

Please use the following checklist to complete the credentialing process. Current copies of all items listed below are required for the facility to participate with AmeriHealth Caritas VIP Care. Please use this Application Checklist for Facilities as a fax cover sheet. Fax all applicable items on the checklist to Provider Network Management at **1-855-306-9762**, or signed documents may be scanned and submitted by secure email to **michiganprovidernetwork@amerihealthcaritas.com**.

Please ensure this checklist is included with the documents.

Please provide AmeriHealth Caritas VIP Care with the following:

Facility information	
Legal business name:	
Practice name to appear in directory (DBA):	
Facility type:	Taxonomy code:
Practice tax ID number (TIN):	
Group NPI number (Please list all NPI numbers. Attach additional sheet if needed.):	
Credentialing contact name:	
Contact email address:	Contact phone number:

Please provide the following:

- Facility Credentialing Application (completed, signed, and dated)
(Application for new credentialing only. For recredentialing, please complete this checklist and include all below applicable documents.)
- State license (applicable to state requirements)
 - Current state license.
 - Current business permit.
 - Current occupational license.
 - Current medical gases permit.
- Accreditation, certification, or Centers for Medicare & Medicaid Services (CMS) state survey
 - **Note:** Any hospital or ancillary facility that is not accredited or does not have a CMS state survey requires a plan site evaluation.
- Drug Enforcement Administration (DEA) registration certificate (if applicable)
 - DEA must have the state in which the provider is rendering services to our members. DEA registration certificate is not transferable by location.
- Controlled dangerous substance (CDS) license (if applicable)
- Malpractice insurance policy face sheet showing expiration dates and limits of liability
- Clinical Laboratory Improvement Amendments (CLIA) (if applicable)
- Proof you have submitted an application for a Medicaid number if one is not listed above. For applications in process, please submit a copy of the first page and signature page of the application you submitted. (If not certified, provide proof of participation.)
- W-9 form
- Facility office hours, which must be completed on the application
- Dual eligible demonstration compliance attestation or ownership disclosure

To check the status of your application, or if you have any questions or concerns regarding this process, please contact the AmeriHealth Caritas VIP Care Credentialing department at **michiganprovidernetwork@amerihealthcaritas.com**.

If you are new to AmeriHealth Caritas VIP Care and you or your group does not have a provider contract, you must first call your Provider Network Management Account Executive or Provider Services at **1-844-964-4767** to discuss obtaining an AmeriHealth Caritas VIP Care provider agreement.

Facility Credentialing Application

Facility identification

Legal business name (as reported to the Internal Revenue Service [IRS]): _____

Doing business as (DBA) name (if applicable): _____

Health system affiliation (if applicable): _____	Tax identification number (TIN): _____
Length of time in business with this name and tax ID: _____ years _____ months	National Provider Identifier (NPI): _____

Is the provider enrolled in the Community Health Automated Medicaid Processing System (CHAMPS*)? Yes No

If yes, effective date: _____ End date: _____ CHAMPS number: _____

* Per state requirements, effective January 1, 2018, providers must be enrolled in CHAMPS, the Michigan Department of Health and Human Services enrollment system, before enrolling in our network.

Medicare status

Is this facility participating in the Medicare program? Yes No Pending

If yes, provide Medicare number / CMS Certification Number (CCN): _____

Date of Initial CCN: _____

Check here if facility is **not eligible** for CMS certification

Facility information (Please refer to Attachment A for services provided at this location and additional locations.)

Facility name: _____

Address line 1: _____

Address line 2: _____

City: _____	State: _____
ZIP: _____	County: _____
Phone: _____	Fax: _____

Website: _____

Credentialing contact name: _____

Phone: _____	Fax: _____
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Email: _____

Facility administrator name: _____

Phone: _____	Fax: _____
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Email: _____

Office hours (use HH:MM format)

Day	Start	a.m./p.m.	End	a.m./p.m.	Day	Start	a.m./p.m.	End	a.m./p.m.
Monday					Saturday				
Tuesday					Sunday				
Wednesday									
Thursday									
Friday									

Services at this location:

<input type="checkbox"/> Americans with Disabilities Act (ADA) accessibility requirements	<input type="checkbox"/> 24/7 phone coverage
<input type="checkbox"/> Handicap accessibility	<input type="checkbox"/> Answering service

