gainwell

Rhode Island Medicaid Disclosure Questions

ALL PROVIDERS

1. Programs – Please check all other programs that you want to participate in, in addition to Medicaid:
   ☐Behavioral Health, Developmental Disabilities, and Hospitals CNOM
   ☐Community Medication Assistance Program (CMAP)
   ☐Dept. of Corrections
   ☐Dept. of Health Pharmacy Program
   ☐Office of Rehab Services
   ☐RI Pharmaceutical Assistance to the Elderly Program (RIPAE)

2. Are you currently or have you ever been a provider with Medicaid? **Yes** **No**
   ***(If yes, complete the following*):**
   a. Please circle your status: **Active Inactive**
   b. What are your enrollment dates: ____
   c. What is your RI Medicaid ID Number (s): ______________________________

3. Are you currently enrolled with Medicare?
   ☐**Yes-** Please be sure you listed your Medicare number on the Provider Identification panel
   ☐ **No -** Have you or will you enroll with Medicare? **Yes** **No**

4. Is there an Owner/Administrator, Agent of the Provider, Managing Employee or Officer for the Corporation? **Yes** **No**
   (If yes, complete the following)
   a. Name: ____
   b. Title: ____
   c. Legal entity or home address:
   ____
   ____
   d. Social Security Number or Employer Identification Number:
   ____
   e. Date of Birth: ____

5. Are there any person(s) and their family relationship(s) with an ownership or control interest in the disclosing entity or in any subcontractor totaling 5% or more?
   Yes **No**

(If yes, complete the following)

a. Name: ____

b. Title: ____

c. Legal entity or home address:

____

____

d. Social Security Number or Employer Identification Number:

____

e. Date of Birth: ____________________________________

f. Family Relationship: _______________________________

6. Are there any persons listed in response to questions 4 or 5, who have an ownership or control interest in another disclosing entity? **Yes** **No**

(If yes, complete the following)

a. Name:____

b. Other Disclosing Entity: _______________________________

c. Other Disclosing Entity Address: ________________________

d. NPI/Service Location (if applicable): ____________________

7. Is there an ownership of any subcontractor, as defined in 42 CFR §§ 455.101, with whom the provider has had business transactions totaling more than $25,000 during the previous 12-month period? **Yes** **No**

(If yes, complete the following)

a. Subcontractor:

____

b. Legal entity or home address:

____

____

c. Social Security Number or Employer Identification Number:

____

d. Name of Owner:

____

e. Legal entity or home address:

____

8. Identify any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period.

9. Is there any documented information on any debarment, suspension, exclusion, or conviction of a criminal offense related to the person(s)' listed in question 4, 5, 6 and/or 7 above, from involvement in any Federal program (Medicaid, Medicare, or the Title XX services program) since the inception of those programs?
   Yes **No**
   (If yes, complete the following)
   a. Name: ______________________________
   b. Legal Entity or Home Address: ______________________________
      ____
   c. Relationship (check one below):
      ☐Person with an ownership or control interest
      ☐Agent
      ☐Managing employee
   d. Conviction Information:
      ____
   e. Crime: ______________________________
   f. Date of Conviction:
      ____

10. If you have more than one individual to disclose for question 4, 5, 6, 7 and/or 9, please complete the Additional Federally Required Disclosures Attachment on the Agreement page and upload with your application. Do you have additional individuals to disclose?
   Yes **No**

11. Is this application due to a merger, buy out or take over? **Yes** **No**

12. List any outstanding balance owed to the RI Executive Office of Health and Human Services Medicaid Program by a previous provider.
   ____

13. Exclusions under 42 CFR and/or sections 1128B and 1932(d)(1) of the Social Security Act: Prohibits you from 1) knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, excluded, or has been convicted of a criminal offence related to that person's involvement in any Federal program, or 2) having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the State where the individual or entity is debarred, suspended, excluded, or convicted of a criminal offence related to that person's involvement in any Federal program. This applies to myself and/or the entity(s): **Yes** **No**
   (If yes, complete the following)
   a. Date of Issuance: ______________________________
   b. Duration: ______________________________
   c. Name of person: ______________________________

d. Address of person: ________________________________
____

INDIVIDUAL PROVIDERS ONLY

14. Are you a Full or Part-time salaried employee of a hospital or institution? **Yes** **No**
(If yes, complete the following)
Name of Facility: ____

OUT OF STATE PROVIDERS ONLY

15. Reason for Enrollment: ***(Please check all that apply)***
☐Anticipating or currently providing services
☐Provided services
☐ Business expanding
☐ Other (please specify) _________________________

16. Services Provided: ***(Check one)***
☐Emergency
☐ Urgent
☐ Elective

17. Number of RI Medicaid recipients you treat or anticipate treating annually:
____

18. Is enrollment based on a contact with a specific recipient? **Yes** **No**
(If yes, complete the following)
a. Recipient Name: ____
b. Diagnosis code: ____
c. Recipient Medicaid Identification Number: _________________________
d. Date(s) of Service: ____
e. Is the reimbursement sought for:
☐ Medicaid Only
☐Medicare Co-pay,
☐Other Insurance Co-pay
f. Name of Other Insurance: ____

Provider Name: ____

Signature: ____ Date: _____________________

Printed Name: ____

Title: ____

Please note: Only one signature is permitted and must be consistent on all enrollment documents