Instructions for Louisiana Medicaid Ownership Disclosure Information
Individual

This is a multi-page form. Please review the instructions in their entirety before completing the form. ***Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.***

Please refer to the web sites listed on the page following these instructions for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Please enter your Provider Name at the top of each page in the space provided.

SECTION I – ENROLLING INDIVIDUAL INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number. If this application is for a new Medicaid provider number, leave this field blank.
NPI Type 1 – Individual – Enter your ten (10) digit Type 1 (Individual) National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
Taxonomy/Tie Breaker, if applicable – Enter your Taxonomy Code or your ZIP+4 Tie Breaker, if applicable.
NPI Type 2 – Organizational, if applicable – Enter your ten (10) digit Type 2 (Organizational) NPI, if necessary.
Tax ID Number (only if self-incorporated) – Enter the nine (9) digit Tax ID number for this self-incorporated provider. If not self-incorporated, leave blank.
Social Security Number of Individual (required) – Enter the social security number of the enrolling individual.
Date of Birth – Enter the date of birth of the enrolling individual in the space provided.
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Re-validation of existing enrollment, or Re-Enrollment.
Provider Type – enter the Louisiana Medicaid Provider Type for the enrolling individual.
Enrolling Individual Provider Information – Enter the following in the spaces provided for the enrolling individual.

- First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable).
- Telephone Number
- Email Address
- Fax Number
- Provider's telephone number to request medical records
- Main Practice Location Address
- Mailing Address/PO Box of Main Practice Location

Is the enrolling individual a U.S. citizen? – Check the appropriate box. If no, provide the Alien Verification number.
Do you practice in any location other than the one listed above? – Check the appropriate box. If yes, provide the following information for each practice location:

- DBA Name of practice location
- Medicaid Provider number
- Second Practice Mailing Address/PO Box
- Second Practice Location Address
- Second Practice Location phone number
- Second Practice Location fax number
- Second Practice Location Email address
- Repeat the information above for third, fourth and fifth practice locations, if applicable. If more practice locations exist, attach additional pages.

SECTION II – ENROLLING INDIVIDUAL ADDITIONAL INFORMATION

Has the enrolling individual listed in Section I ever:

A. **Held a professional license in any state other than Louisiana? –** Check the appropriate box. If yes, list the state(s) and Professional License Numbers in the spaces provided.

B. **Practiced as a Medicare/Medicaid healthcare provider in any state other than Louisiana? –** Check the appropriate box. If yes, list the state(s), Medicare Provider Numbers, and the Medicaid Provider Numbers in the spaces provided. Attach additional pages if needed.

C. **Used or been known by any other name including married, maiden, hyphenated, or alias? –** Check the appropriate box. If yes, enter the names in the spaces provided. Attach additional pages if needed.

D. **Used or been known by any other incorporated or Doing Business As (DBA) names? –** Check the appropriate box. If yes, list all DBA names, Legal Names and Tax IDs in the spaces provided. Attach additional pages if needed.

SECTION III – ENROLLING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE

Has the enrolling individual owner named in Section I (ever) – Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

A. **Is the Social Security Number and/or Tax ID number(s) listed in Section I currently enrolled in any other Federal/State funded healthcare programs? –** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name and address, the Tax ID number/Social Security number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION V – OWNERSHIP OF ENTITIES/BUSINESSES ENROLLED IN FEDERAL/STATE FUNDED HEALTHCARE PROGRAMS

A. **Does the enrolling individual have any direct, indirect or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in a Federal/State funded healthcare program(s)?** – Check the appropriate box. If yes, identify the applicable plan(s) and list the DBA Name(s) and address(es), the Tax ID(s), the Social Security Number(s), % ownership, the location (state) and the Plan Number(s) in the spaces provided.

B. **Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed in item A above?** – Check the appropriate box. If yes, enter the names of each individual, the relationship to the enrolling individual (i.e., spouse, parent, child, sibling), percentage of ownership, date of birth and social security number.

SECTION VI – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

Enter the following in the spaces provided for the preparer of this application.

- First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable)
- Social Security Number
- Date of Birth
- Job Title
- Indicate if the person completing the form is self, staff, third party/independent agent or other. If other, please explain further.
- Physical Location Address
- Telephone Number - indicate the type of telephone number provided: work, home or cell
- Email Address
- Additional Telephone Number
- Additional Email Address

SECTION VII – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

If the enrolling individual is also the owner of the business/entity identified as the Provider Pay-to name and Tax ID in Section B on the form PE-50-I, this section must be completed.

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

A separate VII form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith;* or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. See Federal Regulation 42 CFR § 455.101.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

Section VII Instructions:

A. Does this enrolling individual employ any Agents or Managing employees? – Check the appropriate Box. If yes, make one photocopy of Section VII for each agent or managing employee you report. If no, proceed to Section VIII.

