Dear Provider:

As you are aware, by law, the U.S. Department of Health and Human Services' Office of Inspector General (OIG) and the Office of the Medicaid Inspector General (OMIG) have the legal authority to exclude individuals and entities from participating in federal and State health care programs - including Medicaid and Medicare. The names of these excluded individuals and entities are maintained on State and federal exclusion lists.

If OIG excludes a health care provider under a Medicare program, the Centers for Medicare & Medicaid Services (CMS) prohibits the reimbursement of any items or services furnished, ordered, or prescribed by that Provider. Similarly, the New York State Department of Health (DOH) prohibits the reimbursement of any items or services furnished, ordered or prescribed by a Provider excluded from participating in the NYS Medicaid Program. Under 18 NYCRR 515, iCircle Services of the Finger Lakes, Inc., as a New York State Managed Care Organization (MCO), is prohibited from entering into or renewing an agreement with any Provider that has been excluded from receiving Medicare or Medicaid reimbursement.

Any Provider who is entering into or renewing an agreement with an MCO is required by State and federal law to disclose to the MCO the identity of any individuals or entities with ownership or control interest in its business of five percent (5%) or greater. The MCO is subsequently required to determine if any such individuals or entities who meet these criteria are on either the OIG or OMIG exclusion lists.

All contracted Providers must complete a Business Ownership and Control Disclosure form at the time of initial enrollment and at the time of contract renewal. In addition, contracted Providers are required to complete this form within thirty five (35) days of any subsequent change in ownership or control. 42 CFR 455.106 further requires contracted Providers to disclose the identity of any individual with ownership or control interest in its business that becomes known to it to be convicted of a criminal offense related to that individual's involvement in any program under Medicare, Medicaid, or the Title XX services program.

Please see the following definitions for further explanation of what constitutes an ownership interest, direct and indirect ownership, and other key terms.

Please return the completed form by email to Credentialing@icirclecny.org. This mailbox is secure and can accept encrypted emails.

Definitions

Agent: Any person who has been delegated with the authority to act on the behalf of the provider.

Provider: The individual, group, or entity entering into a contract with an MCO.

Disclosing Entity: Any entity other than an individual practitioner or group of practitioners that is seeking status as a participating provider in an MCO's network.

Indirect Ownership: Any ownership interest in an entity that has an ownership interest in the disclosing entity. This includes ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Ownership Interest: The possession of equity in the capital, the stock or the profits of the disclosing entity.

Person with an Ownership of Control Interest: A person or corporation that:

(A) has an ownership interest totaling five percent (5%) of more in the disclosing entity;

(B) has an indirect ownership interest equal to five percent (5%) or more in the disclosing entity;

(C) has a combination of direct and indirect ownership interests equal to five percent (5%)or more in disclosing entity;

(D) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity if that interest equals at least five percent (5%) of the value of the property or assets of the disclosing entity;

(E) is an officer or director of the disclosing entity that is organized as a corporation; or

(F) is a partner in a disclosing entity that is organized as a partnership.

Subcontractor: An individual, agency or organization to which a disclosing entity has contracted or delegated some or its management functions or responsibilities of provider medical care to its patients.

Supplier: An individual, agency or organization from which a provider purchase goods and services used in carrying out its responsibilities under Medicaid.

Wholly Owned Supplier: A supplier whose total ownership interest is held by a provider or by a person, persons or other entity with an ownership or control interest in the provider.

Disclosure of Ownership and Control Interest Statement

The Federal regulations set forth in 42 CFR 455.104,455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to iCircle Services. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice or Disclosing Entity:
DBA Name:
Address: City: State: Zip code: Telephone:
Federal Tax Identification Number:
☐ Sole Proprietorship ☐ Professional Association ☐ Partnership or LLC ☐ Corporation- For Profit ☐ Corporation- Not For Profit ☐ Other (Identify)
☐ NYS Certified Minority Owned Business ☐ NYS Certified Women Owned business (check one if applicable)

Section 1

For individuals: list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.
For entities: list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

Name of Individual or entity	DOB	Address	SSN (individual) TIN (entity)

Section 2

Are any of the individuals listed above related to each other? ☐ Yes ☐ No
If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of Relation

Section 3

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☐ No
If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5 % or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (individual) TIN (entity)

Disclosure of Ownership and Control Interest Statement

Section 4

Has any person who has an ownership of control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or title XX program? ☐ Yes ☐ No
If yes, please list those persons below. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (individual)

Section 5

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No
If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provide and any subcontractor, during the past 5 year period. (42 CFR 455.104)
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section 6

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No
If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN) and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in denial of participation.

_____ _____

Signature **Title (or indicate if authorized Agent)**

_____ _____

Name (please print) **Date**

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