envolve™
Benefit Options

Credentialing Packet

Packet may be submitted via the following:

Email: DentalCredentialing@EnvolveHealth.com

Fax: 1-844-847-9807

Mail: Envolve Dental, Inc.
P.O. Box 20606
Tampa FL 33622-5656

Checklist:

- ❑ CAQH ID Number (If Applicable, Email, Fax or Mail CAQH ID# along with supplemental documents below.)
- ❑ Provider Application
- ❑ Malpractice Insurance
- ❑ DEA License or DEA Waiver
- ❑ State License
- ❑ CDS License (If Applicable)
- ❑ Anesthesia Permit (If Applicable)
- ❑ Disclosure of Ownership Form (Per Tax Entity, States: AZ, KS, MO, NM, OH, MS, TX, IL, FL, SC, & PA)
- ❑ Provider & Location Roster (Per Tax Entity)
- ❑ W-9 (Per Tax Entity)
- ❑ Signed Contract (New Contracted Tax Entities)

LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.

**** All sections must be completed in their entirety. "See C.V.", not acceptable****

GENERAL INFORMATION

Last Name	Suffix	First GHH	Middle	Gender Male Female

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

Any other name under which you have been known? (AKA) List	ECFMG Number	UPIN Number

Home Street Address	City	State	Zip Code

Home Phone Number	Pager Number/Answering Service	Home Email Address *(optional)*

Social Security Number	Date of Birth	Birth Place *(City, State)*	Race/Ethnicity *(voluntary)*

NPI - Individual	Medicaid Provider Number	Medicare Provider Number

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name *(If Applicable)*	Office Manager

Tax Identification Number	Effective Date of Provider at this Practice Location	NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

Physical Address	City	State	Zip Code

Office Email	Office Website

Main Phone Number	Appointment Phone Number	Fax Number

Billing Address *(Where you want payments sent)*			Contact Person	Phone Number
City	State	Zip Code	Billing Email	Fax Number

Correspondence Address *(Where you want communications sent)*			Contact Person	Phone Number
City	State	Zip Code	Correspondence Email	Fax Number

Medical Records Address *(Where you want medical record requests sent)*			Contact Person	Phone Number
City	State	Zip Code	Medical Records Email	Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based
❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

Office Hours	Mon. _____-_____	Tues. _____-_____	Wed. _____-_____	Thur. _____-_____	Fri. _____-_____	Sat. _____-_____	Sun. _____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ Provider Other

PRIMARY PRACTICE LOCATION CONTINUED

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No

Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other: _____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)

Group, Covering or Collaborating Physician(s):

Contact Name:	Contact Phone Number:

SECOND PRACTICE LOCATION

Institution/Group/Clinic Name *(If Applicable)*	Office Manager

Tax Identification Number	Effective Date of Provider at this Practice Location	NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

Physical Address	City	State	Zip Code

Office Email	Office Website

Main Phone Number	Appointment Phone Number	Fax Number

Billing Address *(Where you want payments sent)*			Contact Person	Phone Number
City	State	Zip Code	Billing Email	Fax Number

Correspondence Address *(Where you want communications sent)*			Contact Person	Phone Number
City	State	Zip Code	Correspondence Email	Fax Number

Medical Records Address *(Where you want medical record requests sent)*			Contact Person	Phone Number
City	State	Zip Code	Medical Records Email	Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name: _____

Office Hours	Mon. _____-_____	Tues. _____-_____	Wed. _____-_____	Thur. _____-_____	Fri. _____-_____	Sat. _____-_____	Sun. _____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ Provider Other

SECOND PRACTICE LOCATION CONTINUED

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No

Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other: _____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)

Group, Covering or Collaborating Physician(s):

Contact Name:	Contact Phone Number:

THIRD PRACTICE LOCATION

Institution/Group/Clinic Name *(If Applicable)*	Office Manager

Tax Identification Number	Effective Date of Provider at this Practice Location	NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

Physical Address	City	State	Zip Code

Office Email	Office Website

Main Phone Number	Appointment Phone Number	Fax Number

Billing Address *(Where you want payments sent)*			Contact Person	Phone Number
City	State	Zip Code	Billing Email	Fax Number

Correspondence Address *(Where you want communications sent)*			Contact Person	Phone Number
City	State	Zip Code	Correspondence Email	Fax Number

Medical Records Address *(Where you want medical record requests sent)*			Contact Person	Phone Number
City	State	Zip Code	Medical Records Email	Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name: _____

Office Hours	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ Provider Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

THIRD PRACTICE LOCATION CONTINUED

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No

Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No
Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other:_____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No
Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

Emergency After Hours Number

Arrangements for 24 hour / 7 day a week coverage (Specify)

Group, Covering or Collaborating Physician(s):

Contact Name:

Contact Phone Number:

FOURTH PRACTICE LOCATION

(If you have more than four locations, attach additional sheets with the following information.)

