



Individual Providers

Disclosure of Ownership, Controlling Interest & Management Statement and Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination

Optum is required to collect disclosure of ownership, controlling interest and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid and/or the Children’s Health Insurance Program (CHIP) managed care program by Optum or by a delegate of Optum, pursuant to a Medicaid and/or CHIP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managing employees, agents and others in a position of influence or authority; and 4) criminal conviction information for the provider, owners, agents and managing employees. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of this Statement is a condition of participation as a credentialed or enrolled provider in the Optum Medicaid or CHIP managed care network for services to members under Medicaid and CHIP benefit plans. Failure to submit the requested information may result in a refusal of participation in the Medicaid or CHIP managed care network or denial of a claim.

This Statement should be submitted at the time of credentialing, enrollment or contracting and updated every three (3) years and at any time there is a revision to the information, or upon a request for updated information. A Statement must be provided to Optum within 35 days of a request for information by the U.S. Department of Health and Human Services (HHS) or the State Agency.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

Individual Provider Information

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will not be processed and will be returned for corrections/completeness. If the form is unreadable due to illegible handwriting, the form will not be processed.

Please choose appropriate category: <input type="checkbox"/> Individual Member of a Medical Group <input type="checkbox"/> Individual Contracted Practitioner <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> HCBS Provider <input type="checkbox"/> Other: _____ Group Affiliation? <input type="checkbox"/> Yes <input type="checkbox"/> No If affiliated with a Group, do you have a Private Practice as well? <input type="checkbox"/> Yes <input type="checkbox"/> No In which state do you participate in Medicaid? _____	Name of Person Completing the Form Title Phone Number Fax Email		
Legal Name of individual (“ Individual Provider ”): _____ Name of Group (if applicable): _____			
Physical Address: STREET _____ CITY _____ STATE _____ ZIP _____			
Additional Addresses (list all Practice locations; attach a separate sheet if necessary): Do you have a list to attach? <input type="checkbox"/> Yes <input type="checkbox"/> No :			
*SSN #: _____	*Medicaid ID #: _____ <input type="checkbox"/> Applied for Medicaid ID <input type="checkbox"/> Not Applicable	*National Provider ID (NPI) #: _____ <input type="checkbox"/> Applied for NPI <input type="checkbox"/> Not Applicable	*CAQH #: _____ <input type="checkbox"/> Applied for CAQH <input type="checkbox"/> Not Applicable
*If billing under an Entity: Federal Tax Identification #: _____		*If billing under an Entity: Billing Entity’s NPI #: _____ <input type="checkbox"/> Applied for NPI <input type="checkbox"/> Not Applicable	
*If billing under an Entity: Billing Entity’s Medicaid ID #: _____ <input type="checkbox"/> Applied for Medicaid ID <input type="checkbox"/> Not Applicable		*If billing under an Entity: Billing Entity’s CAQH#: _____ <input type="checkbox"/> Applied for CAQH <input type="checkbox"/> Not Applicable	

****These fields cannot be left blank; “N/A” non-applicable and “applied for” are acceptable responses.***

Section I: Individual Provider Ownership Information

Are there any individuals or organizations with a Direct or Indirect Ownership Interest of 5% or more in your practice, as an Individual Provider? Yes No

See instructions for more information and examples

If yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104(b)(1)) *Attach additional sheet as necessary* **Do you have a list to attach?** Yes No

Name of Owner	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	** SSN (individual) and/or TIN (entity) <i>List both as applicable</i>	% Interest
		Street City State Zip		
		Street City State Zip		

Section II: Identification of All Individuals & Entities with a Controlling Interest

Officers and Directors: Do you, as an Individual Provider, have any officers or directors? Yes No N/A

Do you have a list to attach? Yes No

If yes, list all officers and directors, including each member of the Board of Directors or Governing Board; include the name, date of birth (DOB), address, and Social Security Number (SSN), and applicable title or position (42 CFR §455.104(b)(1)). *Attach additional sheets as necessary*

Name	DOB (mm/dd/yyyy)	Complete Address(Street/City/State/Zip)	** SSN	Title
		Street City State Zip		
		Street City State Zip		

Are there any other individuals or entities with a Controlling Interest in you, as an Individual Provider (e.g., business partner, etc.)? Yes No N/A

If yes, list the name, address, date of birth (DOB) and Social Security Number (SSN) for each person having a Controlling Interest in the Provider Entity. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having a Controlling Interest. (42 CFR §455.104(b)(1)) *Attach additional sheets as necessary* **Do you have a list to attach?** Yes No

Name of Individual or Entity	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	** SSN (individual) and/or TIN (entity)	Title (as applicable)
		Street City State Zip		

*** SSN and TIN required under §455.104; see Sect 4313 of the Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22*

Section III: Ownership & Controlling Interest in Other Disclosing Entities

Does the Owner *identified in Section I* have an Ownership or Controlling Interest in any Other Disclosing Entity? Yes No N/A

If yes, list the name and the SSN or TIN of the **Other Disclosing Entity** in which the **Owner identified in Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3)) *Attach additional sheet as necessary*

