DISCLOSURE OF OWNERSHIP & CONTROL INTEREST STATEMENT

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 contracted 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. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Louisiana Healthcare Connections within 30 days of the change. *If necessary, please attach a separate sheet to provide complete information.*

Please use below 'Ownership Code' Glossary to determine your appropriate Practice Type:

01 = Voluntary (Non-Profit/Religious Organization) **02 = Voluntary** (Non-Profit/Other) **03 = Voluntary** (Multiple Owners)
04 = Proprietary (Individual) **05 = Proprietary** (Corporation) **06 = Proprietary** (Partnership)
07 = Proprietary (Other) **08 = Proprietary** (Multiple Owners) **09 = Government** (Federal)
10 = Government (State) **11 = Government** (City) **12 = Government** (County)
13 = Government (City-County) **14 = Government** (Hospital District) **15 = Government** (State and City/County)
16 = Government (Other Multiple Owners) **17 = Voluntary/Proprietary** **18 = Proprietary/Government**
19 = Voluntary/Government **88 = N/A** (The individual only practices as part of a group, e.g. as an employee)

PRACTICE INFORMATION

Please enter the appropriate CODE (as determined from above glossary) which most closely describes you:	**OWNERSHIP CODE #** _____ (*as described above*)
Name of Individual/Group/Practice or Disclosing Entity:	
DBA Name:	
Address:	
Federal Tax I.D. #:	Provider CAQH #:

SECTION 1

FOR INDIVIDUALS, 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.

FOR ENTITIES, 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 AS INDIVIDUAL) TIN (IF LISTING AS ENTITY)

SECTION 2

Are any of the individual listed **above** related to each other? ☐YES ☐NO

IF YES, please list the individual(s) named **above** who are related to each other and their **relationship—spouse,** sibling, parent, child (42 CFR 455.104).

NAME(S)	RELATIONSHIP

SECTION 3

Are there any subcontractors with which the Disclosing Entity has direct or indirect ownership of 5% or more? ☐YES ☐NO

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

NAME OF INDIVIDUAL OR ENTITY	DOB	ADDRESS	SSN (IF LISTING AS INDIVIDUAL)

SECTION 4

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 programs under Medicaid, Medicare or Title XX program? ☐YES ☐NO (verify through IUIS-OIG website)

IF YES, please list those individuals below (42 CFR 455.106).

NAME OF INDIVIDUAL OR ENTITY	DOB	ADDRESS	SSN (IF LISTING AS INDIVIDUAL)

SECTION 5

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, please 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 five-year period (42 CFR 455.105).

NAME OF SUPPLIER OR SUBCONTRACTOR	ADDRESS	TRANSACTION AMOUNT

SECTION 6

Have you identified your status (in the Practice Information section) as a Disclosing Entity? ☐YES ☐NO

IF YES, for Disclosing Entities, please list each member of the Board of Directors or Governing Board, including the name, DOB, Address, SSN and percent of interest.

NAME/TITLE	DOB	ADDRESS	SSN	% INTEREST

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

_____ _____

Signature Title *(or indicate if Authorized Agent)*

_____ _____

Name *(please print)* Date

Please submit completed document to lhc_provider_credent@centene.com. If you have any questions about this form, please contact Provider Services at 1-866-595-8133 and we will be happy to assist you.