Institution/Group/Clinic Name *(If Applicable)*

Office Manager

Tax Identification Number

Effective Date of Provider at this Practice Location

NPI – Group

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

Physical Address

City

State

Zip Code

Office Email

Office Website

Main Phone Number

Appointment Phone Number

Fax Number

Billing Address *(Where you want payments sent)*

Contact Person

Phone Number

City

State

Zip Code

Billing Email

Fax Number

Correspondence Address *(Where you want communications sent)*

Contact Person

Phone Number

City

State

Zip Code

Correspondence Email

Fax Number

Medical Records Address *(Where you want medical record requests sent)*

Contact Person

Phone Number

City

State

Zip Code

Medical Records Email

Fax Number

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

Office Hours	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ Provider Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

FOURTH PRACTICE LOCATION CONTINUED

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No	Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No
Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other:_____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No
Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)

Group, Covering or Collaborating Physician(s):

Contact Name:	Contact Phone Number:

SPECIALTY & CERTIFICATION

(as recognized by American Board of Medical Specialties or other national certification body)
Please attach a copy of current certification(s).

Type of Provider: ❑ Primary Care Physician ❑ Physician Specialist ❑ Both ❑ Other Specialty:_____

Primary Specialty:	Specialty Board Certified By:
Second Specialty:	Specialty Board Certified By:
Third Specialty:	Specialty Board Certified By:

DIRECTORY INFORMATION

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. ***Disclaimer: Use of information may vary by healthcare organization*.**

Primary Location	**Second Location**	**Third Location**	**Fourth Location**
❑ Specialty ❑ Directory	❑ Specialty ❑ Directory	❑ Specialty ❑ Directory	❑ Specialty ❑ Directory
❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory
❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory

PHO / IPA AFFILIATIONS*

List any other PHO's, IPA's, which you participate in and dates of participation:

**The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.*

CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

Hospital	Location/Address	Type of Privileges	Effective Date MO/YR

If you do not have admitting privileges, who admits for you and to what hospital? Please list provider's name, specialty and hospital.

EDUCATION

If additional training to what is requested below has been completed, please attach on a separate form.

Medical/Professional School:		
City	State	Zip
Degree	Year of Graduation	Dates Attended (MO/YR): From: _____ to _____
Internship: Institution Name	Type of Training	
City	State	
University Affiliation	Completed ❑ Yes ❑ No	Dates Attended (MO/YR): From: _____ to _____
Residency: Institution Name	Type of Residency	❑ Clinical ❑ Research
City	State	Dates Attended (MO/YR): From: _____ to _____
University Affiliation	Completed: ❑ Yes ❑ No	
Residency: Institution Name	Type of Residency	❑ Clinical ❑ Research
City	State	Dates Attended (MO/YR): From: _____ to _____
University Affiliation	Completed: ❑ Yes ❑ No	
Fellowship: Institution Name	Specialty Field	Dates Attended (MO/YR): From: _____ to _____
City	State	Completed ❑ Yes ❑ No
	Type of Fellowship	❑ Clinical ❑ Research
Fellowship: Institution Name	Subspecialty Fields	Dates Attended (MO/YR): From: _____ to _____
City	State	Completed ❑ Yes ❑ No
	Type of Fellowship	❑ Clinical ❑ Research

WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the MONTH and YEAR for each entity listed**. **Work history is critical. Failure to provide this information may delay your credentialing.**

Code:

C = Clinic/Group **S** = Solo Practice **A** = Academic (Paid Teaching Appointments)
H = Civilian Hospital Medical Staff Appointment **M** = Military Service (Including Hospital Staff Appointments) **O** = Other

CODE	NAME AND ADDRESS OF ENTITY	DATE *(From MO/YR to MO/YR)*
		/ to /
		/ to /
		/ to /
		/ to /
		/ to /
		/ to /
		/ to /
		/ to /

WORK HISTORY GAP

In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history.

Failure to provide this information may delay your credentialing

PROFESSIONAL LICENSES

Professional Licenses	License Number	Date Obtained	Expiration Date
State License			
Federal DEA Reg Number			
State CDS License Number			
CLIA Certificate			

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen?

❑ Yes ❑ No **If yes, a current copy of your CLIA Registration must accompany this application.**

For Dentists Only - Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic?)

❑ Yes ❑ No **If yes, a copy of your Anesthesia Permit must accompany this application.**

Have you been or are you <u>currently</u> licensed in any other state? If YES, please complete the following:

License Number State Date Obtained Expiration Date

License Number State Date Obtained Expiration Date

License Number State Date Obtained Expiration Date

(Please attach a copy of all licenses listed above and additional ones in other states not listed.)

REFERENCES

List, as professional references, three or more peers (Physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years.
(References should not be relatives or current partners.)

Name Specialty Phone Number

Street Address City State Zip

Name Specialty Phone Number

Street Address City State Zip

Name Specialty Phone Number

Street Address City State Zip

Name Specialty Phone Number

Street Address City State Zip

PROFESSIONAL LIABILITY INSURANCE COVERAGE

Name of Carrier:	Policy Number:
Address of Carrier:	Phone Number:
Amounts Per Occurrence/Aggregate:	Dates of Coverage:

Do you participate in the Louisiana Patients' Compensation Fund?	❑ Yes	❑ No
Are you self-insured in accordance with the Louisiana Medical Malpractice Act?	❑ Yes	❑ No
Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation)	❑ Yes	❑ No

Please attach a copy of the current Certificates of Insurance.