Facility Credentialing Application

Facility type

- | | |
|--|---|
| <input type="checkbox"/> Ambulatory surgical center — freestanding only | <input type="checkbox"/> Home health care agency providing both skilled services and PCA services |
| <input type="checkbox"/> Behavioral health care and social services provider | <input type="checkbox"/> Home health hospice |
| <input type="checkbox"/> Behavioral rehabilitation services provider | <input type="checkbox"/> Home infusion services provider |
| <input type="checkbox"/> Comprehensive outpatient rehabilitation facility (CORF) | <input type="checkbox"/> Hospital (acute care and acute rehabilitation) |
| <input type="checkbox"/> Community mental health center | <input type="checkbox"/> Hospital (psychiatric and geriatric) |
| <input type="checkbox"/> Durable medical equipment supplier | <input type="checkbox"/> Intermediate care facility — mental health |
| <input type="checkbox"/> Diabetic education program | <input type="checkbox"/> Mental health clinic |
| <input type="checkbox"/> Dialysis center | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) clinic | <input type="checkbox"/> Portable X-ray supplier |
| <input type="checkbox"/> Federally qualified health center (FQHC) | <input type="checkbox"/> Rural health clinic (RHC) |
| <input type="checkbox"/> FQHC (behavioral health only) | <input type="checkbox"/> Skilled nursing facility or nursing home |
| <input type="checkbox"/> Freestanding radiology center | <input type="checkbox"/> Skilled nursing facility providing sub-acute services |
| <input type="checkbox"/> Freestanding sleep center or sleep lab | <input type="checkbox"/> Other (please indicate): _____ |
| <input type="checkbox"/> Home health care agency providing skilled services only and no personal care assistant (PCA) services | |

Mailing address

Check here if all correspondence can be directed to the facility location above. If not, complete the section below.

Name:

Address line 1:

Address line 2:

City:

State:

ZIP:

County:

Phone:

Fax:

Email:

Remittance/Billing address

Name:

Address line 1:

Address line 2:

City:

State:

ZIP:

County:

Phone:

Fax:

Email:

Facility Credentialing Application

Health care licensure			Attach a copy of each facility license. Do not submit provider licenses.		
License number	State or city	Licensing agency	Initial issue date	Renewal date	Expiration date

Accreditation Select accrediting agency from the list below and attach a copy of current accreditation certificate. If not accredited, skip checklist and go to the site visit requirements section.	
<input type="checkbox"/> American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF) <input type="checkbox"/> American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) <input type="checkbox"/> Accreditation Association for Ambulatory Health Care (AAAHC) <input type="checkbox"/> American Academy of Sleep Medicine (AASM) <input type="checkbox"/> Accreditation Commission for Health Care (ACHC) <input type="checkbox"/> American College of Radiology (ACR) <input type="checkbox"/> American Osteopathic Association (AOA) <input type="checkbox"/> Board of Certification (BOC) <input type="checkbox"/> The Commission on Accreditation of Birth Centers (CABC)	<input type="checkbox"/> Commission on Accreditation of Rehabilitation Facilities (CARF) <input type="checkbox"/> Continuing Care Accreditation Commission (CCAC) <input type="checkbox"/> Community Health Accreditation Program (CHAP) <input type="checkbox"/> Council on Accreditation (COA) <input type="checkbox"/> Det Norske Veritas Healthcare, Inc. (DNVHC) <input type="checkbox"/> National Integrated Accreditation for Healthcare Organizations (NIAHO) <input type="checkbox"/> The Joint Commission, previously known as JCAHO Date of initial accreditation: _____ Date of last full survey: _____

Site visit requirement Attach a copy of most recent on-site survey for each location (with Corrective Action Plan [CAP], if citations were issued) or attach cover letter from government agency stating facility is in substantial compliance.
1. Has facility had a post-licensing on-site visit by a government agency such as the Department of Health or CMS within the past 36 months? <input type="checkbox"/> Yes — Date of most recent standard survey: _____ <input type="checkbox"/> No — Successful completion of a health plan on-site visit will be required to complete credentialing.
2. Were any deficiencies cited during the last full survey? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A — no recent survey If yes, have all deficiencies been corrected? <input type="checkbox"/> Yes — Provide evidence of state acceptance of your CAP <input type="checkbox"/> No — Provide explanation and your plan to correct all deficiencies If no deficiencies were cited during the last full survey, submit verification of no deficiencies.

Facility Credentialing Application

Provider credentialing

Does the facility validate, for each licensed provider employed or contracted at the facility, the credentials necessary to perform health care services? Yes No

If yes, indicate how the facility conducts the credentialing process for each provider:

Credentialing procedures are performed internally.

