PLAN DE SALUD MENONITA

PROVIDER network solutions PUERTO RICO

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF AUTHORIZATION, OWNERSHIPAND CONTROL INTEREST

(42 CFR 455.101-455.106; 42 CFR 420.201-420.206)

According to the Code of Federal Regulations title 42, part 455, sections 101-106 AND part 420, sections 201-206, all providers enrolling with Medicaid and Medicare Advantage programs must complete a Provider Disclosure

Statement. The definitions below are designed to clarify certain questions on the Disclosure form. If you cannot report all the necessary information in a designated section of the form because of space limitations, please provide the information on a separate paper. Definitions Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

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, XVIII, 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 XVIII);

(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 theAct.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Individual practitioner means a physician or other licensed or certified under State law to practice his or her profession.

Managing employee means 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.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity. Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totalling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a 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 disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity 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 (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

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Billing Provider Full Name:	
Billing Provider NPI:	
Billing Provider Tax ID:	
Billing Provider PRMMIS:	

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST INFORMATION (42 CFR 455.101-455.106; 42 CFR 420.201-420.206) According to the Code of Federal Regulations title 42, part 455, sections 101-106 AND part 420, sections 201-206, all providers enrolling with Medicaid and Medicare Advantage programs must complete a Provider Disclosure Statement. **ALL PROVIDERS MUST COMPLETE THIS SECTION.**

Questions 1 -3 to be answered by all providers

1. Has the provider, or any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider ever been suspended, excluded, or debarred related to the person's involvement in any program under Medicare, Medicaid, or the Title XX program or convicted of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX program? If yes, list the name(s) of person(s). (42 CFR 455.106) (Should be verified through appropriate HHS-EPLS-OIG website)	☐ Yes ☐ No

NAME	TITLE	ADDRESS	DESCRIPTION
A.			
B.			
C.			

2. Has the provider had business transactions with any subcontractor totaling more than $25,000 during the preceding 12- month period? If yes, give the information below for each subcontractor. (42 CFR 455.105). If response is NO, continue to question #3.	☐ Yes ☐ No

NAME	ADDRESS
A.	
B.	
C.	

2A. Provide the name and address of all persons with an ownership or control interest in each subcontractor named in question #2. NOTE: Designate relationship to subcontractor listed above by using A., B., C., etc. (42 CFR 455.105).	☐ N/A

NAME	ADDRESS
A.	
B.	
C.	

3. Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five-year period? If yes, give the information below for each wholly owned supplier or subcontractor. (42 CFR 455.105)	☐ Yes ☐ No

NAME	ADDRESS	DESCRIPTION OF BUSINESSTRANSACTION
A.		
B.		
C.		

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Questions 4 – 6 to be answered by fiscal agents and by all providers EXCEPT individual practitioners	
Provide the name and address of each person with an ownership or control interest in the provider/fiscal agent or in any subcontractor in which the provider/fiscal agent has direct or indirect ownership of five percent or more. (42 CFR 455.104)	
NAME	ADDRESS
A.	
B.	
C.	
D.	

Is any person named in question #4 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). NOTE: Designate relationship to each person listed in question #4 by using A., B., C., etc. (42 CFR 455.104)	☐ Yes ☐ No
NAME	RELATIONSHIP
A.	
B.	
C.	
D.	

Does any person named in question #4 have an ownership or control interest in any other Medicaid provider or in 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, XVIII, or XX of the Act? If yes, give the name(s) of and address(es) of the Medicaid provider or entity. NOTE: Designate relationship to each person listed in question #4 by using A., B., C., etc. (42 CFR 455.104)	☐ Yes ☐ No
NAME	ADDRESS
A.	
B.	
C.	
D.	

Whoever knowingly and willfully makes or causes to be made a false statement or representation of 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.

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BILLING INFORMATION- This section captures information on PERSON (INDIVIDUAL) OR BILLING AGENCY that submits claims on behalf of provider. A Person (individual) or billing agency is a company or individual that you contract with to prepare and submit your claims. Ultimately, you are responsible for the claims submitted on your behalf.

