

Disclosure of Ownership & Exclusions Statement for Providers

I. Instructions

This statement should be completed and submitted to each of the health plans listed on page 4. This statement must be submitted by the deadline set by each of the health plans and upon contract renewal. A new statement must be submitted when any information in your statement has changed.

You should complete this form in conjunction with review of the requirements for disclosure of ownership and exclusions of individuals and entities from government programs as provided in each of the health plan's administrative requirements.

This statement must be completed whether or not you have any information to report. If more space is needed, please attach additional information.

For assistance in completing this statement, please reference the "Definitions" on page 5.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As)		
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER ()
FEDERAL EMPLOYER ID (FEIN)		MN TAX ID	

III. Structure

<p>Check the entity type that describes your structure:</p> <p> <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Non-Profit </p> <p> <input type="checkbox"/> Other Partnership (i.e., LP, LLP, LLLP) </p>

IV. Ownership & Control Interests

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% of more. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Driver's License Number	% of Ownership Interest
1					
2					
3					
4					

B. If any Person with an Ownership or Control Interest listed in subsection IV(A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN or FEIN	Name of Person Related To	Related Person's SSN or FEIN	Relationship
1					
2					
3					
4					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than that indicated in section A, please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% of Ownership Interest
1					
2					
3					
4					

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V. Excluded Individuals or Entities

A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?
 Yes No
- Been convicted of a criminal offense related to that person’s involvement in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and 1128A of the Social Security Act?
 Yes No

B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan’s obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who has been convicted of a criminal offense related to involvement in or excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?
 Yes No

If you answered “Yes” to any of the above questions, list the name and social security number or Tax ID of the individual or entity, and reason for answering “Yes” (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			
4			

VI. Certification

I certify that the above information is true and correct. I will notify each of the health plans listed below of any changes to this information.

EMAIL ADDRESS	
NAME (Print)	TITLE
SIGNATURE	DATE

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Return a completed, signed statement to each of the following:

Blue Plus

- ◆ Fax to: 651-662-7362
- ◆ Mail to: Blue Cross and Blue Shield of Minnesota
P. O. Box 64560
Route R337-BR
St. Paul, MN 55164-0560
- ◆ Questions: 651-662-5200 or 1-800-262-0820

First Plan

- ◆ Email to: Communications@First-Solutions.org;
- ◆ Fax to: 218-727-7247
- ◆ Mail to: First Plan
525 South Lake Avenue, Suite 222
Duluth, MN 55802
- ◆ Questions: 218-740-2325

HealthPartners

- ◆ Email to: beverly.g.vacinek@healthpartners.com
- ◆ Fax to: 952-853-8708
- ◆ Mail to: HealthPartners
8170 33rd Avenue South
Mail Stop 21108C
Bloomington, MN 55425
- ◆ Questions: 952-883-5649

Medica Health Plans

- ◆ Email to: DisclosureStatement@medica.com;
- ◆ Fax to: 952-992-8350
- ◆ Mail to: Medica
Mail Route CW210
P.O. Box 9310
Minneapolis, MN 55440-9310
- ◆ Questions: 1-800-458-5512

Metropolitan Health Plan

- ◆ Mail to: MHP400
South Fourth Street, Suite 210
Minneapolis, MN 55415
Attn: Front Desk.
- ◆ Questions: 1-877-620-9090

UCare

- ◆ Email to: PNM_FAX@UCare.org
- ◆ Fax to: 612-884-2232
- ◆ Mail to: UCare
P.O. Box 52
Minneapolis, MN 55440-0052
- ◆ Questions: 612-676-3300

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For the purposes of this statement, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.
2. **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 operations of the Provider.
3. **Ownership Interest** means the possession of equity in the capital, the stock, or the profits of the Provider.
4. **Person with an Ownership or Control Interest** means a person or corporation that: A) has an Ownership Interest, directly or indirectly, totaling five percent (5%) or more in the Provider; B) has a combination of direct and indirect Ownership Interests equal to five percent (5%) or more in the Provider; C) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least five percent (5%) of the value of the property or assets of the Provider; or D) is an officer or director of the Provider (if organized as a corporation) or is a partner in the Provider (if organized as a partnership).
5. **Provider** means an individual or entity that has entered into an agreement with any of the health plans listed on page 4 of this statement and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.
6. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted or delegated some of its management functions or responsibilities of providing medical care to patients.