Credentialing procedures are outsourced or delegated to: _____

Other, specify: _____

If no, please explain:

Insurance	Both facility general and professional liability insurance is required. Minimum coverage requirement is \$1 million per occurrence and \$3 million aggregate.
General liability coverage	Attach certificate showing policy number, coverage amounts, effective and expiration dates.
Current carrier name:	Policy number:
Street/P.O. box:	City:
State:	ZIP:
Effective date:	Expiration date:
Per incident: \$	Aggregate: \$
Coverage type: <input type="checkbox"/> Occurrence based <input type="checkbox"/> Claims based	
Professional liability coverage	Attach certificate showing policy number, coverage amounts, effective and expiration dates.
Current carrier name:	Policy number:
Street or P.O. box:	City:
State:	ZIP:
Effective date:	Expiration date:
Per incident: \$	Aggregate: \$
Coverage type: <input type="checkbox"/> Occurrence based <input type="checkbox"/> Claims based	

Attachments	Indicate which documents are included with this completed application.
<input type="checkbox"/> Copy of all federal, state, and/or local licenses required to operate as a health care facility <input type="checkbox"/> Copy of facility's general liability insurance certificate <input type="checkbox"/> Copy of professional liability insurance certificate covering all facility employees <input type="checkbox"/> Copy of accreditation certificates <input type="checkbox"/> Copy of CMS letter certifying or recertifying facility can provide partial hospitalization services <input type="checkbox"/> Copy of most recent Department of Health or CMS survey including your CAP, if deficiencies were cited, or cover letter from the Department of Health or CMS stating you are in compliance	

Facility Credentialing Application**Disclosure questions****Answer every question yes or no.****Provide a detailed explanation on a separate sheet for any questions answered yes.**

1. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been convicted of any health care-related criminal offense, had adjudication withheld on any health care-related criminal offense, pleaded no contest to any health care-related criminal offense, or entered into a pre-trial agreement for any health care-related criminal offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had disciplinary action taken against any business or professional license held in this or any other state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had his or her license to practice restricted, reduced, or revoked in this or any other state; or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or entered into a consent order issued by a licensing, certifying, or professional standards board or agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or had any sanction imposed by, a federal or state health care program, or been disbarred from participation in any federal executive branch procurement or non-procurement program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had payments suspended by Medicare or Medicaid in any state under any Medicare or Medicaid billing number?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had civil monetary penalties levied by Medicare, Medicaid, or other state or federal agency or program, even if the fines have been paid in full?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has Medicare or Medicaid in any state ever taken recoupment actions against any entity, agent, owner, or managing employee of the facility, under any current or former name or business identity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Does the facility or any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, owe money to Medicare or Medicaid that has not been paid in full?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care item or service?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Facility Credentialing Application

<p>12. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to the delivery of an item or service under Medicare or state health care program?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>13. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>14. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been found to have violated federal or state laws, rules or regulations in any program established under Medicare, any other state's Medicaid program, Title XX, or any other publicly funded federal or state health care or health insurance program?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Attestation

I certify that the information contained in this application is correct and complete to the best of my knowledge. I hereby authorize AmeriHealth Caritas VIP Care to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to facility status, licensure, accreditation, or operations to AmeriHealth Caritas VIP Care. I authorize and agree that AmeriHealth Caritas VIP Care and its agents, employees, and representatives may provide AmeriHealth Caritas VIP Care's subsidiaries and affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing, or peer review. I release AmeriHealth Caritas VIP Care and its affiliates, agents, employees, and representatives of any liability for furnishing any such information that is provided in good faith and without malice. I authorize AmeriHealth Caritas VIP Care and its applicable subsidiaries and affiliates to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as appropriate.

Authorized signature

Print name

Title

Date

Facility Credentialing Application

ATTACHMENT A: ADDITIONAL LOCATION ADDENDUM

COPY PAGE FOR ADDITIONAL LOCATIONS

(Complete section C only if you are an accredited or deemed behavioral health care provider organization.)

List services by location.

Section A – Demographics (If primary location, please skip to section C.)

Location name: _____

Service site address (no P.O. box):

Billing NPI or atypical number: _____ Medicaid number (if applicable): _____

Remittance address (if different from primary location):

Office hours (use HH:MM format)									
Day	Start	a.m./p.m.	End	a.m./p.m.	Day	Start	a.m./p.m.	End	a.m./p.m.
Monday					Saturday				
Tuesday					Sunday				
Wednesday									
Thursday									
Friday									
Services at this location:									
<input type="checkbox"/> ADA accessibility requirements					<input type="checkbox"/> 24/7 phone coverage				
<input type="checkbox"/> Handicap accessibility					<input type="checkbox"/> Answering service				

Section B – Site visit requirement

(Attach a copy of the most recent on-site survey for each location with CAP.)