GENERAL QUESTIONS

Please check the appropriate response to the following questions:
If you answered YES to any of the questions below, please attach a full explanation on a separate page.

	YES	NO	N/A
1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you?	◉	○	○
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending?	○	○	○
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence?	○	○	○
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?	○	○	○
5. Have your clinical privileges at any hospital or healthcare institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board?	○	○	○
6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?	○	○	○
7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.	○	○	○
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	○	○	○
9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business? If YES, please enter the ownership percentage _____ and attach a full explanation.	○	○	○
10. Are you presently a named defendant in a pending professional liability lawsuit? If YES, please enter the number of cases _____ and attach a full explanation of each.	○	○	○
11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action? If YES, please enter the number of cases _____ and attach a full explanation of each.	○	○	○

REQUIRED ATTACHMENTS

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 9.
- ✓ Current Employer Identification Number (EIN) **and** W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:1009 (A) (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:1009, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

	X	
Name *(Please Print)*	**Signature**	**Original Attestation Date**
Second Attestation Date		**Third Attestation Date**

Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.

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DEA/CDS RELEASE

I, _____, NPI # _____, do not hold a DEA/CDS license; therefore, I will not prescribe any Schedule II – V medications while practicing in this state.

Please describe your process for handling instances when a patient requires a controlled substance. Select **one** of the options below and complete any applicable fields:

☐ ***I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management***

☐ I am eligible for a DEA or CDS, but do not have a current certificate. Therefore, I have an arrangement in place with the following provider and/or office, who currently holds an active DEA/CDS license:

_____

Provider Signature: _____ Date: _____

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To whom it may concern-

Please see the attached Disclosure of Ownership form for your location. The State has requested that this document be filled out and returned to us as quickly as possible as the final step in credentialing for your providers.

Only one copy of the Disclosure of Ownership form needs to be completed per Tax Entity.

Please return the completed form

to: Fax: 1-844-847-9807

-Or-

Email: dentalcredentialing@envolvehealth.com

Your assistance is greatly appreciated with this matter. If you have any questions please call our toll-free number at 1-844-342-5582.

Sincerely,

Credentialing Department

Instructions for Louisiana Medicaid Ownership Disclosure Information Entity/Business

This is a multi-page form. Please review the instructions in their entirety before completing the form. ***Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.***

Refer to the web sites listed on the previous pages for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Enter your Provider Name at the top of each page in the space provided.

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.
Taxpayer ID Number – Enter the nine (9) digit Tax ID number for this provider.
National Provider Identifier (NPI) – Enter your ten (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Update to Current Enrollment, Re-Validation, Re-Enrollment or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.
Provider Type – Enter the Louisiana Medicaid Provider Type for this Entity/Business.
Primary Telephone Number(s) of Disclosing Entity/Business - Enter the area code and telephone number(s) at the street address of this Entity/Business.
Doing Business As (DBA) Name – Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the Entity/Business license.
Legal Name of Disclosing Entity/Business – Enter the legal name of the Entity/Business in the space labeled "Legal Name of Entity/Business."
Primary Disclosing Entity/Business Street Address, City, State, Zip - Enter the physical business street address of the Entity/Business requesting enrollment. Enter the city, state and zip code of the physical business street address.
Primary Disclosing Entity/Business Mailing Address/PO Box, City, State, Zip – Enter the mailing address or PO Box of the Entity/Business requesting enrollment. Enter the city, state and zip code of the mailing address.
Additional Post Office Boxes Not Identified Above – Enter any additional Post Office Boxes for the Entity/Business that are stand-alone or not associated with any business location.
Disclosing Entity/Business Telephone Number to Request Medical Records – Enter the area code and telephone number(s) that the Entity/Business uses to answer requests for medical records.
Disclosing Entity/Business Primary Fax Number – Enter the area code and fax number(s) of this Entity/Business.
Email Address of Entity/Business contact person - Enter the email address of the contact person who should receive official LDH notices.
Entity/Business Website – Enter the web address of the Entity/Business website if applicable.

A. Is there a Corporate Office location for the disclosing Entity/Business? Check the appropriate box.
DBA Name of Corporate Office – If the Entity/Business does have a corporate office location, enter the DBA Name of that office.
Corporate Office contact information – Enter the street address, mailing address/PO Box, additional PO boxes, phone number, fax number and email address for the corporate office.

B. Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services? Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below. Lists are not acceptable.
DBA Name of Additional Location – Enter the DBA name of the additional practice location.
Medicaid Provider # - Enter the Medicaid Provider number of the additional practice, if applicable.
Additional Location contact information – Enter the mailing address/PO Box, street address, additional PO boxes, phone number, fax number and email address for the additional location office. Continue identifying additional locations and the contact information in the spaces provided. If needed, please attach additional sheets if there are more than three additional locations.