B. AGENT – or – MANAGING EMPLOYEE– Check on a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, telephone number, email address, primary physical location address and additional business location addresses and mailing addresses in the spaces provided. Attach additional sheets if needed.

C. Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? – Check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional sheets if needed.

D. Is this agent or managing employee a U.S. citizen? – Check the appropriate box. If no, provide Alien Verification number.

E. Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business? Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

F. Has the agent or managing employee named above (ever) – Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

G. Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program? Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

Reference Material for
Louisiana Medicaid Ownership Disclosure Information
For an Individual

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:** http://url.ie/ywri

MAPIL Louisiana R.S., Title 46:437.1-14. http://url.ie/yw45

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://url.ie/yw46

Louisiana Update January/February 2009: http://url.ie/yw47

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://tinyurl.com/ne58pwb

Social Security Act 1128 a: http://tinyurl.com/3lnj2z9

Provider Name: _____

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – INDIVIDUAL

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – ENROLLING INDIVIDUAL INFORMATION

Louisiana Medicaid Provider Number **(Leave blank if applying for new number)**								

NPI Type 1 – Individual										
Taxonomy/Tie Breaker (if applicable)										

NPI Type 2 – Organizational **(if applicable)**										

Tax ID Number (only if self-incorporated)									

Social Security # of Individual (required)									

Date of Birth (required) MM/DD/YYYY			/			/				

This enrollment packet is for a ☐ New Enrollment ☐ Re-validation of existing enrollment ☐ Re-Enrollment	**Provider Type:**

A. ENROLLING INDIVIDUAL PROVIDER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Telephone Number of Enrolling Individual ( ) -	Email Address		
Fax Number ( ) -	Provider's telephone number to request medical records ( ) -		
Main Practice Location Address	City	State LA	Zip +4
Mailing Address/PO Box of Main Practice Location	City	State LA	Zip +4

B. ☐ Yes ☐ No Is the enrolling individual a U.S. Citizen? If no, provide Alien Verification # _____

Provider Name: _____

Make a photocopy of this page if more space is needed to list additional locations

C. ☐ Yes ☐ No Do you practice in any location other than the one listed above?

If yes, complete the section below for each location.

DBA Name of second practice location	Medicaid Provider #		
Second Practice Mailing Address/PO Box	City	State LA	Zip +4
Second Practice Location Address	City	State LA	Zip +4
Second Practice Location Phone Number ( ) -	Second Practice Location Fax Number ( ) -		
Second Practice Location Email address			

DBA Name of third practice location	Medicaid Provider #		
Third Practice Mailing Address/PO Box	City	State LA	Zip +4
Third Practice Location Address	City	State LA	Zip +4
Third Practice Location Phone Number ( ) -	Third Practice Location Fax Number ( ) -		
Third Practice Location Email address			

DBA Name of fourth practice location	Medicaid Provider #		
Fourth Practice Mailing Address/PO Box	City	State LA	Zip +4
Fourth Practice Location Address	City	State LA	Zip +4
Fourth Practice Location Phone Number ( ) -	Fourth Practice Location Fax Number ( ) -		
Fourth Practice Location Email address			

DBA Name of fifth practice location	Medicaid Provider #		
Fifth Practice Mailing Address/PO Box	City	State LA	Zip
Fifth Practice Location Address	City	State LA	Zip
Fifth Practice Location Phone Number ( )	Fifth Practice Location Fax Number ( ) -		
Fifth Practice Location Email address			

Provider Name: _____

**Make a photocopy of this page if more space is needed to respond to all items below **

SECTION II – ENROLLING INDIVIDUAL ADDITIONAL INFORMATION

Has the enrolling individual listed in Section I ever:

A. ☐ **Yes** ☐ **No** **Held a professional license in any state other than Louisiana?**

B. ☐ **Yes** ☐ **No** **Practiced as a Medicare/Medicaid healthcare provider in any state other than Louisiana?**

If yes to either item A or B, complete the section below.

Domicile Sta1te:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:
LA			
LA			
LA			
LA			
LA			

C. ☐ **Yes** ☐ **No** **Used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

D. ☐ **Yes** ☐ **No** **Used or been known by any other incorporated or Doing Business As (DBA) names?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

1. DBA Name	Legal Name	Tax ID
2. DBA Name	Legal Name	Tax ID
3. DBA Name	Legal Name	Tax ID
4. DBA Name	Legal Name	Tax ID

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to Section IV below

SECTION III – ENROLLING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

Has the enrolling individual named in Section I (ever):

☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Had any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had any type of felony conviction(s)?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

☐ **Yes** ☐ **No** **Is the Social Security Number and/or Tax ID number(s) listed in Section I currently enrolled in any other Federal/State funded healthcare programs?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID/SSN	Plan Numbers for Enrollments	
			State	ID#
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to items A and B below

