All application questions must be completed in full in order for the credentialing process to begin. Incomplete applications will be returned for completion.

arkansas health & wellness

arkansas total care

(MD's or DO's) NovaSys Health Practitioner Application

Last Name _____ First Name _____ Middle _____ Degree _____ Soc. Sec. Number _____
(*Used for identification only*)

Date of Birth _____/_____/_____ Sex ____M _____F Language(s) Spoken _____

Individual NPI_____ Medical License Number_____ DEA Certificate Number_____

Are you a participating Medicare Provider? ☐ **Yes** ☐ **No** Medicare Provider Number: _____

Are you a participating Medicaid Provider? ☐ **Yes** ☐ **No** Medicaid Provider Number: _____

Program Participant: PCMH _____ CPC+ Track 1 _____ CPC+ Track 2 _____

Primary Office Location **Effective Date:** _____

Please attach a complete listing of all practice locations including location specialty.

Clinic Name _____

Street Address _____

City, State, Zip _____

( ) _____ ( ) _____
Telephone Number Fax Number

Group NPI _____

Tax ID _____

Mailing Address

Clinic Name _____

Street Address _____

City, State, Zip _____

( ) _____ ( ) _____
Telephone Number Fax Number

E-Mail Address _____

Office Manager _____

Website URL _____

Are interpreters available? ☐ Yes ☐ No If yes, please specify languages: _____

Does this practice location meet ADA Accessibility Standards? ☐ Yes ☐ No

Which of the following facilities are handicapped accessible? ☐ Building ☐ Parking ☐ Parking ☐ Other: _____

Does this location have other services for the disabled? ☐ Text Telephony-TTY ☐ American Sign Language-ASL
☐ Mental/Physical Impairment Services ☐ Other: _____

Is this location accessible by public transportation? ☐ Bus ☐ Other: _____

Revised 02-12-2019
AHW17-H-001.2

Practice information

Are you accepting new patients? ☐ **Yes** ☐ **No**

Any restrictions (age/Gender etc.)? ☐ **Yes** ☐ **No**

If yes, please define:_____

Office Hours:						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Billing Information: **This information must match locator 33 on the HCFA 1500 Form.** ***Please complete the attached W9 form*****.**

_____ ( )_____ ( )_____

Street Address City State Zip Telephone Number Fax Number

Admitting Privileges

_____ _____

Primary Admitting Facility City

Status?
☐ Active
☐ Other_____

Specialty Information

Information provided in this section will determine how you are listed in the Provider Directory.

Primary Taxonomy: _____

Primary Care Provider: Internal Medicine_____ Family Practice _____ General Practice____ Pediatrics _____

Specialty Care Provider: Specialty _____ Sub-Specialty _____

Call Coverage:

_____

(*Name)* ***(Specialty)*** ***(Telephone)***

_____

(*Name)* ***(Specialty)*** ***(Telephone)***

Appointment Availability:

Please list time frames for appointments in your practice according to the following:
(example: Preventive Care Appointments – Seen within 4-6 Weeks)

Timeliness of Routine Care Appointments_____ Timeliness for Preventive Care Appointments _____

Timeliness of Urgent Care Appointments_____ Timeliness of Emergency Care_____

Access to After Hours Care_____

Telephone Service Afterhours: Please list the method for afterhours telephone services in your practice: _____

Do you provide the following services in your offices:			
	Lab Services	☐ Yes	☐ No
	If you answered Yes above,	☐ On-site?	☐ Offsite Lab_____
	Radiology	☐ Yes	☐ No
	EKG	☐ Yes	☐ No
	Audiology	☐ Yes	☐ No
	Treadmill	☐ Yes	☐ No
	Sigmoidoscopy	☐ Yes	☐ No
	Other: _____		

Malpractice Claims History

All information is held in strict confidence and will be used for credentialing and recredentialing purposes only. Failure to supply sufficient details may delay approval of your application or prevent its approval.

During the past five (5) years have there been or are there currently pending any malpractice claims, suits, judgments, settlements or arbitration proceedings involving your professional practice? ☐ Yes ☐ No

If you answered "Yes" to the question above, please supply the following information on Attachment "A." Make copies if more than one page is needed.

- **Name of Insurance Carrier**
- **Date of Incident**
- **Date Suit or Claim was Filed**
- **Your Involvement in Patient's Care**
- **Nature and Substance of Claim**
- **Describe any other Details Pertinent to the Case**
- **Identify other Parties Named in the Suit**
- **Current Status of Case**
- **Total Amount of Settlement/Judgment**
- **Amount Paid on your Behalf**

Health Status Questions: You MUST attach a detailed explanation for any question to which you respond "Yes."

