Disclosure of Ownership Addendum for Participation with Humana Health Plans

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Humana

DISCLOSURE OF OWNERSHIP, BUSINESS TRANSACTIONS & EXCLUSIONS STATEMENT FOR PROVIDERS

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering int or renewing a provider agreement to disclose to managed care organizations that contract with the Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **This statement must be completed whether or not you have any information to report.**

OWNERSHIP & CONTROL INTERESTS (42 CFR 455.104)

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you, as a Provider, have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with an "N/A."

	Full Legal Name	Address	% Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

	Full Legal Name	Address	% Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

	Full Name of Business or Organization	Name of Other	Address	SSN or FEIN	% Ownership of Interest
1					
2					
3					

SIGNIFICANT BUSINESS TRANSACTIONS (42 CFR 455.105)

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty five thousand dollars ($25,000.00) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists please indicate this with an "N/A."

	Full Legal Name	Address	SSN or FEIN	% of Owner Interest
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

	Name of Wholly Owned Supplier	Address	SSN or FEIN	Nature of Business Transaction
1				
2				
3				

EXCLUDED INDIVIDUALS OR ENTITIES (42 CFR 455.106)

A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any type of your managing Employees, Agents or Subcontractors who have ever:

Been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and 1128A of the Social Security Act?

☐ Yes ☐ No

Been excluded from participation in Medicare, Medicaid, or other federally funded governmen health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who has been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity and reason for answering "Yes" (i.e. conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act).

	Full Legal name	Address	SSN or FEIN	Reason
1				
2				
3				

ELECTRONIC HEALTH RECORDS

1 Does your office utilize an electronic health records system? (Yes or No) _____

2 If yes, what EHR system are you using? (Vendor Name)_____

Is your current EHR system certified? (Yes or No)_____

3 Does your current EHR meet meaningful use? (Yes or No)_____

What stage is currently being met? (Stage 1-3)_____

4 If no, is your office in the process of implementing EHR? (Yes/No)_____

What is the expected date of implementation? _____

CERTIFICATION AND ATTESTATION

I certify that the information provided herein, is true and accurate. Additions or revisions out the information above will b submitted to the MCO immediately upon change. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Printed Name: _____ Date: _____

Signature: _____ Title: _____

Email address: _____

I attest and certify that I have answered the above application questions truthfully and that information given in o attached to this application is accurate and completed to the best of my knowledge. I understand that, as a cond to making this application, any misrepresentations or misstatements in, or omission of any of these answers, wh intentional or not shall constitute grounds for rejection of my request for participation with Humana/Choice Care.

Printed Name: _____ Date: _____

Signature: _____

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