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service – Select only 1 of the categories. Multiple selections may result in a rejection for clarification.
Privately owned or Non-profit Providers Only – Identify the type of Entity/Business as it is registered with the Internal Revenue Service (IRS). Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of Entity/Business in the space(s) provided. Optional: May add comments in the space provided. Continue to Section II.
OR
Louisiana Government Providers Only – Identify the type of Entity/Business if Louisiana government owned. Select only one from among City and/or Parish, Department of Children and Family Services (DCFS), Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Villa, Other LDH agency, Local Education Agency (LEA), Louisiana State University (LSU), or Other State-owned entity. Check the appropriate box and complete the applicable fields.

D. Is this disclosing Entity/Business publicly traded? A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check the appropriate box.

E. Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application? Check the appropriate box. If yes, list all names and Tax IDs in the spaces provided. Attach additional pages if needed.

SECTION II – ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A. Has this Entity/Business (since its existence) AND any entity/business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows: Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, 1) provide a written statement including the details on all occurrences and 2) attach all official legal documents, including any reinstatements.

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program? Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the Entity/Business address, Entity/Business telephone number, and the Entity/Business email address of the person completing this form. Finally, enter any additional Entity/Business telephone number(s) and Entity/Business email address(es).

SECTION V – OWNERSHIP INFORMATION

Medicaid requires that an Entity/Business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this Entity/Business. A separate form, Section V(b), is required for each owner, therefore, please make the necessary copies as a list of owners will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Owners are individuals and/or organizations having direct, indirect, or controlling ownership interest in this disclosing Entity/Business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing Entity/Business.
- Indirect ownership is defined as an ownership interest in an Entity/Business that has direct or indirect ownership in this disclosing Entity/Business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the Entity/Business.
    - To dissolve or transfer this disclosing Entity/Business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the Entity/Business:

- Whose personal assets are used to satisfy the Entity/Business creditors.
- Who join together to carry on an Entity/Business and expect to share in the profits and losses of the Entity/Business.
- Who report their share of profits and losses of the Entity/Business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION V(a) – INFORMATION ON ALL OWNERS

***NEW FORMAT! Please read these directions in detail*.**

A. **Individuals & Entities/Businesses with Direct Ownership** –List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/ or controlling interest of 5% or greater in the disclosing Entity/Business. Add additional pages if needed.
NOTE: Section V(b) must be completed for each individual listed. Item B and Section V(c) must be completed for each entity/business listed.

B. **Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business** –
First column: List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business in the first column. The disclosing Entity/Business cannot list itself as an owner.
Second column: Name all owners of the entity/business listed in the first column.
Third column: Indicate the percent of ownership each owner has in the entity/business in the first column.
Fourth column: Indicate the percent ownership each owner has in the disclosing Entity/Business. This percent of indirect ownership in the disclosing Entity/Business is determined by multiplying the percentages of ownership in e

ach entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.
Add additional pages if needed.
NOTE: Section V(c) must be completed for each Entity/Business listed and Section V(b) must be completed for each individual listed.

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for **each and every individual owner named in Section V(a)**, whether the individual owns a direct or indirect stake in the disclosing Entity/Business. A list of all owners will not be accepted. **Make a copy of the blank form for each owner you report before you fill it out the first time.** For example, if you have five owners, you need to submit five completed Section V(b) forms.

A. **Individual Owner Information** – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this Entity/Business, the percentage of ownership of the Entity/Business, the Social Security Number (required), date of birth, current mailing address and physical address, telephone number and email address of the owner in the spaces provided.

B. **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?** – Read the question carefully and check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this owner a U.S. citizen?** Check the appropriate box. If no, provide the Alien Verification number.

D. **Does this owner reside outside the State of Louisiana?** – Check the appropriate box. If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the appropriate box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided. Attach additional pages if needed.

E. **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related (e.g. spouse, parent, child, sibling) in the spaces provided. Attach additional pages if needed.

F. **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

G. **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business participating in a Federal/State funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

H. **Has the individual owner named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. **Entity/Business Owner Information** – Enter the Entity/Business Name, the DBA Name, the Tax ID Number, the current street address of the primary location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided.

B. **Are there any business locations in addition to the location listed above?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location. Enter the DBA Name of the additional location, the Tax ID Number, the current street address of the additional location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided. Attach additional pages if needed.

C. **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?** Check the appropriate box. If yes, list all names and Tax IDs below. Attach additional pages if needed.

D. **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

E. **Is this Entity/Business and Tax ID listed in the Section I currently enrolled in a Federal/State funded healthcare program?** If yes, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments.

F. **Has this Entity/Business (since its existence) AND any Entity/Business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with, since the inception of those programs, as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, provide a written statement including the details on all occurrences. Attach all official legal documents, including any reinstatements.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

A separate VI(b) form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or manager control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

In the first table, enter the names of each agent, member or officer who is a part of management for the disclosing Entity/Business. In the second table, enter the names of each managing employee for the disclosing Entity/Business. Select the appropriate box to indicate if the individual is also an owner. If so, list their percentage of ownership. Add additional pages if needed.