Do you have a list to attach? Yes No

Name of Owner from Section I	Name of Other Disclosing Entity	Other Disclosing Entity's SSN (individual) or TIN (entity)

Section IV: Ownership & Controlling Interest in Subcontractors

Do you, as the Individual Provider, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? Yes No
If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? Yes No
If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104(b)(1)&(2)) *Attach additional sheets as necessary*
Do you have a list to attach? Yes No

Legal Name of Subcontractor	Subcontractor TIN/SSN			
Name of Other Individual/Entity with Ownership or Controlling Interest				
Other Individual/Entity's Complete Address (Street/City/State/ZIP)				
<table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;">City</td> <td style="width:20%; border:none;">State</td> <td style="width:30%; border:none;">Zip</td> </tr> </table>		City	State	Zip
City	State	Zip		
Other Entity's TIN:	Other Individual's SSN:	Other Individual's DOB (mm/dd/yyyy)	% Interest in Subcontractor	

Section V: Familial Relationships

Are any of the individuals identified in Sections I, II, III or IV related to each other? Yes No
If yes, list the individuals identified and the relationship to each other (e.g., spouse, sibling, parent, child)
(42 CFR §455.104(b)(2). *Attach additional sheets as necessary* **Do you have a list to attach?** Yes No

Name of Individual #1:	Name of Individual #2:	Relationship

Section VI: Management & Control

Managing Employees: Do you, as an Individual Provider, have any Managing Employees? Yes No
see Glossary for definition
Do you have a list to attach? Yes No

If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of, your Individual Provider practice (e.g., general manager, business manager, administrator or dept. manager, etc.), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104) *Attach additional sheets as necessary*

Name	DOB <small>(mm/dd/yyyy)</small>	Complete Address (Street/City/State/Zip)	SSN	Title
		Street		
		City State Zip		
		Street		
		City State Zip		

Agents: Do you, as an Individual Provider, have any Agents? Yes No **Do you have a list to attach?** Yes No
see Glossary for definition
If yes, list all Agents that have been delegated the authority to obligate or act on behalf of you, the Individual Provider, (e.g., purchasing agent, broker, etc.) including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104). *Attach additional sheets as necessary*

Name	DOB <small>(mm/dd/yyyy)</small>	Complete Address (Street/City/State/Zip)	SSN
		Street	
		City State Zip	
		Street	
		City State Zip	

Section VII: Criminal Convictions, Sanctions, Exclusions, Debarment or Terminations

1. Have you, the Individual Provider, or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice **ever been convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program since the inception of those programs? Yes No

If yes, list those persons and the required information below. (42 CFR §455.106) *Attach documentation and additional sheets as necessary* **Do you have a documentation to attach?** Yes No

Name		DOB(mm/dd/yyyy)	SSN (individual) or TIN (entity)
Complete Address (Street/City/State/Zip)			
City		State	Zip
Matter of the Offense			
State of Conviction	Date of Conviction (mm/dd/yyyy)	Date of Reinstatement (mm/dd/yyyy)	

2. Have you, the Individual Provider, or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program? Yes No

If yes, list those persons and the required information below. (42 CFR §455.436)

Attach documentation and additional sheets as necessary

Do you have a documentation to attach? Yes No

Name		DOB(mm/dd/yyyy)	SSN (individual) or TIN (entity)
Complete Address (Street/City/State/Zip)			
City		State	Zip
Reason for Sanction, Exclusion or Debarment			
List all States where currently excluded:	Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	Date of Reinstatement (mm/dd/yyyy)	

3. Have you, the Individual Provider, or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been **terminated** from participation Medicaid, Medicare, CHIP or a Title XX program? Yes No

If yes, list those persons and the required information below.

Attach documentation and additional sheets as necessary

Do you have a documentation to attach? Yes No

Name		DOB (mm/dd/yyyy)	SSN(individual) or TIN (entity)
Complete Address (Street/City/State/Zip)			
City		State	Zip
Reason for Termination			
State that originated Termination	Date of Termination (mm/dd/yyyy)	Date of Reinstatement (mm/dd/yyyy)	Medicare billing privileges revoked? Yes_____ No_____

**At any time during the Contract or Credentialing period, it is your responsibility to promptly provide notice of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)*

Section VIII: Business Transaction Information

Business Transactions - Subcontractors: Have you, the Individual Provider, had any business transactions with a Subcontractor totaling more than \$25,000 in the previous twelve (12) month period? Yes No **Do you have a list to attach?** Yes No

If yes, list the information for Subcontractors with whom the Individual Provider has had business transactions totaling more than \$25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) *Attach additional sheets as necessary*

Name of Subcontractor		Subcontractor's SSN (individual) or TIN (entity)	
Subcontractor's Street Address (Street/City/State/Zip)		State	Zip
		City	
Name of Subcontractor's Owner		Subcontractor's Owner's SSN/TIN	
Subcontractor's Owner's Street Address (Street/City/State/Zip)		State	Zip
		City	

Significant Business Transactions – Wholly Owned Suppliers: Have you, the Individual Provider, had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past five (5) year period? Yes No **Do you have a list to attach?** Yes No

