

DISCLOSURE FORM FOR A PROVIDER PERSON

Directions: Use this form if you are trying to get a TennCare/Medicaid provider ID number for a **Provider Person**. If the addition of the **Provider Person** will change the **Ownership** or **Control** structure of the **Provider Entity** that the **Provider Person** is joining (i.e. the new **Provider Person** will also be an owner or high ranking employee of the **Provider Entity**, then you must also fill out a new Disclosure form for the **Provider Entity** to reflect the new **Ownership** or **Control** arrangements.

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 this form to the address on the application packet. Go to the TennCare Program Integrity website for a list of contact information for each MCO. Please retain a copy for your 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**. Website, and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

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).

Name of person completing form	Phone number of person completing form

I. Identifying Information

Provider Person name	SSN	DOB	NPI number (if you have one, if not indicate if applied for)	TennCare/Medicaid Id number (if you have one, if not indicate if applied for")

Provider Person Home Address	City	State	Zip

Provider Entity name (Provider Entity is who the Provider person works for. If you are a sole proprietor you would list yourself as the Provider Entity also.)	Provider Entity DBA (If different from provider Entity Name)	Provider Entity Address (If you have more than one practice location list all locations)

Provider Entity T.I.N.	Provider N.P.I. (if the Entity has one, if not indicate if applied for)	Provider TennCare/Medicaid I.D. number (if the Entity has one, if not indicate if applied for)

II. Criminal Offense Attestation

A) Have you ever been **Convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the CHIP services program since the inception of those programs? **“Convicted”** means been found guilty by a jury or judge, or pled guilty, nolo contendere, best interest plea or pre trial diversion or suspended sentence. Yes No

If ‘Yes’ is checked, provide the following information:

Name on Court records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general(OIG)

B) Have you ever been **Debarred** from participation in Federal Government contracts? **“Debarred”** means you are 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 you were debarred	Length of Debarment	Reason for Debarment

C) Have you ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or Tricare) in the past? “Excluded” means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded healthcare program.

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

Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

D) Have you 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 Provider lost the right to bill a State’s Medicaid or SCHIP 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

E) Have you ever had **Civil Monetary Penalties (CMPs)** assessed against you? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

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

State where practicing when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

III. Questions for a Sole Proprietor

a) If you are a Sole Proprietor, please give the following information for your **Managing Employees and Agents**. A **Managing Employee** is someone who makes day to day decisions on the running of your business such as an office manager or billing manager. An **Agent** is someone besides yourself who can legally act for your business.

Name of Managing Employee or Agent	SSN	DOB	Home Address	City	State	Zip

b) Has any person listed in 3a been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the CHIP services program since the inception of those programs? **“Convicted”** means been found guilty by a jury or judge, or pled guilty, nolo contendere, best interest plea or pre trial diversion or suspended sentence. Yes No . If yes, please provide the following information:

Name on Court records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general(OIG)

c) Has anyone on the list in 3a ever been **Debarred** from participation in Federal Government contracts? **“Debarred”** means someone 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 was debarred	Length of Debarment	Reason for Debarment

d) Has any person on the list in 3a ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or Tricare) in the past?

Yes No If "Yes", please supply the following information:

Name of Individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

e) Have anyone on the list in 3a ever been terminated from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?

Yes No If "Yes", please supply the following information:

State where practicing when terminated	Reason for termination	Date of termination

f) Has any person on the list in 3a ever had **Civil Monetary Penalties (CMPs)** assessed against them?

Yes No If "Yes", please supply the following information:

Name Of Individual	State where practicing when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

IV. Signature

The State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider 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 the Provider;

Name of Provider Person (Printed)	Signature of Provider Person	Date