

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



# (Allied & APN) 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: \_\_\_\_\_

**APNs must provide a copy of their collaborative agreement with an in-network physician.**

## Primary Office Location    Effective Date: \_\_\_\_\_

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

## Mailing Address

\_\_\_\_\_  
Clinic Name

\_\_\_\_\_  
Clinic Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
City, State, Zip

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Telephone Number                      Fax Number

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Telephone Number                      Fax Number

\_\_\_\_\_  
Group NPI

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Tax ID

\_\_\_\_\_  
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: \_\_\_\_\_

**Practice information**

Are you accepting new patients?  Yes  No

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

If yes, please define: \_\_\_\_\_

<b>Office Hours:</b>						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

**Please list all health care facilities in which you currently have privileges:**

\_\_\_\_\_ Primary Admitting Facility \_\_\_\_\_ City \_\_\_\_\_ Status?  
 Active  
 Other \_\_\_\_\_

**Please indicate which participation status you are applying for: Please indicate your specialty. If you are Board Certified, you must attach a copy of your Board Certificate.**

**Primary Care Provider:** Internal Medicine \_\_\_\_\_ Family Practice \_\_\_\_\_ General Practice \_\_\_\_\_ Pediatrics \_\_\_\_\_  
**Specialty Care Provider:** Specialty: \_\_\_\_\_ Sub-Specialty: \_\_\_\_\_  
**Allied Health Professional:** \_\_\_\_\_ (Please indicate type)  
**Primary Taxonomy:** \_\_\_\_\_ (Will determine how you are listed in the directory)

**You may submit a detailed Curriculum Vitae in place of this section. (See Note below)**

Professional School _____	Address _____	Mo/Yr Graduated _____
Internship _____	Address _____	Mo/Yr Completed _____ Specialty _____
Residency _____	Address _____	Mo/Yr Completed _____ Specialty _____
Practice Experience _____	Address _____	From (mo/yr) _____ To (mo/yr) _____
Additional Practice Experience _____	Address _____	From (mo/yr) _____ To (mo/yr) _____
Additional Practice Experience _____	Address _____	From (mo/yr) _____ To (mo/yr) _____

**NOTE: Please use month/year to identify work and educational periods. Also, please provide an explanation for any gaps of 30 days or more. This includes vacation, studying for boards, time relocating or finding a position, etc. Please provide practice experience from Professional School to present.**

**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 After Hours: Please list the method for after hours 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: \_\_\_\_\_

**Billing Information: This information must match locator 33 on the HCFA 1500 Form. Please attach a current W9 form.**

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

**Professional Liability Insurance: (Submit facesheet of current policy)**

Have you ever been denied professional liability insurance or has your coverage ever been cancelled or not renewed.  Yes  No

If "Yes," please explain \_\_\_\_\_

Present Carrier's Name \_\_\_\_\_

Complete Address \_\_\_\_\_

(No and Street) (City) (State) (Zip)  
Policy Number \_\_\_\_\_ Policy Limits \_\_\_\_\_ Effective Dates (From) \_\_\_\_\_ (To) \_\_\_\_\_

**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.

**Have there ever been or are there currently pending** any malpractice claims, suits, judgements, 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"

- 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/Judgement
- Amount Paid on your Behalf

**Confidential Information:** You MUST attach a detailed explanation for any question to which you respond “Yes”.

1. Have you ever been convicted of a crime or do you have any felony or misdemeanor charges pending (other than traffic offenses).  Yes  No
2. Have you ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?
  - A. State License  Yes  No
  - B. DEA registration or other applicable narcotic registration  Yes  No
  - C. Hospital or other health care facility staff membership or privileges  Yes  No
  - D. Professional ethics committee  Yes  No
  - E. Professional organization membership  Yes  No
  - F. Medicare, Medicaid, or other local, state, and/or federal government program participation.  Yes  No
  - G. HMO, PPO, or other prepaid health plan participation  Yes  No
  - H. Regulatory agency (CLIA, OSHA, etc.)  Yes  No
  - I. Professional Training School or Program  Yes  No
3. Have you ever been subject of any reports to a state or federal data bank?  Yes  No
4. Do you or a member of your family own or have an investment in; a testing center, hospital, surgical center, or other business dealing with the provision of ancillary health services, equipment or supplies? If “Yes”, please provide the following information. Attach an additional page, if needed.  Yes  No

Name of Organization	Tax ID Number	Street Address	City	State	Zip
Type of Organization	Size of Organization	% of Business Owned/Invested	Nature of Business Interest		

**Health Status Questions:** You MUST give an explanation for any questions marked “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
3. Do you have **at the present time** a chemical dependency/substance abuse problem, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in any way poses a risk of harm to your patients?  Yes  No
4. Have you **in the past** had a chemical dependency/substance abuse problem, treated or untreated, which in any way impaired your ability to practice to the fullest extent of your licensure and qualifications or in any way posed a risk or harm to your patients?  Yes  No
5. Are you currently taking any medications that may affect either your clinical judgement or motor skills?  Yes  No
6. Do you have **at the present time** any physical or mental health condition, 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?  Yes  No
7. Have you **in the past** had any physical or mental health condition, treated or untreated, which in any way impaired 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?  Yes  No

**Call Coverage:** Please list those Practitioners who cover for you after hours and when you are out of town. It is imperative that you have seven (7) day a week, twenty-four (24) hour coverage.

Please list name, address, and phone number of covering practitioners:

1. \_\_\_\_\_  
(Practitioner) (Specialty) (Address) (Telephone Number)

2. \_\_\_\_\_  
(Practitioner) (Specialty) (Address) (Telephone Number)

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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Provider Attestation, and Obtain/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 upon the basis of this application.

I hereby affirm and attest that no changes to the wording of this application have been made by me or are known to me. I also agree that if any changes are found, I will complete a new application.

I understand that the information contained in this application will be used to evaluate my credentials according to the quality assessment standards of NovaSys Health. As part of this evaluation process and for the purpose of verifying any information provided on or relative to this application, 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 any 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 180 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.





## 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: <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**

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