1. Has the facility had a post-licensing on-site visit by a government agency such as the Department of Health or CMS within the past 36 months?

Yes — Date of most recent standard survey: _____

No — **Successful completion of a health plan on-site visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? Yes No N/A — no recent survey

If yes, have all deficiencies been corrected?

Yes — Provide evidence of state acceptance of your CAP

No — Provide explanation and your plan to correct all deficiencies

If no deficiencies were cited during the last full survey, **submit verification of no deficiencies.**

Facility Provider Credentialing Application

Section C – Services available at this location (Check all that apply.)

Behavioral health (BH) service type and description (Please indicate service type: mental health [MH], substance use [SU], or both.)							
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	BH day treatment	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Integrated health home
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Behavioral therapy under EPSDT	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Intensive community treatment
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Case management	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Intensive in-home services
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Community-based Residential Level A	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Medication management by psychiatrist
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Community-based Residential Level B	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Multi-systemic therapies
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Crisis intervention	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Neuropsychological testing
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Crisis residential	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Opioid treatment
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Crisis stabilization	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Outpatient psychiatric services
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Day treatment or partial hospitalization services for adults	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Partial hospitalization services
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Developmental disability (DD) case management	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Psychosocial rehabilitation
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Electroconvulsive therapy (ECT)	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Peer support
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Health skill-building services	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Psychological testing
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Individual, group, and family therapy	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Telepsychiatry
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	In-home behavioral therapies (including, but not limited to, applied behavioral analysis [ABA])	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Therapeutic day treatment for children and adolescents
<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Inpatient psychiatric hospital services — freestanding psychiatric hospital	<input type="checkbox"/> MH	<input type="checkbox"/> SU	<input type="checkbox"/> Both	Treatment foster care case management

Substance use disorder services
<input type="checkbox"/> Outpatient substance use disorder services
<input type="checkbox"/> Residential substance use disorder treatment for pregnant and postpartum women
<input type="checkbox"/> Substance use disorder day treatment
<input type="checkbox"/> Substance use disorder day treatment for pregnant and postpartum women
<input type="checkbox"/> Substance use disorder intensive outpatient treatment

Waiver services (please list waiver type and all services)

Mental health	Substance use disorder

Other services

Mental health	Substance use disorder

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 needed 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: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> 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: <input type="checkbox"/> NA		
Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	Date of birth:
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	Date of birth:
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: NA

Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	Date of birth:
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	Date of birth:
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: NA

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: NA

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: NA

Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	Date of birth:
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:



Section 3A – Subcontractors

Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	
Date of birth:	% of ownership:	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Relationship Name Section 2		
Name:	Relationship:	
Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	
Date of birth:	% of ownership	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Relationship Name Section 2		
Name:	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: NA

Other Disclosing Entity Name		
First:	Last:	
Social Security #:	Tax ID #:	
Date of birth:	% 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 #:	
Date of birth:	% 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: NA

Subcontractor Complete Name

First:	Last:
Social Security #:	Tax ID #:
Date of birth:	Transaction amount:

Complete Address:

Street 1:	Street 2:	
City:	State:	ZIP Code:

Subcontractor Complete Name

First:	Last:
Social Security #:	Tax ID #:
Date of birth:	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: NA

Complete Name

First:	Last:
<input type="checkbox"/> Wholly Owned Supplier <input type="checkbox"/> Subcontractor	
Social Security #:	Tax ID #:
Date of birth:	Transaction amount

Complete Address:

Street 1:	Street 2:	
City:	State:	ZIP Code:

Complete Name

First:	Last:
<input type="checkbox"/> Wholly Owned Supplier <input type="checkbox"/> Subcontractor	
Social Security #:	Tax ID #:
Date of birth:	Transaction amount

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: NA

Complete Name:

First:	Last:
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Title:	Social Security #:
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Tax ID #:	Date of birth:
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Complete Address:

Street 1:	Street 2:
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City:	State:	ZIP Code:
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Description of offense(s):

Complete Name:

First:	Last:
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Title:	Social Security #:
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Tax ID #:	Date of birth:
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Complete Address:

Street 1:	Street 2:
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City:	State:	ZIP Code:
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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: