

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database. All information entered is maintained according to Federal HIPAA and privacy regulations. For your reference, please visit the link below for Medical Assistance Bulletin (MAB) 99-11-05. This bulletin applies to all providers enrolling in the MA Program.

<http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=4718>

## Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following forms. If you cannot report all of the necessary information in a designated section of the form because of space limitations, please print and attach additional sheets.

### DEFINITIONS

**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider.

**Disclosing entity** means a Medicaid provider (other than an individual practitioner), or a fiscal agent.

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 means:

- a. 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 (title XVIII);
- b. Any Medicare intermediary or carrier; and
- c. Any entity (other than an individual 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.

**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

**Group of practitioners** means 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 interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Individual practitioner means a physician or other person licensed or certified under State Law to practice his or her profession.

**Managing employee** means 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** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**Person with an ownership or control interest** means a person or corporation that –

- a. Has an ownership interest totaling 5 percent or more in a disclosing entity;
- b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

- e. An officer or director of a disclosing entity that is organized as a corporation; or
- f. Is a partner in the disclosing entity that is organized as a partnership.

**Significant business transaction** means any business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

**Subcontractor means** –

- a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Supplier means** an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

**Wholly owned supplier** means 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.

Please return completed document and any applicable application to the address listed below:

**DPW Enrollment Unit**

**PO Box 8045**

**Harrisburg, PA 17105-8045**

\*If you are a non-profit organization please skip this section and complete Attachment II.

\*\*This is the contact name and phone number we will use if we have any questions about this document.

Contact Name: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

### **OWNERSHIP OR CONTROL INTEREST**

Note: Ownership and Controlling Interest information is required in accordance with Federal Regulations 42 CFR, Part 455 published July 17, 1979, and expanded through additional subparts on February 02, 2011 through the Provider Enrollment and Screening provisions of the Affordable Care Act.

Please enter the full name and address of partners, stockholders, corporate owners, or officers that have at least 5% direct or indirect ownership interest.

Complete below for **INDIVIDUALS**:

\_\_\_\_\_  
Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

\_\_\_\_\_  
Date of Birth: Street Address:

\_\_\_\_\_  
City: State: Zip Code:

\_\_\_\_\_  
Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

\_\_\_\_\_  
Date of Birth: Street Address:

\_\_\_\_\_  
City: State: Zip Code:

\_\_\_\_\_  
Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

\_\_\_\_\_  
Date of Birth: Street Address:

\_\_\_\_\_  
City: State: Zip Code:

**\*\*ATTACH ADDITIONAL SHEETS IF NECESSARY\*\***

**Ownership or Control Interest (Cont'd)**

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Complete below for **CORPORATE ENTITIES**:

**\*\*The address for each corporate entity MUST include: primary business address, every business location, and P.O. Box address – Use space provided below or attach a separate sheet of paper if needed.**

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Name of Corporation: \_\_\_\_\_ FEIN/Tax ID number: \_\_\_\_\_

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Street Address: \_\_\_\_\_ PO Box \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

---

Name of Corporation: \_\_\_\_\_ FEIN/Tax ID number: \_\_\_\_\_

---

Street Address: \_\_\_\_\_ PO Box \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

---

Name of Corporation: \_\_\_\_\_ FEIN/Tax ID number: \_\_\_\_\_

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Street Address: \_\_\_\_\_ PO Box \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**\*\* ATTACH ADDITIONAL SHEETS IF NECESSARY \*\***

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**Ownership or Control Interest (Cont'd)**

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**Please enter the full name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

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Date of Birth: Street Address:

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City: State: Zip Code:

**\*\*Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program?  Yes \*  No**

**If "YES" please attach details.**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

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Date of Birth: Street Address:

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City: State: Zip Code:

**\*\*Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program?  Yes \*  No**

**If "YES" please attach details.**

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**\*\*ATTACH ADDITIONAL SHEETS IF NECESSARY\*\***

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**Are any of the aforementioned persons related to each other as a spouse, parent, child or sibling? If so, please list the names of the individuals and how they are related.**

Names: \_\_\_\_\_  
\_\_\_\_\_

Relationship: \_\_\_\_\_

Names: \_\_\_\_\_  
\_\_\_\_\_

Relationship: \_\_\_\_\_



**ATTACHMENT I**

**Managing Employee or Agent Disclosure Form**

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A. Please Provide the name, address, social security number, and date of birth of any person who is an agent or managing employee of the provider.

Is the following individual a: **Managing employee**  or **Agent**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

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Date of Birth: Street Address:

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City: State: Zip Code:

Is the following individual a: **Managing employee**  or **Agent**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

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Date of Birth: Street Address:

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City: State: Zip Code:

B. Please Provide the name, and description of offense of any person who is an agent or managing employee and has been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program.

Name: (First) (Middle) (Last)

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Description of Offense:

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Name: (First) (Middle) (Last)

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Description of Offense:

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**ATTACHMENT II**

**Non-Profit Disclosure**

**Please add anyone who has a Controlling interest or is a Board Member.**

**President:**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

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Date of Birth: Street Address:

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City: State: Zip Code:

**Vice President:**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

---

Date of Birth: Street Address:

---

City: State: Zip Code:

**Secretary:**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

---

Date of Birth: Street Address:

---

City: State: Zip Code:

**Treasurer:**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

---

Date of Birth: Street Address:

---

City: State: Zip Code:

**ATTACHMENT II cont.**

**Other:**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

---

Date of Birth: Street Address:

---

City: State: Zip Code:

---

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

---

Date of Birth: Street Address:

---

City: State: Zip Code:

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Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

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