



Please complete, sign and fax the  
 Provider Disclosure Statement to  
 1-866-886-2839.

### Provider Disclosure Statement

Name of Entity/Individual	EIN/SSN	NPI	Taxonomy	
Address	City	State	Zip Code	

Questions 1 – 3 to be answered by all providers.

1. Have you ever been convicted of a criminal offense related to Medicare, Medicaid or the Title XX services programs? If yes, give description(s) of the offense(s).	YES	NO
1a. Has any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider been convicted of such an offense? If yes, give the name(s) of person(s) and description(s) of offense(s).	YES	NO

Name	Description

2. Has the provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period? If yes, give the information below for each subcontractor.	YES	NO
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	Name	Address
A		
B		
C		
D		

2a. Provide the name and address of all persons with an ownership or control interest in each subcontractor named in question 2  
 \*NOTE: Designate relationship to subcontractor listed above by using A., B., C., etc.

*	Name	Address

3. Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? If yes, give the information below for each wholly owned supplier or subcontractor.	YES	NO
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Name	Address	Description of Business Transaction

## Provider Disclosure Statement – Continued

**Questions 4 – 6 to be answered by fiscal agents and all providers EXCEPT individual practitioners.**

4. Provide the name, date of birth, social security number or TIN and address of each person or corporate entity with an ownership or control interest in the provider. For corporate entities, list the main business addresses, as well as all locations and PO boxes.				
	Name	DOB	SS# or TIN	
A			Address	
B				
C				
D				
5. Does the provider have an ownership or control interest in any of its subcontractors? If so, name the subcontractor and list all of the people or entities with an ownership interest in that subcontractor.			YES	
			NO	
	Name	Address		
E				
F				
G				
6. Is any person named in response to questions 4 and 5 related to another as spouse, parent, child or sibling? If yes, give the name(s) of person(s) and relationship(s).  <i>*NOTE: Designate relation to each person listed in question # 4 by using A., B., C., etc.</i>			YES	
			NO	
*	Name	Relationship		
7. Does any person named in question 4 have an ownership or control interest in an “other disclosing entity” in addition to the entity filling out this form? See the definition of a “disclosing entity” below for more explanation. If yes, list the name(s) of the “other disclosing entity” and identify which persons listed are its owners.  <i>*NOTE: Designate relation to each person listed in question # 4 by using A., B., C., etc.</i>			YES	
			NO	
*	Name	Relationship		
8. List the name, address, date of birth and social security number of each of your managing employees.				
	Name	DOB	SSN	Address

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with Delaware Physicians Care.

\_\_\_\_\_  
Name of Provider or Authorized Representative (Typed)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **Instructions for Completing the Provider Disclosure Statement**

Please complete, sign and fax the Provider Disclosure Statement to 1-866-886-2839.

According to the Code of Federal Regulations title 42, part 455, sections 101-106, all providers enrolling with Delaware Physicians Care must complete a Provider Disclosure Statement. These required disclosures allow Delaware Physicians Care and the State of Delaware to insure program integrity by preventing excluded persons from participating in Medicaid, either as providers, owners and employees of providers.

If you require more space to answer a question, please use an additional sheet of paper.

The definitions below describe the terms used on the disclosure form. They are derived from Code of Federal Regulation title 42, part 455, section 101. In case of any inconsistency between the definitions and the regulations, the regulation will control.

### **Definitions**

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

**Control Interest** – Being an officer or director of an entity that is organized as a corporation; or a partner in an entity that is organized as a partnership

**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.

**Other Disclosing Entity** – Any of the following:

- i) A Medicaid participating provider other than an individual provider or group of practitioners;
- ii) A contractor that processes or pays vendor claims on behalf of a Medicaid agency;
- iii) A hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare;
- iv) A Medicare intermediary or carrier; or
- v) An 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 (maternal and child health grants) or title XX (social services block grants) of the Social Security Act .

**Ownership Interest** – Owning, directly or indirectly, a total of five percent or more of an entity's equity, capital, stock or profits; owning, directly or indirectly, notes or obligations of the entity that are worth, in total, five percent or more of the entity's assets; or being a partner in the entity, if the entity is a partnership.

**Subcontractor** - An individual, agency, or organization to which:

- i) Provider has contracted or delegated some of the management functions or responsibilities of providing medical care to its patients; or
- ii) 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.