Humana
Healthy Horizons®
in Indiana

Disclosure of ownership addendum for participation with Humana health plans

Disclosure of ownership, business transactions and exclusions statement for providers

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to managed care organizations (MCOs) that contract with the Medicaid agency: (a) The identity of all owners with a controlling interest of 5% or greater, (b) certain business transactions as described in 42 CFR 455.105 and (c) the identity of any excluded individual or entity with an ownership or controlling 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 and controlling interests (42 CFR 455.104)

A. Please provide the following information for each person with an ownership or controlling 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 "N/A."

Full legal name	Address	Percentage owner	Interest	Social Security number ("SSN") or Federal employee ID number ("FEIN")	Relationship

B. If any person with an ownership or controlling interest listed in Section (A) is related to another person with an ownership or controlling 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 "N/A."

Full legal name	Address	Percentage owner	Interest	SSN or FEIN	Relationship

C. For each person with an ownership or controlling interest listed in subsection IV (A) who also has an ownership or controlling 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 "N/A."

Full name of business or organization	Name of other	Address	SSN or FEIN	Percentage owner interest

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 $25,000.00 during the previous 12-month period ending on the date of this request. If no such ownership exists, please indicate this with "N/A."

Full legal name	Address	SSN or FEIN	Percentage of owner interest

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 5-year period ending on the date of this request. If no such business transactions exist, please indicate this with "N/A."

Name of wholly owned supplier	Address	SSN or FEIN	Nature of business transaction

Excluded individuals or entities (42 CFR 455.106)

A. Are there any persons with an ownership or controlling 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 healthcare programs in accordance with Sections 1128 and 1128A of the Social Security Act of 1935?

☐ Yes ☐ No

Been excluded from participation in Medicare, Medicaid, or other federally funded government healthcare programs in accordance with Sections 1128 or 1128A of the Social Security Act of 1935?

☐ 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 healthcare programs in accordance with Sections 1128 or 1128A of the Social Security Act of 1935?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and Social Security number or Tax Identification Number 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 healthcare programs in accordance with Sections 1128 or 1128A of the Social Security Act of 1935).

Full legal name	Address	SSN or FEIN	Reason

Certification and attestation

I certify that the information provided herein is true and accurate. Additions or revisions to the information above will be 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 or attached to this application is accurate and completed to the best of my knowledge. I understand that, as a condition of making this application, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not, shall constitute grounds for rejection of my request for participation with Humana/ChoiceCare®.

Printed name: _____ Date: _____

Signature: _____