Entities (ODE) (Complete if any identified in Section 1 has an ownership or controls interest in ODE).

Name (from section 1)	Name of ODE	NPI
Name (from section 1)	Name of ODE	NPI

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 controls interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or interest in one of these subcontractors, complete Section 4.

Owner's Name (from section 1)	Subcontractor's Name	Tax ID
Owner's Name (from section 1)	Subcontractor's Name	Tax ID

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 (from section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 5:

Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider). Include familial relationship to the Applicant (e.g. spouse, parent, child, sibling) if any. If additional space is needed, copy form.

Name	Title	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship (if applicable)

Name	Title	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship (if applicable)

Name	Title	
Home Address (street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship (if applicable)

SECTION 6:

Respond to these questions on behalf of:
1. The Applicant
2. All individuals and entities identified in Sections 1 & 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 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 of Provider 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.
The form can be faxed to (716) 887-8886