NOTE: Section VI(b) must be completed for each individual listed unless individual has already been reported in Section V.

SECTION VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Make a photocopy of Section VI(b) for each managing employee/agent you report.

A. **AGENT– or – MANAGING EMPLOYEE –** Check a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, current physical address, telephone number and email address in the spaces provided.

B. **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? – C**heck the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this agent or managing employee a U.S. citizen?** Check the appropriate box. If no, provide Alien Verification number.

D. **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

E. **Has the agent or managing employee named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

F. **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION VII – AUTHORIZED REPRESENTATIVES

List the individuals who are authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms. Every person listed here must be either an owner or a managing employee as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a managing employee, or other (specify the title in the space provided).

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.
Title/Position of Authorized Representative – indicate the Authorized Representative's relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).
Signature of Authorized Representative – the authorized representative must sign the form. Signatures must be original and in blue ink (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.
Date of Signature – enter the date this agreement was signed.

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date. Please sign in colored ink (not black).

Reference Material for Louisiana Medicaid Ownership Disclosure Information
For an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:** http://url.ie/ywri

MAPIL Louisiana R.S., Title 46:437.1-14. http://url.ie/yw45

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://url.ie/yw46

Louisiana Update January/February 2009: http://url.ie/yw47

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://tinyurl.com/ne58pwb

Social Security Act 1128 a: http://tinyurl.com/3lnj2z9

Provider Name: _____

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number **(Leave blank if applying for new number)**							

Taxpayer ID Number										

National Provider Identifier (NPI)										

This enrollment packet is for a ☐ New Enrollment ☐ Update to Current Enrollment ☐ Re-Validation ☐ Re-Enrollment	☐ Change of Ownership (CHOW) _____ (Date of CHOW) _____ (Current Medicaid Provider Number)
Provider Type:	Primary Telephone Number of Disclosing Entity/Business ( ) -

Doing Business As (DBA) Name	Legal Name of Disclosing Entity/Business		
Primary Disclosing Entity/Business Street Address	City	State	Zip
Primary Disclosing Entity/Business Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Disclosing Entity/Business Telephone number to request medical records ( ) -	Disclosing Entity/Business Primary Fax Number ( ) -		
Email Address of Entity/Business contact person	Entity/Business Website (if applicable)		

A. ☐ Yes ☐ No Is there a Corporate Office location separate from the primary location of the disclosing Entity/Business?

If yes, complete the section below.

DBA Name of Corporate Office			
Corporate Office Street Address	City	State	Zip
Corporate Office Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Corporate Office Phone Number ( ) -	Corporate Office Fax Number ( ) -		
Corporate Office Email address			

Provider Name: _____

Make a photocopy of this page if more space is needed to list additional locations

B. ☐ **Yes** ☐ **No** **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Lists are not acceptable.

☐ If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Medicaid Provider #, if applicable		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item E below

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service

Select only one (1) – multiple selections may result in a rejection for clarification

Privately Owned or Non-profit Providers Only

☐ **Sole Proprietorship**

☐ **Partnership/Limited Liability Partnership**: How many members are identified with this partnership? _____

☐ **Corporation:** Revenue greater than or equal to $5M annually _____ Revenue less than $5M annually _____

In the (current) Articles of Incorporation: How many stakeholders/individual owners are identified? _____

How many Board of Director members are identified? _____

How many officers are identified? _____

☐ **Limited Liability Corporation (LLC)**
In the (current) Articles of Organization: How many members are identified? _____

How many managing employees are identified? _____

☐ **Non-profit:** How many members are appointed to the governing board? _____ (Must attach IRS verification showing the non-profit status)

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**

☐ **DCFS**

☐ **LDH**
☐ OBH ☐ OPH
☐ OAAS ☐ OCDD
☐ Villa ☐ Other _____

☐ **LEA (Local Education Agency)**

☐ **LSU**
Hospital -_____

☐ **Other State-owned entity:** _____

D. ☐ **Yes** ☐ **No** **Is this disclosing Entity/Business publicly traded? See instructions.**

E. ☐ **Yes** ☐ **No** **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID

Provider Name: _____

SECTION II – DISCLOSING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

A. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:

☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item A below

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. ☐ **Yes** ☐ **No** **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, provide the details in the fields below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

SECTION IV - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Social Security Number	Date of Birth	Job Title

The person completing this form is (please check one):

☐ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip

Entity/Business Telephone Number	Entity/Business Email Address
Additional Entity/Business Telephone Number(s)	Additional Entity/Business Email Address(es)

Provider Name: _____

NEW FORMAT! PLEASE REFER TO THE INSTRUCTIONS FOR DETAILED EXPLANTIONS!

Make a photocopy of this page if more space is needed to list owners in items A and B

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals & Entities/Businesses with Direct Ownership

List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/or controlling interest of 5% or greater in the disclosing Entity/Business.

