Dear Provider:

Federal law, specifically, 42 CFR 455.101, 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106, requires providers and fiscal agents to disclose information regarding business ownership and control, business transactions (upon request) and criminal convictions to managed care organizations, in this case, CareSource. In addition, collect and maintain a list of all rendering providers of providers enrolled, even if rendering providers are not required to enroll with Indiana Health Coverage Program (IHCP).

Knowingly and willfully failing to accurately disclose the information requested may result in the inability to contract, credential or recredential your group or facility.

Providers must complete the attached document in its entirety. *Should any of the fields not pertain to your agency or business, please indicate this by writing "N/A." However, a copy of your 501(c)(3) must still be submitted.* The information provided will be used for verification and kept confidential. Providers must execute the attached attestation (in addition to being subject to and cooperating with CareSource verification activities) as part of the credentialing and recredentialing process.

Also note that these disclosures must be updated within 35 calendar days after any change in ownership.

If you have any questions, please call Health Partner Services at **1-844-607-2831** and follow the prompts to speak with a representative.

Overview

Please complete all four sections of this form.

501(c)(3) Organizations

Nonprofit providers must provide information for the business entity that owns their Tax Identification Number (TIN).

**Sections C1(A) and C1(B) are not applicable for nonprofits. You would still need to submit a copy of your 501(c)(3).*

Disclosure Information: When completing this schedule to make changes to the list of disclosed individuals, make sure to include the names of all individuals that meet the disclosure requirements, even if the individuals had been previously disclosed. When an update is processed, any previously disclosed individuals that are not shown on the update form will be removed. In other words, the previous list of disclosed individuals will be **replaced** with the updated list of disclosed individuals.

Privacy Policy and Disclosure Notice

This privacy policy and disclosure notice explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs) and Date of Births, may be requested and used in connection with Provider enrollment and the administration of medical assistance programs. Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the program. Any information may also be provided to the Secretary of State, the Department of Justice including the Medicaid Fraud Unit, or other state or local agencies as appropriate, the Internal Revenue Service, U.S. DHHS Centers for Medicare and Medicaid Services or Office of the Inspector General, or other authorized federal authority.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from CareSource or for encounter purposes.

C.1 − Disclosure Information − Individuals and/or Corporations with an Ownership or Control Interest in the Applicant

Section C.1.(A) − Individuals with an Ownership or Control Interest

Please list **all** individuals with an ownership or control interest in the applicant. Include each person's name, address, the individual's date of birth (DOB), and Social Security Number (SSN). Also indicate the title (e.g., chief executive officer, owner, board member) and if an owner, the percent of ownership. **Ensure ownership totals 100%.** Attach additional pages as needed.

* Please refer to *42 CFR 455.101* for the definition of "persons with an ownership or control interest" to ensure that all individuals are included. This should also include officers, directors, or partners as defined in sections *455.101(e)* and *(f)*.

1a. Name of individual			
2a. Address			
3a. Title	4a. % of ownership (if applicable)	5a. Social Security Number	6a. Date of birth
1b. Name of individual			
2b. Address			
3b. Title	4b. % of ownership (if applicable)	5b. Social Security Number	6b. Date of birth
1c. Name of individual			
2c. Address			
3c. Title	4c. % of ownership (if applicable)	5c. Social Security Number	6c. Date of birth
1d. Name of individual			
2d. Address			
3d. Title	4d. % of ownership (if applicable)	5d. Social Security Number	6d. Date of birth
1e. Name of individual			
2e. Address			
3e. Title	4e. % of ownership (if applicable)	5e. Social Security Number	6e. Date of birth
1f. Name of individual			
2f. Address			
3f. Title	4f. % of ownership (if applicable)	5f. Social Security Number	6f. Date of birth

Section C.1.(B) – Corporations with an Ownership or Control Interest

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the primary business address, every business location, and P.O. Box address(es). **Ensure ownership totals 100%.** Attach additional pages if needed.

1a. Name of corporation	2a. % of ownership
3a. Primary business address	4a. TIN
5a. Every business location	6a. P.O. Box address(es)

1b. Name of corporation	2b. % of ownership
3b. Primary business address	4b. TIN
5b. Every business location	6b. P.O. Box address(es)

1c. Name of corporation	2c. % of ownership
3c. Primary business address	4c. TIN
5c. Every business location	6c. P.O. Box address(es)

Section C.1.(C) – Individuals with an ownership or control interest in any other disclosing entity (or fiscal agent or MCE)

Identify any individuals or legal entities listed in question 1 as having an ownership or control interest, who also have an ownership or control interest in any other disclosing entity (or fiscal agent or MCE), and provide the name of each such other disclosing entity. **If there are no individuals or legal entities with such interest, please respond "None."** Attach a separate sheet if additional space is needed.

1a. Name
1b. Other entity name
1c. Other entity address
2a. Name
2b. Other entity name
2c. Other entity address

C.2 − Disclosure Information − Subcontractors

(Attach additional copies of this page if you need space for additional names.)

