COVERKIDS
Ownership and Control Interest Statement and Criminal Information Form
BlueCross BlueShield of Tennessee (BCBST)
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Chattanooga, TN 37402
Fax: (423) 535-3066
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DISCLOSURE FORM FOR A PROVIDER PERSON

Directions: The Disclosure of Ownership and Control Interest Statement and Criminal Information Form (form) must be submitted as follows: 1) at the time a **Provider Person** is initially enrolled for the CoverKids program; 2) at the time a **Provider Person** is being re-accredited and/or re-contracting for the CoverKids program; 3) at the time a **Provider Person** is being re-enrolled for the CoverKids program; 4) whenever there is a material change in the information required by this form; and 5) upon request by CoverKids, any federal or state agency, or the CoverKids Plan Administrator, BlueCross BlueShield of Tennessee, Inc. (BCBST). If the addition of the **Provider Person** will change the **Ownership** or **Control** structure of the **Provider Entity** that the **Provider Person** is joining, (for example, the new **Provider Person** will also be an owner or high ranking employee of the **Provider Entity)**, then a new form for the **Provider Entity** must also be filled out to reflect the new **Ownership** or **Control** arrangements. Also use this form to update name changes or address changes.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return the original to BCBST at the address or fax numbers above. Additional information on the form may be accessed at the CoverKids website located on-line at http://www.coverkids.com/ and/or the BCBST website located on-line at http://www.bcbst.com/providers/, then select Cover Tennessee. Please retain a copy for the **Provider Person's** files. Completely answer the applicable questions. If a question is not applicable please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***. Website, and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

Social Security Numbers (SSN) must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing SSN.

Name of Individual Completing Form	Phone Number of Individual Completing Form

I. Identifying Information

Name of **Provider Person**	SSN	DOB	**Provider Person** NPI Number (If the Provider Person does not have one, indicate if applied for and date submitted.)	**Provider Person** TennCare/Medicaid/Medicare I.D. Number (If the Provider Person does not have one, indicate if applied for and date submitted.)

Home Address of **Provider Person**	City	State	Zip

Name of Provider Entity (Provider Entity is who the **Provider Person** works for. If the **Provider Person** is a sole proprietor, he/she would also list themselves as the Provider Entity.)	Provider Entity Doing Business As (DBA) Name (If different from Provider Entity Name.)	Provider Entity Address (If the Provider Entity has more than one practice location list all locations.)

Provider Entity T.I.N.	Provider Entity N.P.I. (If the Provider Entity does not have one, indicate if applied for and date submitted.)	Provider Entity TennCare/Medicaid/Medicare I.D. Number (If the Provider Entity does not have one, indicate if applied for and date submitted.)

II. Criminal Offense Attestation

A) Has the **Provider Person** has ever been **Convicted** of a criminal offense related to his/her involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs? **"Convicted"** means been found guilty by a jury or judge, or pled guilty, *nolo contendre*, best interest plea or pre trial diversion or suspended sentence. **Yes** ☐ **No** ☐

If 'Yes' is checked, provide the following information:

Name on Court Records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if **Provider Person** was Sanctioned by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG)

B) Has the **Provider Person** ever been **Debarred** from participation in Federal Government contracts? **"Debarred"** means the **Provider Person** is or was not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes ☐ No ☐

If 'Yes' is checked, provide the following information:

When the **Provider Person** was Debarred	Length of Debarment	Reason for Debarment

C) Has the **Provider Person** ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past? "Excluded" means that a **Provider Person** or Provider Entity has been told by the HHS,OIG that he/she/it may no longer be a provider for any federally funded health care program.

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

Beginning Date of Exclusion or Termination	End Date of Exclusion or Termination	Reason for Exclusion or Termination

D) Has the **Provider Person** ever been **Terminated** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the **Provider Person** lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

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

State where Practicing when Terminated	Reason for Termination	Date of Termination

E) Has the **Provider Person** ever had **Civil Monetary Penalties (CMPs)** assessed against him/her? A CMP is a type of fine assessed against a **Provider Person** by a governmental agency that manages a federal health care program.

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

State where Practicing when CMP Assessed	Reason for CMP	Amount of CMP	Date of CMP

III. Questions for a Sole Proprietor

A) If the **Provider Person** is a Sole Proprietor, please give the following information for his/her **Managing Employees and Agents.** A **Managing Employee** is someone who makes day to day decisions on the running of the **Provider Person's** business, such as, an office manager or billing manager**.** An **Agent** is someone besides the **Provider Person** who can legally act for the **Provider Person's** business.

Name of Managing Employee or Agent	SSN	DOB	Home Address	City	State	Zip

B) Has any individual listed in III. A. been convicted of a criminal offense related to his/her involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs? **"Convicted"** means been found guilty by a jury or judge, or pled guilty, *nolo contendre*, best interest plea or pre trial diversion or suspended sentence. Yes ☐ No ☐ . If yes, please provide the following information:

Name on Court Records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if he/she was Sanctioned by the HHS, OIG

C) Has any individual on the list in III. A. ever been **Debarred** from participation in Federal Government contracts? **"Debarred"** means someone is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes ☐ No☐

If 'Yes' is checked, provide the following information:

When the Individual was Debarred	Length of Debarment	Reason for Debarment

D) Has any individual on the list in III. A. ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past

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

Name of Individual	Beginning Date of Exclusion or Termination	End Date of Exclusion or Termination	Reason for Exclusion or Termination

E) Has any individual on the list in III. A. ever been terminated 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

F) Has any individual on the list in III. A. ever had **Civil Monetary Penalties (CMPs)** assessed against them?

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

Name of Individual	State where Practicing when CMP Assessed	Reason for CMP	Amount of CMP	Date of CMP

IV. Signature

The federal or state CHIP agencies may refuse to enter into, renew, or terminate an agreement with a **Provider Person** if it is determined that a **Provider Person** 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 the **Provider Person**:

Name of **Provider Person** (Printed)	Signature of **Provider Person**	Date