Directions:

In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100- 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program or any line of business that provides healthcare for federal employees. The Centers for Medicaid and Medicare Services (CMS) requires Beacon Health Options, Inc. to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal and state health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.

Please complete the following 2 pages below and fax the completed forms to: **866-612-7795.** This form is required if you wish to participate or continue to participate in the plan. You are also reminded that any changes to this information in the future must be reported to Beacon Health Options, Inc. within 35 business days of the change and updated information will be requested upon recredentialing. Please provide information for Owners, persons with Control interests, Agents and Managing employees of the Provider Entity. Attach a separate sheet/report if needed.

Definitions:

Provider Entity: Any individual or entity engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation.

Master List: The list of owners the provider will be disclosing on form.
- All owners on the master list, must include their Home Address, SSN, DOB, % of Ownership
- If any owners are a Non-Profit agency please indicate the following:
    - Name of Entity
    - Owner DOB & Owner SSN leave Blank.
    - N/A in the % of Ownership column,
    - Check YES in the Non-Profit column.
    - Business address of Entity

Owner: is a person or business entity which owns 5% or more of the assets, stock or profits of the Provider Entity.
- This 5% may be Direct ownership or Indirect ownership i.e., an individual might own 50% of a company that owns the actual Provider Entity meaning their indirect ownership is 50%.
- In addition to ownership of stock, (2) Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Provider Entity.

Control Interest is someone who directs the Provider Entity and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership.

Managing Employee is someone who makes the day to day decisions for the Provider Entity. These individuals include office or billing managers for smaller providers, and for larger Provider Entities the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

Debarred or Excluded means an individual or entity that is not allowed to do business with the Federal government, including healthcare programs receiving Federal funding or reimbursement.

Terminated means the Provider lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

Immediate Family is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. Member of Household is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Agent is an individual who has the legal ability to bind the Provider Entity, i.e., the Provider Entity may use an Agent to obtain contracts for it.

Subcontractor is a person or company that this Provider Entity has contracted with to do some of the Provider Entities' management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

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

I. Identifying Information

____
Name of Person Completing Form

____
Phone Number of Person Completing Form

____
Provider's Name

Provider Entity Information:

____
Name of Entity

____
Entity DBA (If Different from Entity Name)

____
Entity Tax ID

____
Entity NPI Number

____
Practice Address Line 1

____
Practice Address Line 2

____
City

____
State

______
ZIP

II. OWNER OR CONTROL INFORMATION *(If more than 4 owners, please submit make copies of this page)*

A. Master List:

Owners must have minimum of 5% ownership to be considered part of the Master List. Totals of Master list must equal 100%, unless the agency is Non-Profit.

OWNER NAME	OWNER DOB		OWNER SSN		% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

OWNER NAME	OWNER DOB		OWNER SSN		% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

OWNER NAME	OWNER DOB		OWNER SSN		% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

OWNER NAME	OWNER DOB		OWNER SSN		% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

B. Specific Questions

1. Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐

NAME OF FIRST RELATED PERSON	NAME OF SECOND RELATED PERSON	TYPE OF RELATIONSHIP

2. Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**? ? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐

NAME OF OTHER PROVIDER ENTITY	ADDRESS	CITY	STATE	ZIP	TAX ID

3. Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Tricare or the CHIP services program since the inception of those programs?
Yes ☐ No ☐

NAME ON COURT RECORDS	SSN/TIN	MATTER OF OFFENSE	CONVICTION DATE	EXCLUSION PERIOD (IF APPLICABLE)

4. Have any of the individuals or entities on the **Master List** ever been **Debarred or Excluded** from participation in Federal Government contracts (Medicaid, Medicare, CHIP or Tricare)?
Yes ☐ No ☐

WHEN WERE YOU DEBARRED	LENGTH OF DEBARMENT	REASON FOR DEBARMENT

5. Has any person or entity on the **Master List** ever been **Terminated or had Civil Monetary Penalties** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?
Yes ☐ No ☐

PRACTICING STATE WHEN TERMINATED	REASON FOR TERMINATION	DATE OF TERMINATION

6. Did anyone on the **Master List** obtain their **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from participation in a federal healthcare program and 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's household, at the time of the transfer of ownership? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐

NAME OF ORIGINAL OWNER	SSN OR TAX ID OF ORIGINAL OWNER	PLACE OF TRANSFER	DATE OF TRANSFER

7. Do you have any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%?
(A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab) If attaching a report, please indicate corresponding columns below
Yes ☐ No ☐

NAME OF SUBCONTRACTOR	ADDRESS	CITY	STATE	ZIP	TAX ID

8. For each **Subcontractor(s)** listed in question 7 above please provide the following information for the individuals with Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary. If attaching a report, please indicate corresponding columns below.

NAME	ADDRESS	CITY	STATE	ZIP	TAX ID	% OF OWNERSHIP	TITLE

9. Is any persons from question 7, in the list above related to any person in the **Master List**? If attaching a report, please indicate corresponding columns below.

NAME OF FIRST RELATED PERSON	NAME OF SECOND RELATED PERSON	TYPE OF RELATIONSHIP

III. BUSINESS TRANSACTIONS

1. Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.7a. in which you have an **Direct or Indirect Ownership interest**. If attaching a report, please indicate corresponding columns below.

NAME	ADDRESS	CITY	STATE	ZIP

2. Does the **Provider Entity** *wholly own* a **Supplier**? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐ If yes, supply the following information about the **Supplier:**

NAME	ADDRESS	CITY	STATE	ZIP	NPI	TAX ID

Answer the following questions by checking '"Yes" or "No'. If any of the questions are answered "Yes," list names and addresses of individuals or corporations and/or provide date and an explanation on a separate sheet of paper:

1. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVRN providers only) Yes ☐ No ☐
2. Has there been a change in ownership or control within the last year? Yes ☐ No ☐
3. Do you anticipate any change of ownership or control within the year? Yes ☐ No ☐
4. Do you anticipate filing for bankruptcy within the year? Yes ☐ No ☐
5. Is this facility, agency, institution or organization operated by a management company, or leased in whole or part by another organization? Yes ☐ No ☐
6. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? Yes ☐ No ☐
7. Is this facility, agency, institution or organization chain affiliated? (If yes, list name, address of Corporation, and EIN) Yes ☐ No ☐
8. If the answer to Question 7 is No, was the facility, agency, institution or organization ever affiliated with a chain? Yes ☐ No ☐
9. (For Facilities Only) Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? Yes ☐ No ☐

IV. Signature

Beacon Health Options, Inc. may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below MUST be the written signature of an individual who can legally bind this Provider Entity;

_____ Name of Entity Owner

_____ Signature of Entity Owner

_____ Title

_____ Date