PROVIDER QUICK POINTS

Provider information

For the health of all.

May 15, 2012

Disclosure of Ownership Statement

Blue Cross and Blue Shield of Minnesota and Blue Plus are working to make compliance with state and federal requirements as easy and convenient as possible for providers. Therefore, we have provided the Disclosure of Ownership Statement in your provider service agreement renewal packet of information. This form was included in renewal packets for providers whose provider service agreements are updated to be effective July 1, 2012, and will be included in all subsequent renewal packets going forward. The information requested in the Disclosure of Ownership Statement is in accordance with the agreement between the State of Minnesota Department of Human Services and Blue Plus, and is necessary in order to support Minnesota Health Care Program (MHCP) subscribers. This information is also required pursuant to a legislative mandate applicable to all providers and all health plans serving MHCP subscribers. One form is all you need to complete since the information and the single form requesting this information from providers may be used for all health plans in which the provider participates.

Location of the form

A copy of the MCHP Disclosure of Ownership Statement is in your contract renewal packet, on the Blue Cross website at **providers.bluecrossmn.com** (under Forms & publications – forms: clinical operations, MCHP Disclosure Statement) and attached within this quick points.

Questions?

If you have questions, please contact provider services at (**651) 662-5200** or toll free at **1-800-262-0820**.

Enclosure: MCHP Disclosure of Ownership Statement

Disclosure of Ownership and Management Information & 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 a new statement must be submitted when any information in your original statement has changed.

You should complete this form in conjunction with review of the requirements for: (1) disclosure of ownership; and (2) exclusions of individuals and entities from government programs as set forth 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 provided under Section VII.

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

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Co. ☐ Non-Profit

☐ Public ☐ State ☐ Other Partnership (i.e., LP, LLP, LLLP)

IV. Ownership & Control Interests

A. Please provide the following information for each Managing Employee and 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	Date of Birth	SSN or FEIN	% Ownership Interest
1					
2					
3					

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 subsection IV(A) as a spouse, parent, child or sibling, please provide the following information. 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					

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 subsection IV(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	% Ownership Interest
1					
2					
3					

V. Excluded Individuals or Entities

A. Are there any employees, 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 or any of the State health care programs?

☐ Yes ☐ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?

☐ Yes ☐ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provision 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: (i)) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs; or (iii) had civil money penalties or assessments imposed under Section 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, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

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

VI. Certification

I am authorized to bind the entity and 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.

NAME (Print)	TITLE	
SIGNATURE		DATE
EMAIL ADDRESS		

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

- **Blue Plus**
  Email to: DisclosureStatement@bluecrossmn.com
  Mail to: Blue Cross and Blue Shield of Minnesota
  P. O. Box 64560
  Route R337-GP
  St. Paul, MN 55164-0560
  Questions: 651-662-5200 or 1-800-262-0820

- **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: providercertifications@medica.com
  Fax to: 952-992-8666
  Mail to: Medica Health Plans
  Mail Route CP250
  401 Carlson Parkway
  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

VII. DEFINITIONS

For the purpose 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 an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider, or part thereof.

3. **Person with an Ownership or Control Interest** means a person or corporation that: A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider; B) has a combination of direct and indirect ownership interests equal to 5% or more in the Provider; C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 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).

4. **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.

5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with any of the health plans listed on page 4 of this statement and to that health plan's obligations under its contract with the Department of Human Services.