1. Are you currently under the care of a physician for a continuing health problem? ☐ Yes ☐ No
2. Have you been hospitalized or received any other institutional care for a health problem in the last five (5) years? ☐ Yes ☐ No

Physician Signature:_____ **Date:**_____

Provider Attestation and Release Authorization

I hereby affirm and attest that all statements, answers, and information contained in this application are true to the best of my knowledge, information, and belief. I understand that falsification, misrepresentation, or omission of any fact(s) requested would be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted by the participating PHO and/or network, or be subject to applicable state or federal penalties for perjury.

I grant NovaSys Health, its credentialing delegate, or the entity which has employed NovaSys Health to assist in its credentialing process, permission to contact any individual, institution, agency, or other entity identified on or relative to this application.

I also grant permission for NovaSys Health, or its credentialing agent to perform an on-site review of my practice location(s). I understand that this application process will not be considered complete without an on-site review for all primary care providers.

I also grant permission for NovaSys Health who may be acting as the credentialing agent for other organizations under a delegation arrangement, the right to furnish appropriate information in regards to my credentialing process to use in the organizations final decision of appointment.

In the event that I subsequently receive notice of participating status, I authorize NovaSys Health to use this information, excluding the Licenses and DEA Certificates, Professional Liability Insurance, Confidential Information, and the Confidential Health Status sections to answer any questions that covered persons may have about my practice. I further agree that if I receive notice of participating status, I will assume the duty of informing NovaSys Health in a timely manner of subsequent changes in any of the information provided on or relative to this application.

If I hold an active DEA certificate and licensure issued to provide healthcare services in Arkansas, I attest that I have enrolled in the Arkansas Prescription Monitoring Program ("AR PMP"); in addition, I hereby authorize the Arkansas Department of Health to confirm to NovaSys Health my enrollment in the AR PMP.

I hereby release, indemnify, and agree to hold harmless NovaSys Health, its agents, representatives, and employees, and any person or entity who or which provides information described above.

I understand that I will be notified via certified mail if information submitted for Credentialing purposes from outside sources, such as the NPDB, varies substantially from information that I have provided. The credentialing agency is not obligated to reveal the source of information if the information is not obtained to meet the requirements of the credentialing verification requirements or if law prohibits disclosure. (NCQA, CR – 1.6 & 1.7)

It is the Policy of NovaSys Health that Practitioners have the right to review information submitted in support of their credentialing application. (NCQA, CR –1.5)

I understand that this application is effective for 60 days from the date of signature. I also understand that if this application exceeds the maximum allowed time set by NCQA before the credentialing decision has been determined, a new application will be requested.

_____

(Print or type name)

_____ _____/_____/_____

(Signature) **(Date)**

Attachment "A"

Malpractice Claim

(One sheet must be completed for each claim made against you, (in the past five (5) years) regardless of outcome or status; supply copies and attach documents as needed.)

Carrier Name_____

Date of Incident _____

Date Filed_____

Your Status in the Case? Primary Defendant_____ Co-Defendant_____ Other_____

Nature and Substance of Claim _____

_____

_____

_____

_____

Your Involvement in Patient's Care_____

_____

_____

Describe Any Other Details Pertinent to the Case_____

_____

_____

Identify Other Parties Named in the Suit:_____

_____

Current Status of Case Dropped_____ Pending_____ Found for Defendant_____

Dismissed_____ Settled Out of Court_____ Found for Plaintiff_____

If Pending, when was the last contact with the Plaintiff's attorney?_____

What is the likely outcome of the case?_____

If damages were paid, what was the amount: ***Total paid by all parties***_____

Amount Paid on Your Behalf_____

Date Suite was Resolved_____

Name_____

(Print or type)

Signature_____ **Date**_____

Your application will not be processed if you have had a claim and this form is incomplete or not attached to the application.

Revised 02-12-2019
AHW17-H-001.2

AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to ____NovaSys Health Network, Little Rock _____ (a Credentialing Organization) with whom I am affiliating and seek privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years or until revoked by me in writing.

Typed or Printed Name of Physician: _____

Licensure Number: _____

Signature of Physician: _____ Date: _____
(Stamped signature is not acceptable)

*This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.

Arkansas State Medical Board

Centralized Credentials Verification Service

Phone: (501) 296-1951

Fax: (501) 296-1806

www.armedicalboard.org

CCVS ATTESTATION & RENEWAL FORM

DO NOT ALTER THE QUESTIONS ON THIS ATTESTATION FORM!!!

