



## Confidential Questions

**Note: Please attach an explanation on a separate sheet if you have answered “yes” to any of the questions below.**

**Yes**      **No**

- Have you lost your board certification, or failed to recertify in the past three (3) years?
- During the past three (3) years, has your license or certificate to practice medicine or Drug Enforcement Administration registration in any state or jurisdiction been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, or is any such action pending?
- Have you been convicted of a felony in the past three (3) years?
- Has Medicare, Medicaid, or any other local, state or federal government program brought formal charges against you for alleged inappropriate fees or Quality of Care issues in the past three (3) years?
- In the past three (3) years have any claims or damages arising out of medical malpractice been made against you, or has any professional liability lawsuit been filed against you?
- In the past three (3) years have you been the subject of any reports to a state or federal databank?
- Do you now have or have you had in the past three (3) years any physical or mental limitations (including drug or alcohol dependency) treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications, with or without reasonable accommodations according to accepted standards of professional performance and without posing a direct threat to patients?
- Has your professional liability coverage been restricted, limited, denied or nonrenewed in the past three (3) years?
- Has any hospital, facility, HMO, or other health plan limited, denied, revoked, or restricted your professional privileges in the past three (3) years?

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Provider's Signature

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Date



## Disclosure of Ownership and Control Interest Statement for the NovaSys Health network maintained by Arkansas Health and Wellness

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 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 Statement, an updated Statement should be completed and submitted to the NovaSys Health network maintained by Arkansas Health and Wellness within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

### Practice Information

Check one that describes you: <input type="checkbox"/> Individual Practitioner <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity	
Name of Individual Practitioner, Group Practice, or Disclosing Entity ("Provider")	
DBA Name:	
Address:	
TIN or SSN:	NPI:

### Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the Provider (e.g. an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the Definition of "person with ownership or control interest" in the Instructions), list the name, address, date of birth (DOB) and Social Security Number (SSN) for each such individual.

For entities with an ownership or control interest in the Provider, list the name, Tax Identification Number (TIN), and each address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if an individual) TIN (if an entity)

## Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the Provider has an ownership or control interest of 5% or more?  Yes  No  
 If yes, list the name, address, DOB and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if listing an individual) TIN (if listing an entity)

## Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other?  Yes  No  
 If yes, list the individuals who are related to each other, and the type of relationship (spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

Names	Type of relationship

## Section IV: Convictions

Has any person who has an ownership or 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 (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN

## Section V: Business Transactions

Has the Provider had any financial transactions with any subcontractors totaling more than \$25,000 with any subcontractors during the previous 12 months?  Yes  No  
 Has the Provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous 5 years?  Yes  No

If yes, list the ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the previous twelve month period, and any significant business transactions between the Provider and any wholly owned supplier or between the Provider and any subcontractor during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

**Section VI: Managing Employees**

Does the Provider have any managing employees?  Yes  No

If yes, list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and percent of interest. (42 CFR 455.104) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN	% Interest

If "Group Practice" or "Disclosing Entity" is checked in the Practice Information section above, the undersigned hereby represents that he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate, and on behalf of each physician and practitioner listed on Exhibit A attached to this Statement, and the undersigned represents that he, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed physician and practitioner.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading, inaccurate, or incomplete data may result in a denial of participation for the affected providers.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title (or indicate if authorized Agent)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

Please return by fax to **844-357-7890**, by email to **arkcredentialing@centene.com**, or by mail in the enclosed postage paid envelope to:  
**P.O. Box 25538**  
**Little Rock, AR 72221**