Dear Provider,

Please complete this form if:

- You are new in the Medicaid network or
- You believe your Medicaid disclosure will expire soon or
- You have not submitted your Medicaid Disclosure to the state of Delaware.

In accordance with state laws, providers who obtain and maintain a contract with Highmark Delaware (d.b.a. Highmark Blue Cross Blue Shield of Delaware and/or Highmark Health Options, Inc.) are required to maintain a Medicaid disclosure for all individual practitioners.

The state of Delaware will notify you annually of this requirement future going if you enroll for notifications via their provider portal. To enroll for these notifications,

- Please visit https://medicaid.dhss.delaware.gov
- Select Providers
- Then click Notify Me
- Enter your email address and name to be enrolled for alerts from the state including the annual requirement for Medicaid disclosures.

To complete the form here, please scroll down to view an editable pdf.

Upon completion of the form, please return to Highmark via the Delaware Medicaid Disclosure Upload Form on the Provider Resource Center under Provider Information Management forms. You may also click the link below to directly access the form.

https://highmark.co1.qualtrics.com/jfe/form/SV_42EFu0KLwRdOIwR

Thank you,

Provider Information Management

STATE OF DELAWARE
DELAWARE DIVISION OF MEDICAID & MEDICAL ASSISTANCE

INSTRUCTIONS FOR COMPLETING PROVIDER DISCLOSURE STATEMENT

According to the Code of Federal Regulations title 42, part 455, sections 100-106, all providers enrolling with the DMAP program must complete a Provider Disclosure Statement.

The definitions below are designed to clarify certain questions on the Disclosure form. If you cannot report all of the necessary information in a designated section of the form because of space limitations, please provide the information on a separate paper.

Definitions

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 a fiscal agent.

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 Act means:

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 (title XVIII);

b. Any Medicare intermediary or carrier; and

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.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

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.

Individual practitioner means a physician or other person licensed or certified under State law to practice his or her profession.

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. 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.

DELAWARE DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Provider Disclosure Statement

Name of Entity / Individual	EIN / SSN	NPI	Taxonomy

Address	City/ST	Zip Code

Questions 1 - 3 to be answered by all providers.

1. Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? If yes, give the name(s) of person(s) and description(s) of offense(s). **YES** ☐ **NO** ☐

NAME	DESCRIPTION

2. Has the provider had business transactions with any subcontractor totaling more than $25,000 during the preceding 12-month period? If yes, give the information below for each subcontractor. **YES** ☐ **NO** ☐

NAME	ADDRESS
A.	
B.	
C.	
D.	

2a. Provide the name and address of all persons with an ownership or control interest in each subcontractor named in question #2.

***NOTE: Designate relationship to subcontractor listed above by using* A., B., C., etc.**

NAME	ADDRESS

3. Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? If yes, give the information below for each wholly owned supplier or subcontractor. **YES** ☐ **NO** ☐

NAME	ADDRESS	DESCRIPTION OF BUSINESS TRANSACTION

DELAWARE DIVISION OF MEDICAID & MEDICAL ASSISTANCE
Provider Disclosure Statement - Continued

Questions 4 – 6 to be answered by fiscal agents and by all providers EXCEPT individual practitioners.

4. Provide the name and address of each person with an ownership or control interest in the provider/fiscal agent or in any subcontractor in which the provider/fiscal agent has direct or indirect ownership of five percent or more.

NAME	ADDRESS
A.	
B.	
C.	
D.	
E.	
F.	

5. Is any person named in question #4 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s).

***NOTE: Designate relationship to each person listed in question #4 by using* A., B., C., etc.**

YES ☐
NO ☐

NAME	RELATIONSHIP

6. Does any person named in question #4 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 certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act? If yes, give the name(s) of and address(es) of the Medicaid provider or entity.

***NOTE: Designate relationship to each person listed in question #4 by using* A., B., C., etc.**

YES ☐
NO ☐

NAME	ADDRESS

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Name of Provider or Authorized Representative (Typed) _____ Title _____

Signature _____ Date _____