Subcontractors – Please list all subcontractors in which the applicant has a 5% or more ownership or control interest. Include any subcontractor and their address and Tax Identification Number (TIN). Attach additional pages as needed.

Name of subcontractor	Address	TIN

C.3 − Disclosure Information – Managing Individuals

(Attach additional copies of this page if you need space for additional names.)

Managing Individuals - List ALL agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers must also list their managing individuals.

- An agent is any person who has express or implied authority to obligate or act on behalf of the entity.
- An officer is any person whose position is listed as an officer in the provider's articles of incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing body.
- A director is a member of the provider's board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word director in his or her job title, such as director of operations or departmental director.
- A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day- to-day operations of the provider entity.

1a. Name of individual		
2a. Address		
3a. Title	4a. Social Security Number	5a. Date of birth
1b. Name of individual		
2b. Address		
3b. Title	4b. Social Security Number	5b. Date of birth
1c. Name of individual		
2c. Address		
3c. Title	4c. Social Security Number	5c. Date of birth
1d. Name of individual		
2d. Address		
3d. Title	4d. Social Security Number	5d. Date of birth
1e. Name of individual		
2e. Address		
3e. Title	4e. Social Security Number	5e. Date of birth
1f. Name of individual		
2f. Address		
3f. Title	4f. Social Security Number	5f. Date of birth

C.4 − Disclosure Information − Relationships and Background Information

1. Are any parties listed in C.1 or C.3 related to each other as a spouse, parent, child, or sibling? If "Yes", please list their names and the relationship.

Name of person 1	Name of person 2	Relationship

2. Are any parties listed in C.1 or C.3 related to any individuals with an ownership or control interest in any of the subcontractors listed in C.2? If "Yes", please list their names and the relationship.

Name of person 1	Name of person 2	Relationship

3. Do any of the owners included in C.1. have an ownership or control interest in other organization(s) that would qualify as a disclosing entity?

As defined under 42 CFR 455.101, "other disclosing entity" means 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, 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 the Act.

Whereas "disclosing entity" is limited to Medicaid providers, "other disclosing entity" can include entities that are not enrolled in Medicaid.

Yes No

If yes, please list the name of each owner and the name of the other disclosing entity(ies) in which they have an ownership or control interest. **If the entity is a non-profit organization and does not have any 'owners', please write "N/A." However, you would still need to submit a copy of your 501(c)(3).**

Owner's name	Disclosing entity(ies)

4. Please list any party with an ownership or control interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid, or title XX services programs.

Name of convicted party	Date of conviction

5. Indicate any former agent, officer, director, partner, or managing employee who has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion.

Name of person 1	Name of person 2	Relationship

C.5 − Disclosure Information – Rendering Providers
(Attach additional copies of this page or a roster if you need space for additional names. If so, please list below or attach a roster.)

Rendering providers are defined as those who are performing the service for which a provider bills CareSource or IHCP. This includes those eligible who did not, as well as those who cannot, enroll with the IHCP.

Do you have rendering providers (see definition above) YES ☐ NO ☐

If so, please list below:

1a. Name and title of individual

2a. Address

3a. Specialty	3a. National Provider Identifier (NPI)	4a. Medicaid Number (if applicable)	5a. Date of birth

1b. Name and title of individual

2b. Address

3b. Specialty	3b. National Provider Identifier (NPI)	4b. Medicaid Number (if applicable)	5b. Date of birth

1c. Name and title of individual

2c. Address

3c. Specialty	3c. National Provider Identifier (NPI)	4c. Medicaid Number (if applicable)	5c. Date of birth

1d. Name and title of individual			
2d. Address			
3d. Specialty	3d. National Provider Identifier (NPI)	4d. Medicaid Number (if applicable)	5d. Date of birth

1e. Name and title of individual			
2e. Address			
3e. Specialty	3e. National Provider Identifier (NPI)	4e. Medicaid Number (if applicable)	5e. Date of birth

1f. Name and title of individual			
2f. Address			
3f. Specialty	3f. National Provider Identifier (NPI)	4f. Medicaid Number (if applicable)	5f. Date of birth

4. Please list any party with an ownership or control interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid, or title XX services programs.

Name of convicted party	**Date of conviction**

5. Indicate any former agent, officer, director, partner, or managing employee who has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion.

Name of person 1	**Name of person 2**	**Relationship**

Provider Attestation, Signature, and Date

All providers must complete this section.

Attestation

I certify that the information on this form, and any attached statement that I have provided, has been reviewed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that providing false information on this form or in connection with any claim for payment from CareSource,

which may include state and federal funds, may violate state and federal laws. I agree to inform CareSource or its designee, in writing, within 35 days of any changes or if additional information becomes available.

Provider's signature
Signature and date stamps, or the signature of anyone other than the provider, or in the case of a legal entity, person legally authorized to sign on behalf of the entity are not acceptable.

Name of Provider or Authorized Representative	Title
Signature	Date