

COVERKIDS

Ownership and Control Interest Statement and Criminal Information Form
 BlueCross BlueShield of Tennessee (BCBST)
 One Cameron Hill Circle, Suite 0007
 Chattanooga, TN 37402
 Fax: (423) 535-3066
 Fax: (423) 535-5808

DISCLOSURE FORM FOR PROVIDER ENTITIES

Directions: The Disclosure of Ownership and Control Interest Statement and Criminal Information Form (form) must be submitted as follows: 1) at the time a **Provider Entity** is initially enrolled for the CoverKids program; 2) at the time a **Provider Entity** is being re-accredited for the CoverKids program; 3) at the time a **Provider Entity** is being re-enrolled and/or re-contracting for the CoverKids program; 4) whenever there is a material change in the information required by this form, for example, an ownership change, the addition of a new managing employee or the change of your business location; and 5) upon request by CoverKids, any federal or state agency, or the CoverKids Plan Administrator, BlueCross BlueShield of Tennessee, Inc. (BCBST). A **Provider Entity** is a business entity, such as, a partnership or corporation, which provides CoverKids covered services to CoverKids members.

Please answer all questions as of the current date. If additional space is needed, please, note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return the original to BCBST at the address or fax numbers above. Additional information on the form may be accessed at the CoverKids website located on-line at <http://www.coverkids.com/> and/or the BCBST website located on-line at <http://www.bcbst.com/providers/>, then select Cover Tennessee. Please retain a copy for the **Provider Entity's** files. Completely answer the applicable questions. If a question is not applicable please respond N/A for that question. **NO QUESTIONS SHOULD BE LEFT BLANK.** The Social Security Numbers (SSN) must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing SSN.

I. Identifying Information

Name of Individual Completing Form	Phone Number of Person Completing Form

Provider Entity Name	Provider Entity Doing Business As (DBA) Name	Provider Entity Federal Tax Identification Number (TIN)
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	(If Different from Provider Entity Name)	

Provider Entity NPI Number (If the Provider Entity does not have one, indicate if applied for and date submitted.)	Provider Entity TennCare/Medicaid/Medicare I.D. Number (If the Provider Entity does not have one, indicate if applied for and date submitted.)	Provider Entity Telephone Number(s)

Provider Entity Address. Must include at least one street address (attach a separate sheet if needed). List all Practice locations.	City	State	Zip

II. OWNER OR CONTROL INFORMATION

Directions: An “**Owner**” is an Individual or Business Entity which owns 5% or more of the assets, stock or profits of the **Provider Entity**. This 5% may be **Direct Ownership** or **Indirect Ownership**, for example, an individual might own 50% of a company that owns the actual **Provider Entity** meaning their **Indirect Ownership** is 50%. In addition to ownership of stock, an **Owner** is also an Individual who owns a legal obligation like a mortgage or loan that is secured by the assets of the **Provider Entity**.

An individual with “**Control**” is someone who directs the **Provider Entity** and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the **Provider Entity** is a non-profit entity, respond N/A in the column for % of **Direct** or **Indirect Ownership**.

A “**Managing Employee**” is an individual who makes the day to day decisions for the **Provider Entity**. These individuals include office or billing managers for smaller Provider Entities, and for larger Provider Entities the heads of the major operating groups of the Provider Entity, such as, the Head of Accounting, or Director of

B. Specific Questions

1) Is any Individual on the **Master List** related to another Individual on the **Master List** as a spouse, parent, child or sibling?

Yes No . If yes, please, provide the following information about the related Individuals:

Name of First Related Individual	Name of Second Related Individual	Type of Relation

2) Does any Individual or Business Entity on the **Master List** have a **Direct** or **Indirect Ownership** or **Control** interest in any other **Provider Entity**?

Yes No . If “yes”, please, provide the following information about the other **Provider Entity** the Individual or Business Entity on the **Master List** has a **Direct** or **Indirect Ownership** or **Control** interest in.

Name of other Provider Entity	Address	City	State	Zip	TIN

3) Have any of the Individuals or Business Entities on the **Master List** been convicted of a criminal offense related to that Individual’s or Business Entities’ involvement in any program under Medicare, Medicaid, CHIP, TRICARE, or the Title XX services program since the inception of those programs?

Yes No . If yes, please, provide the information requested below:

Name on Court Records	SSN /TIN	Matter of the Offense	Date of the Conviction	Exclusion Period of the Offense if Individual and/or Business Entity was excluded by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG)

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4) Have any of the Individuals or Business Entities on the **Master List** ever been **Debarred** from participation in Federal Government contracts? **“Debarred”** means an Individual and/or Business Entity was/is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area.

