BlueCross BlueShield Minnesota

Disclosure of Ownership and Management Information, Business Transactions & Exclusions Statement

I. Instructions

This statement should be completed and submitted when entering into a new contract with Blue Cross and Blue Shield of Minnesota, Blue Plus and Affiliates ("Blue Cross" or "health plan"), annually during contract renewal, and when any information in your original statement has changed.

For assistance in completing this statement, please reference the Definitions provided under Section VIII.

If more space is needed, please attach additional information.

See Section VII for submission instructions.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS			
DBA (Doing Business As)			
ADDRESS			
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
FEDERAL EMPLOYER ID (FEIN)	MN TAX ID		NPI/UMPI

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Co. ☐ Non-Profit

☐ Public ☐ State ☐ Other Partnership (i.e., LP, LLP, LLLP) ☐ Other: _____

IV. Ownership & Control Interests

A. Please provide the following information for each Managing Employee and Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% of more. If no such ownership exists, please indicate this with an "N/A." ☐ N/A

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1					
2					
3					

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in subsection IV (A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A." ☐ N/A

No.	Full Legal Name	SSN or FEIN	Name of Person Related To	Related Person's SSN or FEIN	Relationship
1					
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A." ☐ N/A

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1					
2					
3					

V. Significant Business Transactions

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty-five thousand dollars ($25,000) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists, please indicate this with an "N/A." ☐ N/A

No.	Name of Subcontractor	Address	SSN or FEIN	% Ownership Interest
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A." ☐ N/A

No.	Name of Wholly Owned Supplier	Address	SSN or FEIN	Nature of Business Transaction
1				
2				
3				

VI. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare or any of the State health care programs?

  ☐ Yes ☐ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?

  ☐ Yes ☐ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

  ☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provision of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who: (i)) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act). ☐ N/A

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			

VII. Certification and Submission

I am authorized to bind the entity, and I certify that the above information is true and correct. I will notify Blue Cross of any changes to this information.

NAME (Print):	TITLE:
SIGNATURE:	DATE:
EMAIL ADDRESS:	

Email the completed, signed form to: DisclosureStatement@bluecrossmn.com **or Fax to: 651-662-6923**

Or mail to: Blue Cross and Blue Shield of Minnesota
P. O. Box 64560
Route R317-GP
St. Paul, MN 55164-0560

If you have any **questions,** email DisclosureStatement@bluecrossmn.com or contact Provider Service at 651-662-5200 or 1-800-262-0820.

VIII. Definitions

For the purpose of this statement, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.

2. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider, or part thereof.

3. **Person with an Ownership or Control Interest** means a person or corporation that: A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider; B) has a combination of direct and indirect ownership interests equal to 5% or more in the Provider; C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider; or D) is an officer or director of the Provider (if organized as a corporation) or is a partner in the Provider (if organized as a partnership).

4. **Provider** means an individual or entity that has entered into an agreement with the health plan and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.

5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with the health plan and to the health plan's obligations under its contract with the Department of Human Services.

6. **Significant Business Transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the less of $25,000 and 5% of the Provider's total operating expenses.

7. **Wholly Owned Supplier** means a supplier (i.e., an individual, agency, or organization from which a Medicaid provider purchases good and services used in carrying out its responsibilities under Medicaid) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.