AmeriHealth Caritas MI
Disclosure of Ownership and Control Interest Form

Per the Code of Federal Regulations, AmeriHealth Caritas MI is required to obtain a completed Disclosure of Ownership and Control Interest form from our contracted providers and delegates. One form is needs to be completed for each entity that has its own Tax ID number.

1. Respond to all questions. Read the instructions in each shaded box:
   - ✓ If standard applies, complete the fields.
   - ✓ If standard does not apply, please check the box next to N/A.
2. **No questions can be left blank. Please attach a separate sheet if necessary**.
3. Website and email addresses are not acceptable answers to any of the questions.
4. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).
5. Any authorized/designated representative of the provider/disclosing entity may complete and sign this form on behalf of the provider/disclosing entity.
6. This disclosure will be renewed every three (3) years and/or at any time there is a revision to the information or upon a request for updated information.

Practice Information							
Check one that most closely describes you	☐ Individual ☐ Group Practice ☐ Disclosing Entity						
Name of Provider / Disclosing Entity							
Doing Business as Name							
Complete Address	Street 1		Street 2				
	City		State		Zip Code		
Tax Identification Number			NPI Type 1 Number				
			NPI Type 2 Number				
Section 1 – Managing Employee Complete the information below for any managing employees of the Disclosing Entity, if applicable. If not, check here: ☐ N/A							
Complete Name	First		Last				
Social Security #		Tax ID #			DOB		
Complete Address	Street 1		Street 2				
	City		State		Zip Code		
Complete Name	First		Last				
Social Security #		Tax ID #			DOB		
Complete Address	Street 1		Street 2				
	City		State		Zip Code		
Section 2 – Ownership and Control Interests List and individual or corporation with an ownership or control interest of 5% or more in the Disclosing Entity. • For Individuals: List the name, title, home address, date of birth (DOB) and Social Security Number (#), if applicable. • For Entities: List the name, entity Tax Identification Number (Tax ID #), business address of each organization, corporation, or entity if applicable. • If neither apply, check here: ☐ N/A							
Complete Name	First		Last				
Social Security #		Tax ID #			DOB		
Complete Address	Street 1		Street 2				
	City		State		Zip Code		
Complete Name	First		Last				
Social Security #		Tax ID #			DOB		
Complete Address	Street 1		Street 2				
	City		State		Zip Code		

Section 2A – Relationships

Complete this section if any of the individuals in Section 2 are related (e.g., spouse, sibling, parent, child, etc.) to each other, if applicable. If not, check here: ☐ N/A

Complete Name		Relationship	
Complete Name		Relationship	

Section 3 – Subcontractors

Complete this section if any of the individuals in Section 2 are related (e.g., spouse, sibling, parent, child, etc.) to each other, if applicable. If not, check here: ☐ N/A

Name of subcontractor		Name of subcontractor	

Section 3A – Subcontractors

Complete for any person with an ownership or control interest in any subcontractor in section 3. Also indicate if related to anyone in section 2 (e.g., spouse, sibling, parent, child, etc.), if applicable. If not, check here: ☐ N/A

Complete Name	First				Last			
Social Security #			Tax ID #		DOB		% of ownership	
Complete Address	Street 1				Street 2			
	City				State		Zip Code	
Relationship Name Section 2					Relationship			
Complete Name	First				Last			
Social Security #			Tax ID #		DOB		% of ownership	
Complete Address	Street 1				Street 2			
	City				State		Zip Code	
Relationship Name section 2					Relationship			

Section 4 – Other Disclosing Entity (or Fiscal Agent or Managed Care Entity)

Complete the fields below if the Disclosing Entity has an ownership or control interest for any Other Disclosing Entity, if applicable. If not, check here: ☐ N/A

Other Disclosing Entity Name	First				Last			
Social Security #			Tax ID #		DOB		% of ownership	
Complete Address	Street 1				Street 2			
	City				State		Zip Code	
Name of person with ownership or control interest:	First				Last			
Other Disclosing Entity Name	First				Last			
Social Security #			Tax ID #		DOB		% of ownership	
Complete Address	Street 1				Street 2			
	City				State		Zip Code	
Name of person with ownership or control interest:	First				Last			

Section 5 – Business Transactions Disclosures

Indicate if the provider/disclosing entity or part B supplier has any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) months period (12-month period ending as of the date of this request), if applicable. If not, check here: ☐ N/A

Subcontractor Complete Name	First				Last			
Social Security #			Tax ID #		DOB		Transaction amount	
Complete Address	Street 1				Street 2			
	City				State		Zip Code	
Subcontractor Complete Name	First				Last			
Social Security #			Tax ID #		DOB		Transaction amount	
Complete Address	Street 1				Street 2			
	City				State		Zip Code	

Section 5A – Significant Business Transactions Disclosure

Indicate if the provider/disclosing entity or part B supplier had any significant business transactions with a wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending on the date on this request), if applicable.
If not, check here ☐ N/A

Complete Name	First		Last				
☐ Wholly Owned Supplier		☐ Subcontractor			Transaction amount		
Social Security #		Tax ID #		DOB			
Complete Address	Street 1		Street 2				
	City		State			Zip Code	
Complete Name	First		Last				
☐ Wholly Owned Supplier		☐ Subcontractor			Transaction amount		
Social Security #		Tax ID #		DOB			
Complete Address	Street 1		Street 2				
	City		State			Zip Code	

Section 6 – Criminal Offense Disclosure

Identify any person who has ownership or control interest in the provider; or is an agent or managing employee of the provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare and/or Medicaid, or the title XX services program since the inception of those programs, if applicable. If not, check here ☐ N/A

Complete Name	First		Last				
Title							
Social Security #		Tax ID #		DOB			
Complete Address	Street 1		Street 2				
	City		State			Zip Code	
Description of offense(s)							
Complete Name	First		Last				
Title							
Social Security #		Tax ID #		DOB			
Complete Address	Street 1		Street 2				
	City		State			Zip Code	
Description of offense(s)							

Attestation

Through signature below, I certify that the information provided herein is true, accurate and complete. Additions to or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in denial of participation. Individuals and Sole Proprietors must sign their own form. An authorized representative may sign for Partnership, Corporation, LLC or Other disclosing entities.

Provider or Authorized Agent name (please print)		Title (or indicate if Authorized Agent)	
Provider or Authorized Agent signature		Date	