1. Do you currently maintain individual or group malpractice insurance coverage? ☐ Yes ☐ No
   If NO, list reason: _____
   Policy Number(s): _____ Coverage Amounts: _____
   Expiration Date: _____ Insurance Carrier Name(s): _____
   If Group, list Group Name policy is under: _____

2. Will you be providing telemedicine services from another state (an act that is part of patient care through electronic means)? ☐ Yes ☐ No

3. *Since your last attestation,* have your privileges or medical staff membership at any hospital or other healthcare organization been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

4. *Since your last attestation,* have you been charged or convicted of (including a plea of guilty or nolo contendere) a felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.) *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

5. *Since your last attestation,* has your license or certificate to practice medicine or Drug Enforcement Administration registration in any jurisdiction (state or country) been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, reprimanded, received a written warning, or otherwise sanctioned, or is any such action pending? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

6. *Since your last attestation,* have you been or are you presently being treated for alcoholism or substance abuse due to an Order of the Arkansas State Medical Board or an Order of the medical licensing authority of any other state? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

7. *Since your last attestation,* have you been advised or required by the Arkansas State Medical Board or any other licensing board to seek treatment for a physical or mental health condition? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

8. *Since your last attestation,* do you currently, or have you had since your last renewal, any physical or mental health condition, including alcohol or drug dependency, which, with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

9. *Since your last attestation,* are you presently involved in the use of any illegal substance? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

10. *Since your last attestation,* have any malpractice claims or professional liability lawsuits been filed against you, or have you received notification of a suit alleging you have committed medical malpractice? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No
    CLAIM DATE: ____/____/____ CLAIMANT'S INITIALS _____ (ASMB requirement per Medical Practices Act 17-95-103)

11. *Since your last attestation,* have any malpractice judgments been entered against you, or settlements been agreed to, in professional liability lawsuits or malpractice claims? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

    CLAIM DATE: ____/____/____ CLAIMANT'S INITIALS _____ (ASMB requirement per Medical Practices Act 17-95-103)

I affirm and attest that I am the license holder and all information contained in the original application or most recent update is true, correct, current, and complete in all respects to the best of my ability. I accept the responsibility to keep the Arkansas State Medical Board advised of any change or appropriate addition to any information contained in this form between now and the time such information is updated by subsequent renewals or updates.

Licensee's Signature (Required) *(no rubber stamps)*

Date Signed (Month/Day/Year – Required)

Licensee's Printed/Typed Name (Required)

Arkansas Medical License Number (Required)

Form **W-9**
(Rev. October 2018)
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.*

Disclosure of Ownership and Control Interest Statement Instructions

The instructions below provide guidance on how to complete the Disclosure of Ownership and Control Interest Statement. The Individual Practitioner, Group Practice or Disclosing Entity with respect to which the Disclosure of Ownership and Control Interest Statement is being completed is referred to herein as the "Provider". For each Section of the Statement, attach a separate sheet if necessary to provide complete information.

Practice Information Section

Check one that describes you – Check the box that most closely describes how you are contracted with the Health Plan. See the Definitions section of these instructions for assistance in determining if you are an Individual Practitioner, Group Practice or Disclosing Entity. An "Individual Practitioner" is a practitioner that hold a direct contract with the Health Plan, and not a practitioner that is participating indirectly through the contract of a Group Practice or Disclosing Entity.

Name of Individual Practitioner, Group Practice or Disclosing Entity – Provide the name of the Individual Practitioner, Group Practice or Disclosing Entity. If you are an individual who is participating through a Group Practice or Disclosing Entity, enter your name.

DBA Name – If you are a Disclosing Entity or Group Practice, enter any doing business as or "DBA" name (e.g., fictitious or trade name). If you are an individual participating through a Group Practice or Disclosing Entity, enter the Group Practice or Disclosing Entity name.

Address – Enter your main physical address.

TIN or SSN – If you are a Disclosing Entity or Group Practice, enter the Federal Tax Identification Number (TIN). If you are an Individual Practitioner who is participating through a Group Practice or Disclosing Entity, enter the TIN of the Group Practice or Disclosing Entity. If you are an Individual Practitioner, enter your TIN or Social Security Number (SSN).

NPI – Enter your National Provider Identifier.

Section I: Provider Ownership and Control Interest – Provide the information requested for any individual or entity with an ownership or controlling interest in the Provider. Please refer to the Determination of Ownership or Control Interest Section below for assistance in reporting such interests. The address for any corporate entities must include, as applicable, primary business address, every business location and every post office box address. Write "None" or "Not applicable" if you are an Individual Practitioner or if there are no ownership or control interests in the Provider that require reporting.

Section II: Subcontractor Ownership and Control Interest – Indicate whether or not the Provider has a 5% or more direct or indirect ownership or control interest in a subcontractor by checking the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each subcontractor in which the Provider has such an interest.

Section III: Relationships – Indicate whether or not any individuals listed in Section I or Section II are related to each other by checking the "Yes" or "No" box as applicable. If "Yes" is checked, list the individuals that are related to each other and the type of relationship.

