

Anthem Blue Cross
Disclosure of Ownership And Control Interest Statement
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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.**

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 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 above related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)	
Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

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Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? Yes No (verify through HHS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$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 \$25,000** during the previous twelve 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 5-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 Information¹) 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

Please return the form by fax to **1-877-608-6752**, or by mail in the enclosed postage paid envelope to:

Provider Services - CMS Disclosure Form
State Sponsored Business
P.O. Box 9055
Oxnard, CA 93031-9754

¹ Practice Information refers to the first area of this form