*Fill out Section V(b) for each **Individual**. Fill out both item B and Section V(c) for each **Entity/Business** listed below.*

Individuals or Entities/Businesses with ownership	% of ownership
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business

List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business. Identify the owners of that Entity/Business and their % of ownership below.* The disclosing Entity/Business cannot be listed as an owner.

*Fill out Section V(b) for each **Individual** and Section V(c) for each **Entity/Business** listed below.*

Entity/Business/Organization with a direct ownership interest listed in item A	Owners of the Entity/Business identified on the left.	% of ownership in Entity/Business identified on the left	% of ownership in the disclosing Entity/Business
1.	a.		
	b.		
	c.		
	d.		
2.	a.		
	b.		
	c.		
	d.		
3.	a.		
	b.		
	c.		
	d.		
4.	a.		
	b.		
	c.		
	d.		
5.	a.		
	b.		
	c.		
	d.		

*The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

Provider Name: ____

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required) - -	Date of Birth / /

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
Mailing Address/PO Box	City	State	Zip Code

Telephone Number - -	Email address

B. ☐ **Yes** ☐ **No** **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☐ **Yes** ☐ **No** **Is this owner a U.S. citizen? If no, provide Alien Verification** ___________________________

D. ☐ **Yes** ☐ **No** **Does this owner reside outside the State of Louisiana?**

☐ Yes ☐ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☐ **Yes** ☐ **No** **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: _____

F. ☐ **Yes** ☐ **No** **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

G. ☐ **Yes** ☐ **No** **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: _____

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

H. Has the individual owner named above (ever):

☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name	Legal Name of Entity/Business	Tax ID Number (required)

Entity/Business Street Address – Primary Location	City	State	Zip
Entity/Business Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip

Telephone Number ( ) -	Fax Number ( ) -

Email address of Entity/Business contact person	Entity/Business Website (if applicable)

B. ☐ Yes ☐ No Are there any business locations in addition to the location listed above?

☐ If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number

Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip

Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -

Additional Location Email address

DBA Name of Additional Location	Tax ID Number

Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip

Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -

Additional Location Email address

C. ☐ Yes ☐ No Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: _____

D. ☐ Yes ☐ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

E. ☐ Yes ☐ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: _____

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. **F. Has this Entity/Business (since its existence) – AND –** **Any Entity/Business affiliated with the same Tax ID number – AND –** **Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:**	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: _____

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required) - -	Date of Birth / /

Mailing Address/PO Box	City	State	Zip Code
Physical Address	**City**	**State**	**Zip Code**

Telephone Number - -	Email address

B. ☐ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☐ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☐ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: _____

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ☐ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1.	☐ Owner ☐ Managing employee ☐ Other _____
2.	☐ Owner ☐ Managing employee ☐ Other _____
3.	☐ Owner ☐ Managing employee ☐ Other _____
4.	☐ Owner ☐ Managing employee ☐ Other _____
5.	☐ Owner ☐ Managing employee ☐ Other _____
6.	☐ Owner ☐ Managing employee ☐ Other _____
7.	☐ Owner ☐ Managing employee ☐ Other _____
8.	☐ Owner ☐ Managing employee ☐ Other _____
9.	☐ Owner ☐ Managing employee ☐ Other _____
10.	☐ Owner ☐ Managing employee ☐ Other _____

Please sign in blue ink (not black)

Printed Name of Authorized Representative

Signature of Authorized Representative
(sign in blue ink)

Title/Position

Date of Signature

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Printed Name of Authorized Representative	Signature of Authorized Representative *(sign in blue ink)*
Title/Position of Authorized Representative	Date of Signature

EXHIBIT B
LIST OF CONTRACTED PROVIDERS
(List ALL entities/providers affiliated with this Agreement)

PROVIDER									LOCATION															HOURS OF OPERATION							
FIRST NAME	LAST NAME	CAQH ID	NPI	DEGREE	SPECIALTY	SSN	DOB	TAX ID	LOCATION NPI	PRIMARY LOCATION	LOCATION NAME	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP CODE	PHONE	FAX	EMAIL	HANDICAP ACCESS	SPECIAL NEEDS	LANGUAGE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	HOLIDAYS

envolve®
Benefit Options

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

To enroll in Envolve Dental's EFT payment program, complete this form and return it with a **voided check** via one of the following:

Mail: Envolve Dental
P.O. Box 25656
Tampa, FL, 33622-5656

Fax: 844-847-9807

Email: Envolve.DentalPDM@envolvehealth.com

I – CHECK APPLICABLE REASON FOR SUBMISSION

❑ New EFT Authorization OR ❑ EFT setup revision (e.g. account number or bank changes)

II – PROVIDER/PAYEE INFORMATION

Payee name: _____

Tax Identification Number (TIN): (Designate SSN ❑ or EIN ❑) _____

Payee street address, City, State, Zip Code: _____

III – DEPOSITORY INFORMATION (Financial Institution)

