Disclosure of Ownership and Control Interest Statement

The Disclosure of Ownership and Control Interest Form is required of all contracted offices (one per tax identification number). This document is a new form that allows entities such as Envolve Vision Benefits (Envolve) to query state and federal databases to identify any individuals or entities that have been excluded from state or federally funded programs.

The following are step-by-step instructions for each section of the form. Please contact Envolve's Network Management Department at (800) 531-2818 if you have any questions while completing this document.

Practice Information
Check the box that most closely describes your practice
Provide the full practice name, DBA name (if applicable), address, Federal Tax ID number and Provider CAQH number in the applicable boxes.

Section I
Provide information regarding the ownership of your practice/business (individuals or entities). All owners must be listed with complete information.

Section II
Indicate whether or not any individuals listed in Section 1 are related to each other by checking "Yes" or "No." If yes, list any owners that are related to each other.

Section III
Indicate whether or not there are any subcontractors used in which the Disclosing Entity has direct or indirect ownership of 5% or more by checking "Yes" or "No." If yes, list the name and address of each person with an ownership or controlling interest in the subcontractor.

Section IV
Indicate whether or not there are any individuals who have ownership or control interest in the office/practice, or any agents or managing employees, who have ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX by checking "Yes" or "No." If yes, list the individuals and their information.

Section V
Indicate whether or not your practice/business has had any financial transaction with subcontractors totaling more than $25,000 (in the past 12 months) or any significant business transactions with subcontractors (in the past 5 years) by checking "Yes" or "No." If yes, list the ownership of the subcontractors, their address and the transaction amount. Attach a separate sheet if necessary.

Section VI
If your practice is a Disclosing Entity (indicated in the Practice Information Section above), check yes and list each member of the Board of Directors or Governing Board, and managing employees (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) including the name, date of birth (DOB), address, social security number (SSN) and percent of interest. If your practice is not a Disclosing Entity, check "No."

Provider/Fiscal Agent/MCE/Applicant, Signature, and Date
Sign, date, print name and title

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The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 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 form, an updated form should be completed and submitted to Envolve within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing
Entity: DBA Name:
Address:
Federal Tax Identification Number: Provider CAQH #:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

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Section IV

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 IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this 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

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, and managing employees (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) including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Please return the form via toll free fax to (866) 267-3022, or by mail to:
Envolve Vision Benefits, P.O. Box 7548, Rocky Mount, NC 27804.
Please contact Envolves's Network Management Department at (800) 531-2818, option 4 if you have any questions while completing this document.