United Healthcare Community Plan

Individual Providers

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

UnitedHealthcare Community Plan ("UnitedHealthcare") 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 UnitedHealthcare or by a delegate of UnitedHealthcare, 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).

Providers participating in UnitedHealthcare's Medicaid and/or CHIP managed care networks must complete and submit the disclosure statement below in accordance with the terms of their participation agreement and as a condition of participation in Medicaid and/or CHIP. Failure to submit the requested information may result in claims denials, exclusion from UnitedHealthcare's network, or termination of an existing provider agreement.

This statement should be submitted with the initial contract and updated:

- Every three (3) years
- Upon renewal of the participation agreement
- At any time there is a revision to the information
- Within 35 days of a request for updated information.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form.

Tips to Avoid Delays in Processing Your Disclosure Form

- ✓ **For any question answered with a "Yes" response, please fill out all subsequent fields.**
- ✓ **Every field must have a response. "N/A", "non-applicable" and "applied for" are acceptable.**
- ✓ **If fields are left blank, the form will be returned for corrections/completeness.**
- ✓ **If the form is unreadable due to illegible handwriting, the form will not be processed.**
- ✓ **All attachments must indicate which section they apply to.**

Individual Provider/Sole Proprietor Information

Type of provider Please choose appropriate category: ◯ Individual Member of a Medical Group ◯ Individual Contracted Practitioner ◯ Sole Proprietor ◯ HCBS Provider ◯ Other: _____ **Group Affiliation?** ◯ **Yes** ◯ **No** **If affiliated with a Group, do you have a Private Practice as well?** ◯ **Yes** ◯ **No** **In which state(s) do you participate in Medicaid and/or CHIP?** _____	**Name of Person Completing the Form** **Title** **Phone Number** **Fax** **Email**
Legal Name:	**DBA Name**:

Practice Address:			
Street	**City**	**State**	**Zip**

Additional Addresses
Do you have additional addresses? ◯ **Yes** ◯ **No**:
If **Yes**, list all practice locations on an attachment labeled "Additional Addresses".
Note: At least one physical location must be listed, either in the chart above or on the attachment.

** **Individual Provider SSN #:**	**Medicaid ID #:**	**Individual Provider NPI #:**
	◯ Applied for Medicaid ID ◯ Not Applicable	◯ Applied for NPI ◯ Not Applicable
Federal Tax Identification #: *Enter SSN if billing with SSN*	**Entity/Group Medicaid ID #:**	**Entity/Group NPI #:**
	◯ Applied for Medicaid ID ◯ Not Applicable	◯ Applied for NPI ◯ Not Applicable

***SSN is required per 42 CFR § 455.104.**

Section I: Ownership Information

Section I, Question 1: List individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of 5% or more in your practice.

Refer to the Glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest

◯ **Yes** There are individual(s) and/or entity(ies) that have a 5% or greater ownership interest.

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))

Sole Proprietors: List the name, primary address, date of birth (DOB) and Social Security Number (SSN) of the Sole Proprietor.

Note: If there is 1 owner, fill out the chart below. If there are 2 or more owners, you **must** attach a list with the required fields labeled "Section I, Question 1". Do you have a list to attach? ◯ **Yes** ◯ **No**

◯ **No** There is no individual or entity that owns 5% or more of this practice.

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

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

Section II, Question 1: Do you have any **Officers or Directors**? ◯ **Yes** ◯ **No** ◯ **N/A**

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)).

Note: If there are 1-2 directors, fill out the chart below. If there are 3 or more directors, you **must** attach a list with the required fields labeled "Section II, Question 1". Do you have a list to attach? ◯ **Yes** ◯ **No**

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

***SSN is required per 42 CFR § 455.104.**

Section II, Question 2: Are there any other individuals or entities with a **Controlling Interest** (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))

Note: If there is 1 individual/entity, fill out the chart below. If there are 2 or more individuals/entities, you **must** attach a list with the required fields labeled "Section II, Question 2". Do you have a list to attach? ◯ **Yes** ◯ **No**

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

Section III: Ownership & Controlling Interest in Other Disclosing Entities

Section III, Question 1: Do any of the individuals or entities *identified in **Section I*** as an owner have an Ownership or Controlling Interest in any **Other Disclosing Entity**? ◯ **Yes** ◯ **No** ◯ **N/A**

Refer to the Glossary and Instructions to determine who should be listed as an Owner in Other Disclosing Entities

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))

Note: If there are 1-2 owners, fill out the chart below. If there are 3 or more owners, you **must** attach a list with the required fields labeled "Section III, Question 1". 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)**

SSN is required per 42 CFR § 455.104.

Section IV: Ownership & Controlling Interest in Subcontractors

Section IV, Question 1:

Do you have a Direct or Indirect Ownership Interest of 5% or more in any **Subcontractor**? ◯ **Yes** ◯ **No**

Refer to the Glossary and Instructions to determine who should be listed as a Subcontractor

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)))

Note: If there is 1 subcontractor, fill out the chart below. If there are 2 or more subcontractors, attach a list with the required fields labeled "Section IV, Question 1". 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)**	**Street** **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

Section V, Question 1: 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)

Note: If there are 1-2 relationships, fill out the chart below. If there are 3 or more relationships, you **must** attach a list with the required fields labeled "Section V, Question 1". Do you have a list to attach? ◯ **Yes** ◯ **No**

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

SSN is required per 42 CFR § 455.104.