Your bank/depository name: _____

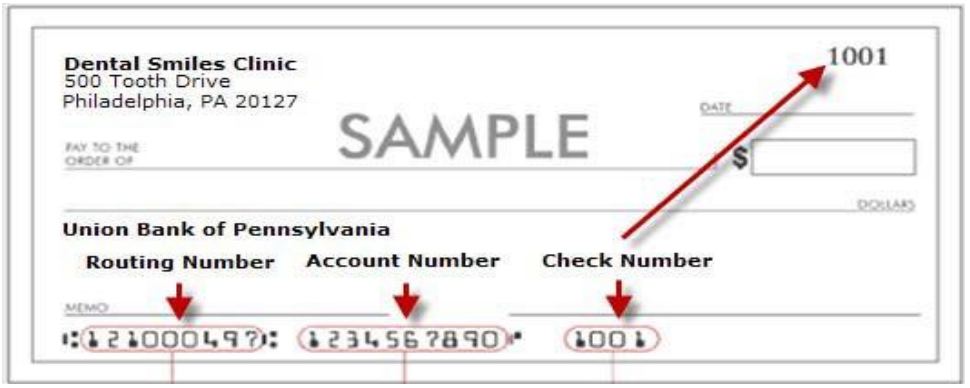
Account type (check one):
❑ Checking ❑ Savings

Depository routing transit number
(Nine digits. Include any leading zeroes):

_____

Depositor account number
(Include any leading zeroes):

_____



IV – CONTACT INFORMATION

Name of billing contact person:_____

Phone number of billing contact:_____

Email address of billing contact:_____

V – AUTHORIZATION

I hereby authorize Envolve Dental to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of authorized billing contact: _____ Date: _____

