

FEDERALLY REQUIRED DISCLOSURES

INDIVIDUAL PRACTITIONERS

Please ensure that all sections of this form are completed before submission.

Federal law requires that individual practitioners providing or seeking to provide services to MassHealth members disclose certain information to MassHealth. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3. MassHealth requires the submission of tax identification numbers (TINs), e.g., social security numbers (SSNs) or employer identification numbers (EINs), for purposes necessary to properly administer the MassHealth program (see 42 U.S.C. § 1320a-3 and 42 U.S.C. § 405(c)(1)). Unless otherwise instructed by MassHealth, individual practitioners must use this form when disclosing such information to MassHealth.

SECTION 1: PRACTITIONER INFORMATION

| | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|-----|--|--|----------------|--|--|--|--|
| Legal Name of Practitioner: Last | | | | | First | | | | | Middle Initial | | | | |
| Date of Birth | | | | | National Provider Identifier Number (NPI) | | | | | SSN | | | | |
| Home Street Address | | | | | | | | | | | | | | |
| City | | | | | State | | Zip | | | | | | | |
| Tel. # | | | | | Fax # | | | | | | | | | |
| E-mail | | | | | | | | | | | | | | |
| Preferred Contact Name (if different than above) | | | | | | | | | | | | | | |
| Preferred Contact E-mail (if different than above) | | | | | | | | | | | | | | |
| Tel. # | | | | | | | | | | | | | | |

SECTION 2: PRIMARY SERVICE LOCATION (PSL) INFORMATION

DBA Name (Primarily applies to individuals who are sole proprietors and NOT to entities separately completing PE-FRD)
 NONE

Is PSL address same as home address in Section 1? Yes No. If yes, practitioner need not complete remainder of Section 2.

PSL Street Address (street address only; P.O. Boxes are not acceptable)

| | | | | | | | | | | | | | | |
|--------|--|--|--|--|-------|--|-----|--|--|--|--|--|--|--|
| City | | | | | State | | Zip | | | | | | | |
| Tel. # | | | | | Fax # | | | | | | | | | |
| E-mail | | | | | | | | | | | | | | |

SECTION 3: INDIVIDUALS AND ENTITIES RELATED TO PRACTITIONER

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

List any individual or entity with which the practitioner has one or more of the relationships described below, whether such relationship is defined by the practitioner's relationship to or interest in the other party, or by the other party's relationship to or interest in the practitioner (e.g., list entities in which the practitioner is a managing employee, AND managing employees of the practitioner). Although unusual, check "NONE" if none.

- i. Has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the applicant;
- ii. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the applicant or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the applicant;
- iii. Is an officer or director of the applicant, if the applicant is organized as a corporation;
- iv. Is partner in the applicant, if the applicant is organized as a partnership;
- v. Is an agent of the applicant;
- vi. Is a managing employee—that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the applicant or part thereof, or directly or indirectly conducts the day-to-day operations of the applicant or part thereof; or
- vii. Was formerly described in i through vi of this section, but is no longer so described, because of a transfer of ownership or control interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, assessment of a civil money penalty, or imposition of an exclusion.

The definitions applicable to this section are as follows:

- *Agent* means any person who has express or implied authority to obligate or act on behalf of another party (e.g., office manager, billing agent, group practice organization).
- *Immediate family member* means 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.
- *Indirect ownership interest* includes an ownership interest through any other entities that ultimately have an ownership interest in the applicant (e.g., an individual has a 10 percent ownership interest in the applicant if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the applicant).
- *Member of household* means, with respect to a person, any individual with whom he or she is 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.
- *Ownership interest* means an interest in:
 - the capital, the stock, or the profits of the applicant; or
 - any mortgage, deed, trust, or note, or other obligation secured in whole or in part by the property or assets of the applicant.

NONE (if NONE continue to Section 4) Ownership/Controlling Interest (of 5% or more)* Managing Employee* Agent*

Name of Individual (Last, First, Middle Initial) or Entity

NPI % of Ownership (if 5% or more)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City State Zip -

SSN (if Individual) Date of Birth EIN (if Entity)

*For definition and further explanation of these terms, please see the top of Section 3 above.

PLEASE MAKE A COPY OF THIS PAGE IF YOU NEED TO LIST MORE THAN THREE INDIVIDUALS OR ENTITIES OR ADDITIONAL ADDRESSES. NUMBER OF
(All business, corporate, and P.O. boxes must be listed.)

Please attach each such copy to the signed form. Please refer to all attached pages when answering the disclosure questions in Section 4.

Ownership/Controlling Interest (of 5% or more)* Managing Employee* Agent*

Name of Individual (Last, First, Middle Initial) or Entity

NPI % of Ownership (if 5% or more)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City State Zip -

SSN (if Individual) Date of Birth EIN (if Entity)

Ownership/Controlling Interest (of 5% or more)* Managing Employee* Agent*

Name of Individual (Last, First, Middle Initial) or Entity

NPI % of Ownership (if 5% or more)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City State Zip -

SSN (if Individual) Date of Birth EIN (if Entity)

* For definition and further explanation of these terms, please see the top of Section 3 above.

SECTION 4: DISCLOSURES

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

4A. DISCLOSURE INFORMATION

Respond to the following questions on behalf of the practitioner AND any individuals/entities identified in Section 3 (except for question 5, where your response may be limited to the practitioner). If you answer “yes” to any question, provide a detailed explanation in Section 4B, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number.

1. Have any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?
 Yes No
2. Have any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?
 Yes No
3. Have any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)?
 Yes No
4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?
 Yes No
5. Has the practitioner ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities?
 Yes No
6. Is there currently pending any proceeding(s) that could result in a conviction, sanction, or other action reportable in questions 1 – 5, above?
 Yes No

4B. ADDITIONAL EXPLANATION

If you answered "yes" to any question in Section 4A, you must provide a detailed explanation below, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

SECTION 5: CERTIFICATION STATEMENT

PLEASE READ CAREFULLY AND SIGN

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Printed Legal Name of Practitioner

Signature

Date

Note: Signature or date stamps, electronically generated signatures or dates, or the signature of anyone other than the practitioner are not acceptable.

Return your completed form to providersupport@mahealth.net or mail to the following:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
P.O. Box 121205
Boston MA 02112-1205

If you have questions about or need assistance with the completion of this form, please e-mail the MassHealth Customer Service Center at providersupport@mahealth.net or call 1-800-841-2900.