Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Attachment 1
Disclosure of Ownership and Control Interest statement

Please note, this communication applies to Anthem HealthKeepers Plus Medicaid products offered by HealthKeepers, Inc. By federal law, the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) can exclude individuals and entities from participating in federal health care programs – including Medicaid and Medicare. If the HHS-OIG excludes a health care provider under a federal health care program, the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) policy also prohibits the reimbursement of any items or services furnished, ordered or prescribed by that provider.

The federal regulation set forth in 42 CFR 455.106 requires providers who are entering into or renewing a provider agreement to disclose the identity of any excluded individuals/entities with ownership or control interest in the provider of 5% or greater. This disclosure of information is required by the U.S. Department of Health and Human Services, the Commonwealth of Virginia Department of Medical Assistance Services (DMAS) and managed care organizations that contract with DMAS such as HealthKeepers, Inc. (HMO). **Please see the Attachment 1 definitions for further explanation of an ownership interest, managing employee and direct and indirect ownership.**

Federal regulation 42 CFR 455.105 requires contracting providers to disclose information within 35 days of a request by CMS, DMAS or HMO on:

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than twenty five thousand dollars ($25,000) during the 12-month period ending on the date of the request; and

2. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

As part of the HMO's obligation to verify the credentials of all providers within its network(s), the HMO requires that all contracted providers fully complete and submit this form prior to providing services to members as part of the HMO's network.

Instructions

Please follow these instructions to adhere to federal regulations:

1. Review the HHS-OIG list for excluded individuals at **oig.hhs.gov/fraud/exclusions.asp** and determine if any individuals who meet the criteria for ownership or control interest are on the exclusion list. If anyone with an ownership or control interest is on the excluded list, you must notify us immediately.
2. Please return this completed form with the supplemental materials to your Network Manager.

3 Tips for accurately completing a Disclosure of Ownership (DOO) form:

- If any section(s) of the DOO do not pertain to a provider, those section(s) should be marked "N/A" or checked "no." No sections of the form may be left blank.
- Practice Information[1] and Section I must always be completed.
- If you are a disclosing entity, Section VI must be completed.
- Should a change in ownership occur subsequent to submission of the DOO, the disclosing entity must update all relevant information within 35 days.

Please note, this communication applies to Anthem HealthKeepers Plus Medicaid products offered by HealthKeepers, Inc. If you have any questions about this communication, call Anthem HealthKeepers Plus Provider Services at **800-901 0020**,or MMP Provider Services at **855-817-5788**.

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The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency and to managed care organizations that contract with the State Medicaid Agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **Please attach a separate sheet if necessary**.

[1]Practice information

Check one that most closely describes you: ☐ **Individual** ☐ **Group practice** ☐ **Disclosing entity**	
Name of individual, group practice, or disclosing entity	
DBA name:	
Address:	
Federal Tax Identification number:	Provider CAQH #:

Section I

List the name, title, address, date of birth (DOB) and Social Security number (SSN) for each individual having an ownership or control interest in this provider entity of **5% or greater**.

List the name, Tax Identification number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of **5% or greater**. Please attach a separate sheet if necessary. (42 CFR 455.104)

Name of individual or entity	**DOB**	**Address**	**SSN (if listing an individual) TIN (if listing an entity)**

Section II

Are any of the individuals listed in Section I related to each other? ☐ Yes ☐ No
Are any of the individuals listed in Section III related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Section I names	**Type of relation**
Section III names	**Type of relation**

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Section III

Are there any subcontractors that the **disclosing entity** has direct or indirect ownership of **5%** or more? ☐ Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership **of 5% or more**. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider or disclosing entity, or is an agent or managing employee of the provider ever been convicted (including deferred adjudications and all types of pretrial diversion programs as set forth in 42 CFR 455.106) of a crime related to that person's involvement in any program under Medicaid, Medicare or Title XX or been excluded or debarred from any such program? ☐ Yes ☐ No

Refer to the Federal Debarment list at: **sam.gov** or for a listing of federally debarred and suspended individuals/entities and the Federal List of Excluded Individuals/Entities (LEIE) database, available at **oig.hhs.gov/exclusions/exclusions_list.asp**
If yes, please list those persons below. (42 CFR 455.106)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

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Section V

Business transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than twenty five thousand dollars ($25,000) or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider **has had business transactions totaling more than twenty five thousand dollars ($25,000)** during the previous 12-month period; **and any significant business transactions** between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name supplier/subcontractor	Address	Transaction amount

Section VI

Have you identified your status (under Practice Information) as a disclosing entity? ☐ Yes ☐ No

If yes, for disclosing entities, list each member of the board of directors or governing board, including the name, date of birth (DOB), address, Social Security number (SSN) and percent (%) of interest.

Name/title	DOB	Address	SSN	% interest

I certify that the information provided herein is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in a denial of participation.

_____ _____

Signature Title (or indicate if authorized agent)

_____ _____

Name (please print) Date

[1] Practice Information refers to the first area of this form

Attachment 1
Definitions

Agent: Any person who has been delegated with the authority to obligate or act on behalf of the provider.

Disclosing entity: A Medicaid provider (other than a practitioner or group of practitioners), or fiscal agent.

Other disclosing entity: Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII or XX of the Act. This includes any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare or, any entity (other than a practitioner or group of practitioners) that furnishes or arranges for the furnishing of health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Group of practitioners: Two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff or common equipment).

Indirect ownership: Any ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee: A general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Ownership interest: The possession of equity in the capital, the stock or the profits of the disclosing entity.

Person with an ownership or control interest: A person or corporation that a) has an ownership interest totaling 5% or more in a disclosing entity; b) has an indirect ownership interest equal to 5% or more in a disclosing entity; c) has a combination of direct and indirect interests equal to 5% or more in a disclosing entity; d) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity if that interest equals 5% of the value of the property or assets of the disclosing entity; e) is an officer or director of a disclosing entity that is organized as a corporation; or f) is an partner in a disclosing entity that is organized as a partnership.

Significant business transaction: Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5% of a provider's total operational expenses.

Subcontractor: An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of provider medical care to its patients.

Supplier: An individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid.

Wholly owned supplier: A supplier whose total ownership interest is held by a provider or by a person, persons or other entity with an ownership or control interest in a provider.