ELECTRONIC FUNDS TRANSFER (EFT) Terms of Use

The following terms and conditions, as amended from time to time ("Agreement") apply to all use of the Envolve Dental's Electronic Funds Transfer solution, and the use of any service provided in connection therewith (collectively the "EFT Services"). In this Agreement, the words "you", "your" and "yours" means the individual(s) entity or entities identified on the attached Electronic Fund Transfer (EFT) Authorization Agreement, and the words "we," "our," "us" refers to Envolve Dental affiliates and designees. Your enrollment or use of the EFT Services signifies your agreement to be legally bound by the terms and conditions set forth herein. **ACH and Wire Transfers.** This Agreement is subject to Article 4A of the Uniform Commercial Code -- Funds Transfers. By signing this Agreement, you authorize Envolve Dental, acting on behalf of any third party administrator, health care coalition, or health plan carrier (each a "Carrier") that participates in the EFT Services, to credit or debit the accounts listed on your Enrollment Form (the "Accounts") in connection with processing transactions between you and the Carriers. We may rely upon all Account information and identifying numbers provided by you on the Authorization Agreement to receive payment. We may rely on the routing and account numbers you provided even if they identify a financial institution, person or account other than the one named on the Enrollment Form You agree to be bound by National Automated Clearing House Association (NACHA) rules. These rules provide, among other things, that payments made to you, are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the Uniform Commercial Code. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your Account and the Carrier that originated or instructed such payment will not be considered to have paid the amount so credited. We are not required to give you any notice of debits or credits to your Accounts. We may make adjustments to your Accounts whenever a correction or change is required. For example, if we make an error with respect to your Account, you agree that we may correct such error immediately and without notice to you. Such errors may include, but are not limited to, reversing an improper credit to your Account, making adjustments for returned items, and correcting calculation and input errors. Our right to make adjustments shall not be subject to any limitations or time constraints, except as required by law. **Accounts.** You represent and warrant that (a) you are the owner of each of the Accounts and (b) none of the Accounts is used primarily for personal, family or household purposes. **Confidentiality.** During the term of this Agreement, from time to time, we may disclose or make available to you, whether orally, electronically or in physical form, confidential or proprietary information concerning us and/or our business, products or services in connection with this Agreement(together, "Confidential Information"). Confidential Information includes, without limitation, business plans, health plan relationships, acquisition plans, systems architecture, information systems, technology, data, computer programs and codes, processes, methods, operational procedures, finances, budgets, policies and procedures, customer, employee, provider, member, patient and beneficiary information, claims information, vendor information(including agreements, software and products), product plans, projections, analyses, plans, results, and any other information which is normally and reasonably considered confidential. You agree that during the term of this Agreement and thereafter: (i) you will use Confidential Information belonging to us solely for the purpose(s) of this Agreement; and (ii) you will take all reasonable precautions to ensure that you do not disclose Confidential Information belonging to us to any third party (other than to your employees, contractors and/or professional advisors on a need-to-know basis who are bound by obligations of nondisclosure and limited use precautions at least as stringent as those contained herein) without first obtaining our written consent. **Confidentiality Exclusions.** For purposes hereof, "Confidential Information" will not include any information that you can establish by convincing written evidence: (i) was independently developed by you without use of or reference to any Confidential Information belonging to us; (ii) was acquired by you from a third party having the legal right to furnish same to the you without disclosure restrictions; or (iii) was at the time in question (whether at disclosure or thereafter) generally known by or available to the public (through no fault of you).**Amendments and Termination.** Envolve Dental may add, remove, change or otherwise modify any term of this Agreement at any time. We may also terminate or discontinue some or all of the EFT Services at any time without notice to you. **Governing Law and Venue.** The laws of the State of WI shall govern this Agreement and all disputes arising hereunder. You hereby consent that jurisdiction and venue are proper in the State of WI for the resolution of any dispute arising under this Agreement. **Severability.** If any provision of this document is found to be unenforceable according to its terms, all remaining provisions will continue in full force and effect. **Headings.** Headings in this document are for convenience or reference only and will not govern the interpretation of the provisions. **Construction.** Except where it would be unreasonable or illogical to do so, words and phrases used in this document should be construed so the singular includes the plural and the plural includes the singular. **Cooperation.** You agree to cooperate fully with us in furnishing any information, documentation or performing any action requested by us. You shall furnish us, upon forty-eight (48) hours notice, with true, accurate and complete copies of such records, documentation or any other information we or our authorized employees, representatives, agents and any regulatory agencies may request; provided, however, that you shall not be required to divulge any records to the extent prohibited by applicable law. **Ownership.** Except as provided in this Agreement, Envolve Dental shall have and own all rights, title and interests in the EFT Services and any information arising from or in connection therewith. You hereby acknowledge the specific ownership interests of Envolve Dental as set forth herein and you shall not acquire any ownership rights by virtue of this Agreement. **Assignment.** You agree not to assign this Agreement, directly or by operation of law or subcontract, delegate or appoint any third-party agent to perform any or all of its duties obligations or services hereunder without our written consent, and any such attempted assignment, subcontracting, delegation or appointment without such consent shall be void. All written notices shall be delivered by registered or certified mail, return receipt requested, and shall be deemed effective seventy-two (72) hours after the same is mailed via certified mail as described above with postage prepaid. Notice sent by any other method shall be effective only upon actual receipt. The parties to this Agreement, by notice in writing, may designate another to whom notices shall be given pursuant to this Agreement. **Relationship of the Parties.** The relationship between both parties under this Agreement is that of independent contractor. Nothing herein contained shall be construed as constituting a partnership, joint venture or agency between the parties hereto. **Entire Agreement.** This Agreement, which is an integral part hereof and are incorporated herein as a part of this Agreement, constitute the only agreement between the parties hereto relating to the subject matter hereof, except where expressly noted herein, and all prior negotiations, agreements and understandings relating to the subject matter hereof, whether oral or written, are superseded or canceled hereby. **Force Majeure.** Envolve Dental shall not be liable for a delay in performance or failure to perform any obligation under this Agreement to the extent such delay is due to causes beyond our control, including, but not limited to, governmental requests, regulations or orders, utility or communications failure, delays in transportation, national emergency, war, civil commotion or disturbance, war conditions, fires, floods, storms, earthquakes, tidal waves, failure or delay in receiving electronic data, equipment or systems failure or communication failures. **Warranties.** ENVOLVE DENTAL HEREBY DISCLAIMS ALL WARRANTIES WITH RESPECT TO THE SERVICES AND PRODUCTS PROVIDEDHEREUNDER, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING WITHOUT LIMITATION ANYWARRANTY OFMERCHANTABILITY OR FITNESS FOR USE FOR A PARTICULAR PURPOSE. Under no circumstances shall the financial responsibility of Envolve Dental for any failure of performance by us under this Agreement exceed the fees or charges paid by you to Envolve Dental for the transaction, or activity that is or was the subject of the alleged failure of performance. IN NO EVENT SHALL ENVOLVE DENTAL, ITS PARENT,AFFILIATES, SUBSIDIARIES, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES BE LIABLE FOR SPECIAL,INCIDENTAL OR CONSEQUENTIAL DAMAGES OR CLAIMS BY YOU OR ANY THIRD PARTY RELATIVE TO THE TRANSACTIONS HERE UNDER. **Indemnification.** You shall be liable to and shall indemnify, defend and hold Envolve Dental its directors, officers, employees, representatives, successors and permitted assigns harmless from and against any and all claims, demands by third parties, losses, liability, cost, damage and expense, including litigation expenses and reasonable attorneys' fees and allocated costs for in-house legal services, to which Envolve Dental, its directors, officers, employees, representatives, successors and permitted assigns may be subjected or which it may incur in connection with any claims which arise from or out of or as the result of (a) your breach of this Agreement; (b) your performance, duties and obligations under this Agreement; or (c) the negligence or willful misconduct of you, your directors, officers, employees, agents and affiliates in the performance of their duties and obligations under this Agreement. You shall bear all risk of loss of items, records, data and materials during transit from you to Envolve Dental's location or that of Envolve Dental's agents or sub-contractors. **Waiver.** No waiver or failure to exercise any option, right, or privilege under the terms of this Agreement on any occasion or occasions shall be construed to be a waiver of the same or any other option, right or privilege on any other occasion.

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.