PO Box 240808
Anchorage, AK 99524

tel 907.644.6800
tel 800.770.5650 (toll-free in AK)

Disclosure Statement

IMPORTANT NOTICE PLEASE READ

Dear Group/Facility Applicant,

The Affordable Care Act requires that the Alaska Department of Health and Social Services collect certain additional information from an applicant at the time of an enrollment request. You are required to complete, sign and return this addendum prior to enrollment in Alaska Medicaid. The Federal regulations that support collection of provider disclosures are found at CFR Title 42 Part 455 Subpart B – *Disclosure of information by providers and fiscal agents*.

Complete, sign and return the Group/Facility Provider Disclosure Statement with your enrollment signature page and any other required documentation to:

Conduent State Healthcare, LLC
Provider Enrollment Unit
PO Box 240808
Anchorage, AK 99524-0808

If you have any questions concerning this addendum, please contact the enrollment staff at AK-Enrollment@conduent.com.

Sincerely,

Provider Enrollment Unit
Conduent State Healthcare, LLC

Alaska Medical Assistance
Group/Facility Provider Disclosure Statement

Name of Group or Facility: _____

Check the reason for disclosure.

☐ Initial Enrollment - *Enterprise Application Tracking Number* _____

☐ Enrollment Re-Validation

☐ Change in Ownership* – *Current Provider ID Number or NPI* _____

*All ownership changes must be disclosed within 35 days of the change under 42 CFR 455.104(c)(iv). A change in the disclosing group/facility tax identification number or the category of services rendered requires a new enrollment application.

All fields must be completed. The following information is required under 42 CFR 455.104 Subpart B - *Disclosure of Information by Providers and Fiscal Agents: Information on Ownership and Control*. If a field or section does not apply to the disclosing group/facility, annotate an "N/A". If additional space is needed, attach separate sheets as necessary. Appropriately mark the continued section(s) with the application tracking number or current Alaska Medicaid Provider ID.

Ownership – Corporate Owner

List all corporations with an ownership or control interest of 5 percent or more in the disclosing group/facility. Include the name, corporate tax identification number, primary business address, all Alaska business location addresses, and any P.O. Box addresses.

Legal Name	Address	Primary Address?	Tax Identification	% Owned
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		

Ownership – Individual Owner

List the name, address, date of birth, and social security number of any individual with an ownership or control interest of 5 percent or more in the disclosing group/facility.

Legal Name	Address	Date of Birth (mm/dd/yyyy)	Social Security Number	% Owned
		___ / ___ / _____		
		___ / ___ / _____		
		___ / ___ / _____		
		___ / ___ / _____		
		___ / ___ / _____		

Mortgages, Deeds of Trust, Notes

List the creditor name, business address, tax identification number, and value percentage of any mortgage, deed of trust, note or other obligation secured by the disclosing group/facility if the obligation is 5 percent or more of the value of the group/facility.

Creditor Name	Business Address	Tax Identification Number	% of Value

Owner Relationships

List any person with ownership or control interest in the disclosing group/facility that is related to another person with ownership or control interest in the disclosing group/facility as a **spouse**, **parent**, **child**, or **sibling**.

Owner Name	Owner Name	Relationship Type

Alaska Medical Assistance
Group/Facility Provider Disclosure Statement

CONDUENT

Subcontractor Ownership

List the name and tax identification number of any subcontractor in which the disclosing group/facility has a 5 percent or more interest.

Legal Name	Tax Identification Number / Social Security Number	% Owned

Owner/Subcontractor Relationships

List any person with ownership or control interest in any subcontractor in which the disclosing group/facility has a 5 percent or more interest that is related to another person with ownership or control interest in the disclosing group/facility as a **spouse**, **parent**, **child**, or **sibling**.

Group/Facility Owner Name	Subcontractor Owner name	Relationship Type

Ownership in Other Disclosing Entities

Does any person with ownership or control interest in the disclosing group/facility listed above have an ownership or control interest in any other Medicaid provider or in any entity that does not participate in Medicaid but is required to disclose ownership and control information because of participation in any of the programs established under Title V Maternal and Child Health Services Block Grant, Title XVIII Social Security Act, or Title XX Social Services Block Grant?

If yes, list the name of the owning person and the name and address of the other disclosing entity.

Other disclosing entities may include a) 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; b) any Medicare intermediary or carrier; c) 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.

Owner Name	Other Disclosing Entity Name	Other Disclosing Entity Address

Application Tracking Number / Provider ID: _____

Alaska Medical Assistance
Group/Facility Provider Disclosure Statement

Managing Employees

List the name, address, date of birth, and social security number of any managing employee in the disclosing group/facility.

Managing employee may be 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.

Legal Name	Address	Date of Birth (mm/dd/yyyy)	Social Security Number
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	

Board of Directors, Officers or Agents

List the name, address, date of birth, and social security number of any person serving as a Board of Director, Officer or Agent in the disclosing group/facility.

Legal Name	Address	Date of Birth (mm/dd/yyyy)	Social Security Number
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	
		___ / ___ / _____	

Alaska Medical Assistance
Group/Facility Provider Disclosure Statement

Whoever knowingly and willfully makes or causes to be made a false statement or misrepresentation of this statement, may be prosecuted under applicable federal or state laws. Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of participation in the Alaska Medicaid program.

Original Signature Required

_____ _____

Name of Authorized Representative | Title

_____ _____

Signature of Authorized Representative | Date

Complete all sections of the Group/Facility Provider Disclosure Statement and return to:

Conduent State Healthcare, LLC
Provider Enrollment Unit
PO Box 240808
Anchorage, AK 99524-0808

Application Tracking Number / Provider ID: _____