SECTION V – OWNERSHIP OF ENTITIES/BUSINESSES ENROLLED IN FEDERAL/STATE FUNDED HEALTHCARE PROGRAMS

A. ☐ Yes ☐ No Does the enrolling individual have any direct, indirect or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in a Federal/State funded healthcare program(s)?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name and Address	Tax ID/SSN	% ownership	Plan Numbers for Enrollments	
				State	ID#
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	
				LA	

B. ☐ Yes ☐ No Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed in item A above?

If yes, list all individuals and how they are related (i.e., spouse, parent, child, sibling) below.
Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth MM/DD/YYYY		Social Security # - -
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth MM/DD/YYYY		Social Security # - -
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth MM/DD/YYYY		Social Security # - -
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth MM/DD/YYYY		Social Security # - -

Provider Name: _____

SECTION VI – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Social Security Number - -	Date of Birth MM/DD/YYYY	Job Title

The person completing this form is (please check one):

☐ Self ☐ Staff ☐ Third Party/Independent Agent ☐ Other (explain)) _____

Physical Location Address	City	State LA	Zip +4

Telephone Number ☐ Work ☐ Home ☐ Cell ( ) -	Email Address

Additional Telephone Number ☐ Work ☐ Home ☐ Cell ( ) -	Additional Email Address

Provider Name: _____

Make photocopies of the next 2 pages to complete Section VII for each agent or managing employee AND make a photocopy of this page if more space is needed to respond to items C and E below

SECTION VII – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

If the enrolling individual is also the owner of the business/entity identified as the Provider Pay-to name and Tax ID in Section B on the form PE-50-I, this section must be completed.

A. ☐ **Yes** ☐ **No** **Does this enrolling individual employ any Agents or Managing employees?**
If yes, complete the following information for each agent or managing employee.
If no, proceed to Section VIII.

B. ☐ **AGENT – or –** ☐ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Title/Job Position within this entity/business	Social Security Number (required) - -	Date of Birth (required) MM/DD/YYYY

Mailing Address/PO Box	City	State LA	Zip Code +4
Physical Address	**City**	**State LA**	**Zip Code +4**

Telephone Number ( ) -	Email Address

Additional business location address	City	State LA	Zip +4
Mailing address for above location	City	State LA	Zip +4
Additional business location address	City	State LA	Zip +4
Mailing address for above location	City	State LA	Zip +4

C. ☐ **Yes** ☐ **No** **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**
If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

D. ☐ **Yes** ☐ **No** **Is this agent or managing employee a U.S. citizen?** If no, provide Alien Verification # _____

E. ☐ **Yes** ☐ **No** **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?**
If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item G below

Name of Agent or Managing Employee: _____

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
F. Has the agent or managing employee named above (ever):	
☐ Yes ☐ No	Convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Has a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Denied malpractice insurance?
☐ Yes ☐ No	Has a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

G. ☐ Yes ☐ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	**Doing Business As (DBA) Name**	**Tax ID**	**Plan Numbers for Enrollments**	
			State	**ID#**
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	
			LA	

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That I have disclosed all necessary information;
2. That I am the individual identified in Section I and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That I have reviewed the information on this Individual Disclosure form and attest that it is true, accurate and complete;
4. That I understand that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the individual already participates, a termination of the provider agreement or contract with LDH or the Secretary, as appropriate;
5. That I understand that a denial or termination of the provider agreement or contract with LDH or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That I understand that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to LDH or the Secretary may be prosecuted under applicable federal or state laws;
7. That I understand it is my responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That I understand that the failure to maintain current and correct information may result in payments being delayed or closure of my Medicaid provider number;
9. That I understand if my number is closed due to inaccurate information, I will have to complete a new Provider Enrollment Packet in its entirety to reactivate my provider number;
10. I understand that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, I must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US and I understand that it is my responsibility to ensure that all my managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
13. I understand that it is my responsibility to ensure that I have disclosed on this form if I, or any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
14. I understand that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), I am required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
15. I understand that I shall report any of the above conditions to the Department of Health (LDH), and once enrolled, I understand that upon discovery of any of the above conditions, it is my responsibility to report them immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
16. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any federally funded healthcare program, I am required to submit this information and the requested documentation.
17. I understand that I am being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." I understand that this criminal statute means that if I, or any managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or been terminated from participation in the Medicare, Medicaid, or any other Federally or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. I also understand that "participation" includes providing any services which will be billed, directly or indirectly, to Medicaid, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to Louisiana's Medicaid Program. I also understand that this new crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Printed Name of Individual Provider

Signature of Individual Provider
(sign in blue ink)

Date of Signature MM/DD/YYYY