# AMERIGROUP IOWA, INC. DISCLOSURE FORM FOR PROVIDER ENTITIES

**Directions:** Please answer ALL questions. For any "Yes" response, please provide an explanation or listing as required. If you do not believe a question is applicable to you or your organization/entity, you should answer the question "NA." If you need additional space to respond to a question, please add a separate sheet: Include your entity name on each sheet, identify the question and header for the listing. ***NO QUESTIONS SHOULD BE LEFT BLANK***. One Disclosure Entity Form is required per TIN.

***Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).***

**I. Identifying Information**

| Provider entity name | Provider dba name (if different from provider entity name) | Provider federal Tax ID Number | |
|---|---|---|---|
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| Provider NPI number | Medicaid ID number | Provider telephone number | |
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| Provider address - must include at least one street address (attach a separate sheet if needed). List all practice locations | City | State | ZIP |
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**II. Ownership and Control Information**

Directions: The entity/organization must list all controllers, owners, agents, and managing employees on the Master List. For the purposes of this form these terms are defined as follows:

***Controller*:** includes all directors, trustees and officers of a corporation or partners in a partnership. If the entity is a non-profit or not-for-profit entity, please respond "N/A" to the percentage of ownership question below, but still list all controllers.
***Owner*:** includes any person or business entity that owns 5% or more of the assets, stock or profits of the provider entity either directly or indirectly.
***Agent*:** includes any person or entity that has the authority to obligate the provider to a contract, mortgage or loan that may or may not be secured by the entity's assets.
***Managing employee*:** includes anyone who has the authority to make material business decisions on behalf of the provider entity.

**A. Master List ( Use additional pages if needed utilizing the headers for the table)**

| Full name | Address (Street and/or PO Box) | City | State | ZIP | DOB | SSN for individuals or Tax ID for business entities | Percent of ownership | Title |
|---|---|---|---|---|---|---|---|---|
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**B. Specific questions**

1) Is any person listed in the Master List related to another person on the Master List as a spouse, parent, child or sibling?
   Yes ☐ No ☐ **If "Yes", please provide the following information about the related persons. If "No", go to the next question.**

| Full name of first-related person | Full name of second-related person | Type of relation |
|---|---|---|
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2) Does any person or entity listed in the Master List have an ownership or control interest in any other provider entity?
Yes ☐ No ☐
**If "Yes", please provide the following information about the other <u>provider entity</u> the person on the Master List has an interest in.**
**If "No", go to the next question.**

| Name of other provider entity | Address | City | State | ZIP | Tax ID |
|---|---|---|---|---|---|
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3) Has any person or entity listed in the Master list been convicted of a criminal offense related to that person or entity's involvement in any program under Medicare, Medicaid, TRICARE or the CHIP services program since the inception of those programs?
Yes ☐ No ☐ **If "Yes", please provide the following information. If "No", go to the next question.**

| Name on court records | SSN/DOB | Matter of the offense | Date of the conviction | Exclusion period of the offense, if excluded by the federal Office of the Inspector General(OIG) |
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4) Has any person or entity listed in the Master List ever been **<u>debarred</u>** from participation in federal government contracts? **<u>Debarred</u>** means an individual is prohibited from participation in contracts paid for by the federal government, whether or not those contracts are in the health care area.
Yes ☐ No ☐ **If "Yes", please provide the following information. If "No", go to the next question.**

| Date of debarment | Length of debarment | Reason for debarment |
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5) Has any person or entity listed in the Master List ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past. **Excluded** means a provider or entity has been notified by the Department of Health and Human Services, Office of the Inspector General (HHS, OIG) that they are prohibited from participating as a provider in any federally funded health care program.

Yes ☐ No☐ **If "Yes", please provide the following information. If "No", go to the next question.**

| Full name of individual or entity | Beginning date of exclusion or termination | End date of exclusion or termination | Reason for exclusion or termination |
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6) Has any person or entity listed in the Master List ever been **terminated** from a state's Medicaid or CHIP program for reasons having to do with program integrity (fraud or abuse)? **Terminated** means the provider lost the right to bill a state's Medicaid and/or CHIP programs for a cause related to fraud or abuse.

Yes ☐ No☐ **If "Yes", please provide the following information. If "No", go to the next question.**

| Full name of provider | State of practice when terminated | Reason for termination | Date of termination |
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7) Has any person or entity listed in the Master List ever had **civil monetary penalties** ("CMP") assessed against them? A **CMP** is a type of fine assessed against a provider by a governmental agency that manages a federal health care program.

Yes ☐ No☐ **If "Yes", please provide the following information. If "No", go to the next question.**

| Full name of individual or entity | State of practice when CMP assessed | Reason for CMP | Amount of CMP | Date of CMP |
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8) Has any person listed in the Master List obtained an ownership interest in a provider entity: 1) As a result of a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal health care program, or was in fact excluded or terminated from participation in a federal health care program, 2), where the original owner is or was a member of the current owner's immediate family or member of the current owner's household at the time of the transfer of ownership? (**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** means, 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 renter or boarder is not considered a member of the household.)

Yes ☐ No ☐ **If "Yes", please provide the following information. If "No", go to the next question.**

| Full name of original **owner** | SSN or TAX ID of original **owner** | Place of transfer | Date of transfer |
|---|---|---|---|
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9) Does any person or entity listed in the Master List have a direct or indirect ownership interest of at least 5 percent in a **subcontractor** of the provider entity? A **subcontractor** is a person or company that the provider entity has contracted with to provide some of the provider entities' management functions (i.e., billing agent, or provide medical services—such as, a medical lab).

Yes ☐ No ☐ **If "Yes", please list each Subcontractor. If "No", go to Section III.**

| Full Name of subcontractor | Address | City | State | ZIP | Tax ID |
|---|---|---|---|---|---|
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9a) For each subcontractor listed in item 9 above, please provide the following information about the individuals with an ownership or control interest in the subcontractor. See the directions for Section II above for a definition of these terms. Attach a separate sheet if necessary.

| Full Name | Address (Street and/or PO Box) | City | State | ZIP | DOB | SSN for individuals or Tax ID for business entities | % of owner-ship | Title |
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9b) Is anyone listed in 9a related to any person in the Master List?

Yes ☐ No☐ **If "Yes", please provide the following information about the related persons. If "No", go to Section III.**

| Full name of first related person | Full name of second related person | Type of relation |
|---|---|---|
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**III. Business transactions**

1) Does the provider entity wholly own a **supplier**? **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).

Yes ☐ No ☐ **If "Yes", please provide the following information. If "No", go to next question.**

| Name | Address | City | State | ZIP | NPI | TIN |
|---|---|---|---|---|---|---|
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**IV. Signature**

The state or federal Medicaid agency 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. The signature below **MUST** be the written signature of an individual who can legally bind this provider.

In compliance with 42 CFR 455.104(c), provider shall complete this disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement, at the time of recredentialing/reenrollment, and within 35 days after any change in ownership by the provider. In compliance with 42 CFR 455.105(b), provider certifies that it will submit within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete subcontractor information as outlined in section III, Business Transactions, above.

| Name of person (printed) | Signature of person | Title | Date |
|---|---|---|---|
| | | | |
| Name of person completing form | | Phone number of person completing form | |
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