Yes No If ‘yes’ is checked, provide the following information:

When the Individual/Business Entity was Debarred	Length of Debarment	Reason for Debarment

5) Has any Individual or Business Entity on the **Master List** ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past. “Excluded” means that a Individual or Business Entity has been told by the HHS,OIG that they may no longer be a Provider Person and/or Provider Entity for any federally funded health care program.

Yes No If “Yes” please, supply the following information:

Name of Individual/Business Entity	Beginning Date of Exclusion or Termination	End Date of Exclusion or Termination	Reason for Exclusion or Termination

6) Has any Individual or Business Entity on the **Master List** ever been **Terminated** from a State’s Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Individual or Business Entity lost the right to bill a State’s Medicaid or CHIP programs for a cause related to fraud or abuse.

Yes No If “Yes”, please, supply the following information:

State where Practicing when Terminated	Reason for Termination	Date of Termination

7) Has any Individual or Business Entity on the **Master List** ever had Civil Monetary Penalties (CMPs) assessed against them? A CMP is a type of fine assessed against an Individual and/or Business Entity by a governmental agency that manages a federal health care program.

Yes No If “Yes” please, supply the following information:

Name Of Individual/Business Entity	State where Practicing when CMP Assessed	Reason for CMP	Amount of CMP	Date of CMP

8) Did any Individual or Business Entity on the **Master List** obtain their **Direct** or **Indirect Ownership** interest 1) as a result of a transfer of **Direct** or **Indirect Ownership** from someone who was about to be Excluded or Terminated from participation in a Federal health care program, or was in fact Excluded or terminated from participation in a federal health care Program; and 2) where the original **Owner** is or was a member of the **current Owner’s Immediate Family** or **Member of the current Owner’s Household**, at the time of the transfer of **Direct** or **Indirect Ownership**? [**Immediate Family** is defined as an Individual's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Member of Household** is, with respect to an Individual, any other Individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a **Member of Household**.]

Yes No If “Yes” please, supply the following information:

Name of Original Owner	SSN or TIN of Original Owner	Place of Transfer	Date of Transfer

9a) List any **Subcontractor** in which this **Provider Entity** has a **Direct** or **Indirect Ownership** or **Control** interest of at least a 5%. A **Subcontractor** is an Individual or Business Entity that this **Provider Entity** has contracted with to do some of the **Provider Entities’** management functions, for example, billing agent, or to provide medical services, such as, a medical lab.

Name of Subcontractor	Address	City	State	Zip	TIN

9b) For each **Subcontractor(s)** listed in 9a above, please, provide the following information for the Individuals or Business Entities with a **Direct** or **Indirect Ownership** or **Control** interest in the **Subcontractor(s)**. See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

Name	Address(es) (for Individuals use home address, for Business Entities that might have a Direct or Indirect Ownership and/or Control interest use the Business Entities' street addresses and P.O. Box addresses, if any.)	City	State	Zip	DOB	SSN for Individuals or TIN for Business Entities	% of Ownership	Title

9c) Is any Individual on the list in 9a list related to any Individual on the **Master List** above?

Yes No If yes, please, supply the following information about the related persons:

Name of First Related person	Name of Second Related Person	Type of Relation

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III. Business Transactions

- 1) Please list the **Subcontractors** with whom this **Provider Entity** has done business with over the last 5 years where the contract is worth at least 5% of this **Provider Entity's** total operating expenses *or* \$25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.B.9a. in which this Provider Entity has a **Direct** or **Indirect Ownership** and/or **Control** interest. A **Subcontractor** is an Individual or Business Entity that this **Provider Entity** has contracted with to do some of this **Provider Entity's** business functions, for example, a billing agent, or to provide medical services, such as, a medical lab.

Name	Address	City	State	Zip

- 2) Does this **Provider Entity** *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **Provider Entity** *purchases goods and services* used in carrying out its responsibilities under CHIP, such as, a commercial laundry, a manufacturer of hospital beds or a pharmacy.

Yes No . If yes, supply the following information about the **Supplier**:

Name	Address	City	State	Zip	NPI	TIN

IV. SIGNATURE

The federal or state CHIP agencies may refuse to enter into, renew, or terminate an agreement with a **Provider Entity** if it is determined that a **Provider Entity** did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be

prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of an Individual who can legally bind this **Provider Entity**:

Name of Individual (Printed)	Signature of Individual	Title	Date