BILLING PERSON OR AGENCY NAME AND ADDRESS

Check One: Individual (Employee) in Office | Individual not in office | Billing Agency

BILLING AGENCYINFORMATION

Legal Business Name (as Reported to Internal Revenue-Hacienda)	Doing Business As (DBA) name (If applicable)

Billing Agency Address (Street Name and Address)	Tax ID Number or Social Security Number (required)	E-mail Address (If Applicable)

Telephone Number	Fax Number (If Applicable)	City	State	Zip Code

IF INDIVIDUAL IN OFFICE OR NOT INOFFICE:

Full Name and Title of Individual (include both paternal and maternal Last names):	Date of Birth:	Telephone Number:	Fax Number:

Address (Street Name and Address)	City	State	Zip Code

EMPLOYEES INFORMATION (For additional employees, make copies of section 1D, complete and submit information)

Employee Roster must include first name and two last names for all Managing Employees, which means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the institution, organization or agency ether under contract or through some other arrangement.

NAME (Father's Last Name, Mother's Last Name, First Name, MI)	Title	Professional License #	Professional License Exp. Date (If applicable)

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AUTHORIZATION AND RELEASE OF INFORMATION

An Authorized Official means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll, to make changes or updates to the organization's status in the Federal, State and/or local programs, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Federal, State and/or local programs.

A Delegated Official means an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a) (3) of the Social Security Act), or be a W-2 managing employee of, the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's status. The provider can have as many authorized officials as it wants. If the provider has more than two authorized officials, it should copy and complete this section as needed.

By his/her signature(s), an authorized official binds the provider and agrees that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Application (hereinafter , each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity") and any of the Entity's affiliated entities, he/she is required to provide sufficient and accurate information for a proper evaluation of the provider's current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

By his/her signature(s), an authorized official binds the provider and acknowledges that each Entity has its own criteria for acceptance, and the provider may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information does not guarantee that any Entity will grant the provider clinical privileges or contract as a provider of services. I understand that the provider's application for participation with the Entity is not an application for employment with the Entity and that acceptance of application by the Entity will not result in the provider's employment by the Entity.

Authorization of investigation concerning application for participation. By his/her signature(s), an authorized official binds the provider and authorizes the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agents; the entity's affiliated entities and their representatives, employees and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements records, and documents, concerning my application for participation. The provider agrees to allow the Entity and/or its agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of third-party sources to release information concerning application for participation. By his/her signature(s), an authorized official binds the provider and authorizes any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, Junta de Licenciamiento y Disciplina Médica de Puerto Rico, Office of Personnel Management (OPM), and the Office of the Inspector General (OIG), to release to the Entity and/or its agent(s), information, including otherwise privileged or confidential information, concerning the provider's professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on the provider's qualifications for participation in, or with, the Entity. I authorize the provider's current and past professional liability carrier(s) to release history of claims that have been made and/or are currently pending against the provider. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of release and exchange of disciplinary information. By his/her signature(s), an authorized official binds the provider and hereby further authorizes any third party at which the provider's currently have participation or had participation and/or each party's agents to release "Disciplinary Information" as defined below, to the Entity and/or its agent(s). I hereby further authorize the agent(s) to release disciplinary information about any disciplinary action taken against the provider to its participating entities at which the provider has participation, and as may be otherwise required by law. As used herein, 'Disciplinary Action" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my participation or impose a corrective action plan; (ii) any other disciplinary action involving the provider, including, but not limited to, discipline in the employment context; or (iii) the provider's resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after the provider have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from liability. By his/her signature(s), an authorized official binds the provider and releases from all liability and hold harmless any Entity, its agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. The provider further agrees not to sue any entity, any agent(s), or any other third party for their acts, defamation or any other claims based on

statements made in good faith and without malice or misconduct of such entity, agent(s) or third party in connection with the credentialing process, This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the entity, its agent(s) and/or other third party include their respective employees, directors, officers, advisors, counsel and agents. The entity or any of its affiliates or agents retain the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which the provider is an applicant for participation at an entity, a member of an entity's medical or health care staff, or a participating provider of an entity. The provider agrees to execute another form of consent if law or regulation limits the application of this irrevocable authorization. The provider understands that failure to promptly provide another consent may be grounds for termination or discipline by the entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the entity, or grounds for my termination of participation at or with the entity. The provider agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the entity and /or its agent(s) within 30 days of any material changes to the information (including any changes/ challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of participation by the entity of the provider, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of participation; and/or immediate suspension or termination of participation or be subject to applicable state or federal penalties for perjury of the provider. This action may be disclosed to the entity and/or its agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I agree to abide by its terms, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Identify Official Signature: ▪ Authorized Official ▪ Delegated Official			
First Name	Middle Initial	Last Name	Suffix (e.g. Jr. Sr.)
Title		Position:	
Vendor NPI:		Telephone:	
Signature:		Date Signed (mm/dd/yyyy):	