Section IV: Convictions – Indicate whether or not there are any persons who have an ownership or control interest in the Provider, or is an agent or managing employee of the Provider who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Social Security Title XX services program since the inception of those programs by checking the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each person.

Section V: Business Transactions – Indicate by checking either the Yes or No box whether or not the Provider has had any financial transaction with a subcontractor totaling more than $25,000 in the 12 months prior to the completion date of this Statement or any significant business transaction (see the Definitions Section below) between the Provider and a wholly owned supplier or between Provider and any subcontractor in the 5 years prior to the completion date of this Statement. If "Yes", provide the requested information.

Section VI: Managing Employees – If the Provider has any managing employees, check the "Yes" box and list each member of the Board of Directors or Governing Board and each managing employee with their name, date of birth, address, SSN and percent of interest. If the Provider has no managing employees, check the "No" box.

Signature/Title/Date – Provide the printed name, signature and title of the individual completing the Statement either as an Individual Practitioner or on behalf of the Provider. In the date field, enter the date the Statement was completed. If the individual completing the Statement is completing it on behalf of physicians and/or practitioners that are part of a Group Practice or Disclosing Entity, attach a list as "Exhibit A" identifying such physicians and/or practitioners, including their names, addresses, specialty and NPI.

Definitions

Terms used in the Disclosure of Ownership and Control Interest Statement have the meanings set forth at 42 C.F.R § 455.101. Such definitions, effective as of the date of these Instructions, are set forth below for your convenience.

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

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Social Security Act (the "Act"). This includes: any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); any Medicare intermediary or carrier; and any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

As used in the Disclosure of Ownership and Control Interest Statement, "Disclosing Entity" includes a "disclosing entity" and a "other disclosing entity", as those terms are defined above.

Group practice or group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

a) has an ownership interest totaling 5 percent or more in a disclosing entity;
b) has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
c) has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
d) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
e) is an officer or director of a disclosing entity that is organized as a corporation; or
f) is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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

Wholly owned supplier means 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 a provider.

Determination of Ownership or Control Percentages

Guidance regarding the determination of certain ownership or control percentages is set forth in 42 C.F.R. § 455.102. Such guidance, effective as of the date of these Instructions, is set forth below for your convenience.

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

Person with an ownership or control interest. Please also refer to the Definition Section. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Provider Type Scenarios

The scenarios below are examples of how the Disclosure of Ownership and Control Interest Statement may be completed.

Individual Practitioner – An individual practitioner would check the “Individual Practitioner” checkbox in the Practice Information Section, indicate “None” in Section I: Provider Ownership and Control Interest, indicate “Yes” or “No” in the remaining check boxes as appropriate then sign and date the Statement.

Group of Practitioners – A group practice would check the “Group Practice” checkbox in the Practice Information Section, and complete a Disclosure of Ownership and Control Interest Statement for the Group Practice. Each individual participating under the Group Practice’s contract with the Health Plan that is either an employee or co-owner would fill out a Disclosure of Ownership and Control Interest Statement as an individual and list the Group Practice name in the “DBA Name” field in the Practice Information Section, use the Group Practice address and use the practitioner’s individual TIN or SSN. As an alternative to each individual completing a Statement, the Group Practice may complete, execute and submit a Statement on his or her behalf as long as the person executing the Statement is legally authorized, as an agent or attorney-in-fact, to do so.

Hospital or Hospital System – A hospital would check the “Disclosing Entity” checkbox in the Practice Information Section, and complete a Disclosure of Ownership and Control Interest Statement for the hospital. Each individual participating under the hospital’s contract with the Health Plan that is either an employee or co-owner would fill out a Disclosure of Ownership and Control Interest Statement as an individual and list the hospital name in the “DBA Name” field in the Practice Information Section, use the hospital address and use the practitioner’s individual TIN or SSN. As an alternative to each individual completing a Statement, the hospital may complete, execute and submit a Statement on his or her behalf as long as the person executing the Statement is legally authorized, as an agent or attorney-in-fact, to do so.

Independent Clinical Lab – An independent clinical laboratory would check the “Disclosing Entity” checkbox in the Practice Information Section, and complete a Disclosure of Ownership and Control Interest Statement for the laboratory. Each individual participating under the

laboratory's contract with the Health Plan that is either an employee or co-owner would fill out a Disclosure of Ownership and Control Interest Statement as an individual and list the laboratory name in the "DBA Name" field in the Practice Information Section, use the laboratory address and use the practitioner's individual TIN or SSN. As an alternative to each individual completing a Statement, the laboratory may complete, execute and submit a Statement on his or her behalf as long as the person executing the Statement is legally authorized, as an agent or attorney-in-fact, to do so.

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: ☐ Individual Practitioner ☐ Group Practice ☐ 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