Provider & Subcontractor Disclosure of Ownership & Controlling Interest Worksheet

To comply with Federal law (42 CFR 455.100–106), health plans with Medicaid business must obtain certain information about the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid program.

The Centers for Medicare & Medicaid Services and the State Medicaid agency require Aetna (including Coventry and First Health) to obtain this information to show that we are not contracting with an entity that has been excluded from Federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.

We require this form if you want to or keep participating with Aetna. You must promptly report any future changes to this information, and in no event more than 35 days after any such change, to the health plan. Use more blank sheets of paper if you need space to continue your responses. If you have questions, please contact the health plan.

If the practice group with which the Provider belongs has completed this form within the previous 180 days, and can certify that no information on the form he/she sent previously has changed, you can initial below. Leave the "Disclosure of Ownership & Control Interest" Section of this Worksheet blank. Otherwise, you must complete all fields.

____ I hereby certify that the information in the ownership and controlling interest worksheet that the practice group submitted within the previous 180 days is still complete and accurate.

Identifying information of provider/subcontractor

Name of provider/subcontractor: ________________________ ____________________________________

Type of provider/subcontractor: ____

Tax ID #: _______________________ NPI #: __________________________

Medicaid provider ID #: _______________________________

Primary business address: ____

If the provider is no longer affiliated with this tax ID#, please check this box and sign and date the second page. ☐

If the primary business address has changed, please provide new address and continue. ______________________________

Additional business locations, including PO boxes, if applicable: ____

Type of ownership: __________________________________ (examples may include: partnership, corporation, government, limited partnership, corporate-owned, investor-owned, etc.)

Disclosure of Ownership & Control Interest (Use & attach more sheets of paper if necessary)

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

a) List any individual or organization (hereinafter referred to as "Person") & their address that has a direct or indirect ownership or control interest of 5 percent or more in your entity (hereinafter referred to as "Interest"). If the Person with the interest is a corporation, please include (i) the primary business address, (ii) every business location; (iii) PO box addresses, if applicable; and (iv) the tax identification number. If the person with the interest is an individual (this includes officers and directors of the corporation, or partners in the case of a partnership), list the individual's name, date of birth and Social Security number.

b) For any person disclosed above in (a) with an ownership or control interest, list whether such person is related to another person with ownership or control interest in your entity as a spouse, parent, child or sibling.

c) For any person disclosed above in (a), list the name(s) of any other disclosing entity (defined as a Medicaid/Medicare provider, other than an individual practitioner or group of practitioners, or any entity that is otherwise required to disclose certain ownership and control information because of participation in a Federal health care program) in which such person has an ownership or control interest.

For each service location:

d) List any managing employees and their address, date of birth and Social Security number. Managing employees are individuals such as general managers, business managers, administrators or directors who exercise operational or managerial control over the entity or part thereof, or directly/indirectly conduct the daily operations of the entity, or part thereof.

Primary service address: ____

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Service address #2: ____

____ ____
____ ____
____ ____
____ ____
____ ____

Service address #3: ____

____ ____
____ ____
____ ____
____ ____
____ ____

Repeat for all service addresses covered under this provider/tax ID#. Any service addresses not listed will be considered nonparticipating for Medicaid.

e) Has there been a change in ownership or control within the last year? _________ If yes, give date ________________________

f) Has any person listed on this form ever been excluded from Federal health programs, had civil monetary penalties imposed against them, or been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs? __ Yes __ No
If yes, list those persons below in addition to the exclusion type, date of exclusion and date the exclusion ended, as applicable:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

[__] Check if you listed more information on other pages

I certify that the information contained above is true, complete and accurate. If you knowingly and willfully fail to fully and accurately disclose the information requested, the Plan may deny your request to join the network.

Signed: ___________________________________ **Print:** ___________________________________
Date: ____________________________________ **Title:** ____________________________________

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