UnitedHealthcare 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 of 5% or greater; 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 UnitedHealthcare Community Plan 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 UnitedHealthcare 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: ◉ **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 do you participate in Medicaid?** -select one-	**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 -select one- ZIP

Additional Addresses (list all Practice locations – attach a separate sheet if necessary): Do you have a list to attach? ○ **Yes** ○ **No**:

*SSN #:	○ Medicaid ID #: ○ Applied for Medicaid ID ○ Not Applicable	○ *National Provider ID (NPI) #: ○ Applied for NPI ○ Not Applicable	○ CAQH #: ○ Applied for CAQH ○ Not Applicable
*If billing under an Entity: Federal Tax Identification #:		○ *If billing under an Entity: Billing Entity's NPI #: ○ Applied for NPI ○ Not Applicable	
○ *If billing under an Entity: Billing Entity's Medicaid ID #: ○ Applied for Medicaid ID ○ Not Applicable		○ *If billing under an Entity: Billing Entity's CAQH#: ○ Applied for CAQH ○ 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) *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)** *List both as applicable*	**% Interest**
		Street **City** **State** -select one- **Zip**		
		Street **City** **State** -select one- **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 II: Ownership in Other Providers & Entities

Does the Owner *identified in* ***Section I*** have an Ownership or Controlling Interest in *any other* provider or entity? ◯ **Yes** ◯ **No**

If yes, list the name and the SSN or TIN of the **other provider or 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 Provider or Entity***	**Other Provider or Entity's SSN (individual) or TIN (entity)**

Section III: Subcontractor Ownership

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) *Attach additional sheets as necessary*

Do you have a list to attach? ◯ Yes ◯ No

Legal Name of Subcontractor			
Name of Subcontractor's *Other Owner*			
***Other Owner's* Complete Address (Street/City/State/ZIP)** **City** **State** -select one- **Zip**			
***Other Owner's* TIN:**	***Other Owner's* SSN:**	***Other Owner's* DOB (mm/dd/yyyy)**	**% Interest in Subcontractor**

Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Sections I, II or III 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 Owner 1:	**Name of Owner 2:**	**Relationship**

Section V: 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** -select one- **Zip**

Matter of the Offense

State of Conviction	**Date of Conviction (mm/dd/yyyy)**	**Date of Reinstatement (mm/dd/yyyy)**
-select one-		

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** -select one- **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** -select one- **Zip**

Reason for Termination

State that originated Termination	**Date of Termination (mm/dd/yyyy)**	**Date of Reinstatement (mm/dd/yyyy)**	**Terminated from Medicare?**
-select one-			**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 VI: 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) **City** **State** -select one- **Zip**	
Name of Subcontractor's Owner	**Subcontractor's Owner's SSN/TIN**
Subcontractor's Owner's Street Address (Street/City/State/Zip) **City** **State** -select one- **Zip**	

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) **City** **State** -select one- **Zip**	

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) **City** **State** -select one- **Zip**	
Name of Subcontractor's Owner	**Subcontractor's Owner's SSN/TIN**
Subcontractor's Owner's Street Address (Street/City/State/Zip) **City** **State** -select one- **Zip**	

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)

Section VII: Management & Control

Managing Employees: Do you as an Individual Provider have any Managing Employees? ____**Yes** ____**No**
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 (general manager, business manager, administrator or director), 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 (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN	Title
		Street **City** **State** -select one- **Zip**		
		Street **City** **State** -select one- **Zip**		

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

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

Board of Directors: Do you as an Individual Provider have any Directors? ____**Yes** ___**No**_____**N/A**
Do you have a list to attach? ___**Yes**____**No**
If yes, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104). Attach additional sheets as necessary.

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

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 or has a Controlling Interest 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.

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.

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.

Section II: Ownership in Other Providers & Entities:
Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has 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 III: Subcontractor Ownership:
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 IV: Familial Relationships of All Owners:
Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship.

Section V: 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:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at https://oig.hhs.gov/exclusions/index.asp
2. Sanction information is available in the GSA's SAM (System for Award Management) database
3. State specific exclusion/sanction databases may be accessed through the State Agency's website.

Section VI: 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.

Section VII: 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.
3. List the required information for all individuals on the governing board or board of directors if your private practice is organized as a corporation. CMS requires the identification of officers and directors of any entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

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 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 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.