Section VI: Management & Control

Section VI, Question 1: Do you have any **Managing Employees** or anyone that exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of your practice (e.g., general manager, business manager, administrator or dept. manager, etc.)? ◯ **Yes** ◯ **No**

All Managing Employees must be listed. Include all Managing Employees' information including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104)

Sole Proprietors: If there are no managing employees, please list the name, date of birth (DOB), address, Social Security Number (SSN) and title of the Sole Proprietor.

Note: If there are 1-3 managing employees, fill out the chart below. If there are 4 or more managing employees, attach a list with the required fields labeled "Section VI, Question 1". Do you have a list to attach? ◯ **Yes** ◯ **No**

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

Section VI, Question 2: Do you have any **Agents**? ◯ **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).

Note: If there is 1 agent, fill out the chart below. If there are 2 or more agents, attach a list with the required fields labeled "Section VI, Question 2". Do you have a list to attach? ◯ **Yes** ◯ **No**

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

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

Section VII, Question 1:

Have you, or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee **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)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VII, Question 1". 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)

Street

City **State** **Zip**

Matter of the Offense

State of Conviction	**Date of Conviction (mm/dd/yyyy)**	**Date of Reinstatement (mm/dd/yyyy)** *Enter N/A if not reinstated

Section VII, Question 2:

Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee 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)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VII, Question 2". Do you have additional documentation to attach? ◯ **Yes** ◯ **No**

Name	**DOB (mm/dd/yyyy)**	**SSN (individual) or TIN (entity)**

Complete Address (Street/City/State/Zip)

Street

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)** *Enter N/A if not reinstated

Section VII, Question 3:

Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee 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.

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VII, Question 2". 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)

Street

City **State** **Zip**

Reason for Termination

State that originated Termination	**Date of Termination (mm/dd/yyyy)**	**Date of Reinstatement (mm/dd/yyyy)** *Enter N/A if not reinstated	**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

Section VIII is not required at the time of supplying this form but may be required upon request of CMS. By signing this form, you are acknowledging that you will supply the following information within 35 days if requested by the Secretary of Health and Human Services or the Medicaid agency.

Section VIII, Question 1: Business Transactions – Subcontractors

List the information for Subcontractors with whom you have 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)). *See Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

Section VIII, Question 2: Significant Business Transactions – Wholly Owned Suppliers

List the information for any Wholly Owned Supplier with whom you have 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)). *See Glossary for definition*.

- Name of Supplier, Supplier's SSN (individual) or TIN (entity), and Supplier's Address

Section VIII, Question 3: Significant Business Transactions – Subcontractors

List the information for Subcontractor with whom you have 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)). *See Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

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 Providers must sign the form**.

**Signature must be a wet signature or an e-signature from a state-approved source (ex. Adobe Sign)*
**If fields are left blank, the form will be returned for corrections/completeness.*

Signature (Individual Provider *must* sign form)	Title
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. Date of Birth and SSN* must be included for each individual owner.

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*). Date of Birth and SSN* must be included for each individual with controlling interest.

Answer "Yes" to this section 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.

Section III: Ownership & Controlling Interest in Other Disclosing Entities:
If any of the individuals or entities listed in Section I and/or Section II as having ownership or controlling interest in your individual practice also have ownership or controlling interest of 5% or more in any other entities, identify those entities in Section III. This information is to identify shared and interconnected ownership and controlling interests.

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.

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. Relationships must be disclosed if the parties are spouses, parent/child, or siblings.

Section VI: Management & Control:
1. List the required information for all employees that hold 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.
Date of Birth and SSN* must be included for each Managing Employee and Agent.

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 necessary databases to verify this information.

Section VIII: Business Transaction Information:
The following is not required at this time, but will need to be provided within 35 days of request from the Secretary of Health and Human Services or the Medicaid agency:
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.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year. 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.

GLOSSARY

Individual Provider: a healthcare practitioner who is solely contracted with UnitedHealthcare or is a member of a group or facility contracted with UnitedHealthcare 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*** who provides Home and Community Based Services for Medicaid beneficiaries.

Direct Ownership Interest: an individual or entity that possesses equity in the capital, the stock, or the profits of the Individual Provider's practice (disclosing entity). Ownership Interest also includes an interest in any mortgage, deed of trust, note, or other obligations (42 CFR §455.101).
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 (42 CFR §455.102).

***Indirect Ownership Interest*:** an individual or entity that has an ownership interest in an entity that has an ownership interest in the Individual Provider's practice (disclosing entity) (42 CFR §455.101).
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 (42 CFR §455.102).

***Controlling Interest*:** An individual or entity that has: (1) An officer or director of a disclosing entity that is organized as a corporation; or (2) A partner in a disclosing entity that is organized as a partnership (42 CFR §455.101)

***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 (42 CFR §455.101).

***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 (42 CFR §455.101).

***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 (42 CFR §455.101).

***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) (42 CFR §455.101).

***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 (42 CFR §455.101).

***Agent*:** any person who has been delegated the authority to obligate or act on behalf of the Individual Provider (42 CFR §455.101).

***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 (42 CFR §455.101).