BEACON HEALTH OPTIONS, INC. DISCLOSURE OF OWNERSHIP FORM

Directions: In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100- 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program or any line of business that provides healthcare for federal employees. The Centers for Medicaid and Medicare Services (CMS) requires Beacon Health Options, Inc. to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal and state health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.

Please complete the following 3 pages below and fax the completed forms to: **866-612-7795.** This form is required if you wish to participate or continue to participate in the plan. You are also reminded that any changes to this information in the future must be reported to Beacon Health Options, Inc. within 35 business days of the change and updated information will be requested upon recredentialing. Please provide information for Owners, persons with Control interests, Agents and Managing employees of the Provider Entity. Attach a separate sheet/report if needed. If the company is a non-profit please put N/A in % ownership column.

Definitions:

Owner (1) is a person or business entity which owns 5% or more of the assets, stock or profits of the Provider Entity. This 5% may be Direct ownership or Indirect ownership i.e., an individual might own 50% of a company that owns the actual Provider Entity meaning their indirect ownership is 50%. In addition to ownership of stock, (2) Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Provider Entity.

Control Interest is someone who directs the Provider Entity and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the Provider Entity is a non-profit entity, respond N/A in the column for % of ownership.

Managing Employee is someone who makes the day to day decisions for the Provider Entity. These individuals include office or billing managers for smaller providers, and for larger Provider Entities the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

Agent is an individual who has the legal ability to bind the Provider Entity, i.e., the Provider Entity may use an Agent to obtain contracts for it.

Debarred or Excluded means an individual or entity that is not allowed to do business with the Federal government, including healthcare programs receiving Federal funding or reimbursement.

Terminated means the Provider lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

Immediate Family is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. Member of Household is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

A **Subcontractor** is a person or company that this Provider Entity has contracted with to do some of the Provider Entities' management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Supplier means an individual, agency, or organization from which the Provider Entity purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

Master List: The list of owners the provider will be disclosing on form.

Provider Entity: Any individual or entity engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation

I. IDENTIFYING INFORMATION

Name of person Completing form	**Phone number of person completing form**
Provider Name	

Provider Entity Name	**Provider Entity DBA Name (if different from Provider Entity name)**	**Provider Entity Federal Tax Id number**

Provider Entity NPI number (If you have one, if not indicate if applied for.)	**Provider Entity Medicaid ID number** (If you have one, if not indicate if applied for.)	**Provider Entity Telephone Number**

Provider Entity Address- Must include at least one street address. List all Practice locations (attach a separate sheet if needed)**.**	**City**	**State**	**Zip**

II. OWNER OR CONTROL INFORMATION

A. Master List- If attaching reports please indicate corresponding columns below.

Name	**Address** (For *individuals* use Home address. For *business entities* that might have Ownership/Control interest use all street addresses (if more than one location), and P.O. Box address if any.)	**City**	**ST**	**ZIP**	**DOB**	**SSN** for individuals **or Tax ID** for business entities	**% own er-ship.**	**Title**

B. Specific Questions

1) Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If yes, please provide the following information about the related persons:

Name of First related person	**Name of Second related Person**	**Type of relation**

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**? ? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If "yes", please provide the following information about the other Provider Entity the person on the Master List has an interest in.

Name of other Provider Entity	**Address**	**City**	**State**	**Zip**	**Tax I.D.**

3) Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Tricare or the CHIP services program since the inception of those programs?

Yes ☐ No ☐. If yes, please provide the information requested below:

Name on Court records	**SSN /TIN**	**Matter of the Offense**	**Date of the Conviction**	**Exclusion Period of the Offense** if you were excluded by the Federal Office of the Inspector General(OIG)

4) Have any of the individuals or entities on the **Master List** ever been **Debarred or Excluded** from participation in Federal Government contracts (Medicaid, Medicare, CHIP or Tricare)?

Yes ☐ No ☐ If 'yes' is checked, provide the following information:

When you were debarred	**Length of Debarment**	**Reason for Debarment**

5) Has any person or entity on the **Master List** ever been **Terminated or had Civil Monetary Penalties** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?

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

State where practicing when terminated	**Reason for termination**	**Date of termination**

6) Did anyone on the **Master List** obtain their **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from participation in a federal healthcare program and 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's household, at the time of the transfer of ownership? If attaching a report, please indicate corresponding columns below.

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

Name of original **Owner**	SSN or TAX ID of original **Owner**	Place of Transfer	Date of Transfer

7a) List any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab. If attaching a report, please indicate corresponding columns below.

Name of Subcontractor	**Address**	**City**	**State**	**Zip**	**Tax I.D.**

7b) For each **Subcontractor(s)** listed in 7a above please provide the following information for the individuals with an Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary. If attaching a report, please indicate corresponding columns below.

Name	**Address** (for individuals use Home address, for business entities that might have Ownership/Control interest use all street addresses (if more than one location), and P.O. Box address (if any)	**City**	**ST**	**Zip**	**DOB**	**SSN** for individuals **or Tax ID** for business entities	**% of owner-ship**	**Title**

7c) Is anybody in the list in 7b list related to any person in the **Master List** above? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If yes, please supply the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

III. BUSINESS TRANSACTIONS

1) Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.7a. in which you have an **Direct or Indirect Ownership interest**. If attaching a report, please indicate corresponding columns below.

Name	Address	City	State	Zip

2) Does the **Provider Entity** *wholly own* a **Supplier**? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If yes, supply the following information about the **Supplier:**

Name	Address	City	State	Zip	NPI	TIN

Answer the following questions by checking '"Yes" or "No'•. If any of the questions are answered "Yes," list names and addresses of individuals or corporations and/or provide date and an explanation.

1. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVRN providers only)
   Yes☐ No☐
2. Has there been a change in ownership or control within the last year? If yes, give date and provide explanation below.
   Yes ☐ No☐
3. Do you anticipate any change of ownership or control within the year? If yes, provide date and explanation below.
   Yes☐ No☐
4. Do you anticipate filing for bankruptcy within the year? If yes, when?
   Yes☐ No☐
5. Is this facility, agency, institution or organization operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations and provide explanation below.
   Yes☐ No☐
6. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
   Yes☐ No☐
7. Is this facility, agency, institution or organization chain affiliated? (If yes, list name, address of Corporation, and EIN)
   Yes☐ No☐
   If the answer to Question 7 is No, was the facility, agency, institution or organization ever affiliated with a chain? If yes, list Name, Address of Corporation, and EIN.
8. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?
   Yes☐ No☐ N/A☐

IV. SIGNATURE

Beacon Health Options, Inc. may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of an individual who can legally bind this **Provider Entity**;

Name of Person (Printed)	Signature of Person	Title	Date