If yes, list the information for any Wholly Owned Supplier with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2)) . *Attach additional sheets as necessary. See Glossary for definition.*

Name of Supplier:		Supplier's SSN (individual) or TIN (entity)	
Supplier's Address (Street/City/State/Zip)		State	Zip
		City	

Significant Business Transactions – Subcontractors: Have you, the Individual Provider, had any Significant Business Transactions with a Subcontractor exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past five (5) year period? Yes No **Do you have a list to attach?** Yes No

If yes, list the information for Subcontractor with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2))

Attach additional sheets

Name of Subcontractor		Subcontractor's SSN (individual) or TIN (entity)	
Subcontractor's Street Address (Street/City/State/Zip)		State	Zip
		City	
Name of Subcontractor's Owner		Subcontractor's Owner's SSN/TIN	
Subcontractor's Owner's Street Address (Street/City/State/Zip)		State	Zip
		City	

This information must be provided and/or updated within 35 days of a request.

Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received. (42 CFR §455.105)

Through signature below, I hereby certify that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation and denial of claims. **Individual Provider must sign the form.**

Signature (Individual Provider *must* sign form)

Full Name (please print)

Date

Phone Number

Fax Number

Email Address

Instructions for Disclosure of Ownership/Controlling Interest and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Individual Provider Ownership Information:

Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more in your entity. If the owner is a corporation: the primary business address must be listed and every business location and P.O. Box address.

Section II: Identification of All Individuals & Entities with a Controlling Interest:

Please list the required information for each individual or organization that has a Controlling Interest in your individual practice. Individuals with a Controlling Interest include officers and directors of a governing board, as well as business partners (see Glossary for definition).

You would answer "Yes" if an individual or entity had an ownership or controlling interest in your practice of medicine outside of your membership or employment in a medical group. For example, if a spouse has a legal right of 5% or more ownership or control in any Medicaid or Medicare billing that you as an Individual Provider submits outside of a medical group's billing.

Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Section III: Ownership & Controlling Interest in Other Disclosing Entities:

Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Sections I & II that have an Ownership or Controlling Interest in your individual practice. This information is to identify shared and interconnected ownership and controlling interests.

For example, if you answered "Yes" in Section I for a partner or spouse, then this section may apply to that partner or spouse ownership interest in other providers.

Section IV: Ownership & Controlling Interest in Subcontractors:

If you have a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners. For example, if you hired anyone to do purchasing or if you contract with an entity/person to lease space, etc.

Section V: Familial Relationships:

Report whether any of the persons listed in Sections I, II, III or IV are related to each other and identify the parties and their relationship.

Section VI: Management & Control:

1. List the required information for anyone who holds a position of Managing Employee within your individual private practice.
2. List the required information for all Agents that have the authority to act on your behalf.

Section VII: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:

List your own criminal convictions, exclusions, sanctions, debarments and terminations, and for any person who has an Ownership or Controlling Interest, or is an Agent or Managing Employee of your individual private practice. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information.

Section VIII: Business Transaction Information:

1. List the Ownership of any Subcontractors that you, as an Individual Provider, have had business transactions totaling more than \$25,000 within the last twelve (12) month period ending on the date of the request.
2. List any Significant Business Transaction between yourself and any Wholly Owned Supplier during the past 5 years.
3. List any Significant Business Transaction between yourself and any Subcontractor during the past 5 years.

Do not list transactions that are managed by a medical group or independent provider association (IPA); only list your own individual practice business transactions, if applicable. This information must be available within 35 days of a request by the U.S. Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

GLOSSARY

Individual Provider: a healthcare practitioner who is solely contracted with Optum or is a member of a group or facility contracted with Optum and who is licensed or certified by the state in which he/she delivers services and is credentialed and/or enrolled as a Medicaid or CHIP participating provider.

HCBS Provider: an Individual Provider as defined above, who provides Home and Community Based Services for Medicaid beneficiaries.

Ownership or Control Interest: an individual or corporation that—

- (a) Has an ownership interest totaling 5 percent or more in the Individual Provider's practice (disclosing entity);
- (b) Has an indirect ownership interest equal to 5 percent or more in the Individual Provider's practice (disclosing entity);
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in the Individual Provider's practice (disclosing entity);
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the Individual Provider's practice (disclosing entity);
- (e) Is an officer or director of a the Individual Provider's practice (disclosing entity) that is organized as a corporation; or
- (f) Is a partner in the Individual Provider's practice (disclosing entity) that is organized as a partnership.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the Individual Provider's practice (disclosing entity).

Indirect Ownership Interest: an ownership interest in an entity that has an ownership interest in the Individual Provider's practice (disclosing entity). This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Controlling Interest: defined as the operational direction or management of the Individual Provider's practice (disclosing entity) which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control percentages :(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Other Disclosing Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes:

- (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XV III);
- (b) Any Medicare intermediary or carrier; and
- (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand (\$25,000) or five percent (5 %) of the Individual Provider's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which the Individual Provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Individual Provider or by a person(s) or other entity with an ownership or control interest in the Individual Provider's practice.

Agent: any person who has been delegated the authority to obligate or act on behalf of the Individual Provider.

Managing Employee: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.