Rhode Island Medicaid Disclosure Questions

INDIVIDUAL PROVIDERS ONLY

1. 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

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

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

4. Number of RI Medicaid recipients you treat or anticipate treating annually:
   _____

5. 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: _____

ALL PROVIDERS

6. 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)

7. 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): _____

8**.** 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**

9. 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.

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

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

_____

12. Who is the Owner/Administrator, Agent of the Provider, Managing Employee or Officer for the Corporation?

(If you are the sole owner, list yourself)

a. Name: _____

b. Title: _____

c. Legal entity or home address:

_____

_____

d. Social Security Number or Employer Identification Number: _____

e. Date of Birth: _____

13. 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: _____

14. Are there any persons listed in response to questions 12 or 13, 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: _____

15. 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: _____

16. Is there any documented information on any debarment, suspension, exclusion, or conviction of a criminal offense related to the person(s)' listed in question 12, 13, 14 and/or 15 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:

_____

17. 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: _____

_____

Provider Name: _____

NPI: _____

Signature: _____ Date: _____

Printed Name: _____

Title: _____

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