Effective Date	
Last Name	
First Name	
Middle Name	
Degree	
Provider NPI	
DOB	
Gender	
CAQH	
Supervising Provider Name (Mid-level)	
Supervising Provider NPI (Med-level)	
Group /W9 Name	
Group NPI	
Tax ID #	
Billing/Pay to Name (as is on W9)	
Billing/Pay to Address (as is on W9)	
Billing/Pay to City (as is on W9)	
Billing/Pay to State (as is on W9)	
Billing/Pay to Zip Code (as is on W9)	
Type (PCP or Specialist)	
Primary Specialty	
Board Certified (Y/N)	
Certifying Board	
Certification Exp date	
Secondary Specialty	
Include in Directory (Y/N)	
New Patients (Open/Closed)	
Age Limits?	
Service Location Name	
Primary Service Location Address	
Service Location City	
Service Location State	
Service Location Zip	
Service Location Fax	
Office hours	
PCMH Certified (Y/N)	
Hospital Affiliation	

Molina Healthcare, Inc.

OWNERSHIP AND CONTROL DISCLOSURE FORM

Completion and submission of this form is a condition of participation and full and accurate disclosure of ownership and financial interest is required. A failure to submit the requested information may result in a refusal by Plan/Network to enter into an agreement or contract with individual and/or entity or in termination of any existing agreements.

Please answer all questions as of the current date. If additional space is needed please use an attached sheet. Federal statutes and regulations clearly prohibit Plan/Network from paying for items or services furnished, ordered or prescribed by excluded persons. Plan/Network is required to search the exclusions database not only by the name of the entity seeking to participate in the program, but also by the name of any owner or managing employee.

Under 42 CFR 455: Identifying information must be supplied as described in the below sub-sections. For additional detail, please see the federal CFR database. A link to this specific section is supplied below (relevant portions are subsections 455.100 through 455.106): https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr455_main_02.tpl

Complete this form for all locations contracted or being contracted with Molina Healthcare, Inc. (Molina) where Molina members will be seen. Only one form is needed if multiple locations are owned by the same parent company.

I. Identifying Information	
Owner Type (check one) ☐ Organization Ownership – If checking this box, sections 2-6 are required to be completed. ☐ Individual Ownership – Check this box if: If the practitioner named below is a sole proprietor or the practitioner. (ITEMS 2-6 ARE NOT APPLICABLE, PROCEED TO SIGN AND DATE AT THE BOTTOM OF THE FORM.) ☐ Federal/State Owned – Check this box if: the facility named below is entirely state or federally funded. (ITEMS 2-6 ARE NOT APPLICABLE, PROCEED TO SIGN AND DATE AT THE BOTTOM OF THE FORM.)	
INDIVIDUAL NAME:	
SSN (if Individual Ownership):	
DOING BUSINESS AS:	ORGANIZATION NAME:
FEDERAL TAX ID:	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):

OWNERSHIP AND CONTROL DISCLOSURE FORM (CONT'D)

II. Ownership and Control Information

List each office and/or individual, organization, corporation or entity that has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. Attach additional pages as necessary. If there are no individuals or entities with 5% or more ownership/control interest, complete for managing employees.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE #	TAX ID#	ADDRESS

List those persons named that are related to each other (spouse, parent, child or sibling). Attach additional pages if necessary.

NAME AND TITLE	RELATIONSHIP	DOB

Does any owner of the disclosing entity also have an ownership or controlling interest of 5% or more in any other entity? Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR no owner or managing employee has ownership or controlling interest of 5% or more in any other entity.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE #	TAX ID #	ADDRESS

OWNERSHIP AND CONTROL DISCLOSURE FORM (CONT'D)

III. SUBCONTRACTOR INFORMATION

List each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have controlling interest in any subcontract in which the disclosing entity has direct or indirect ownership of 5% or more.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID#	ADDRESS

Please provide the ownership name and address of any subcontractor with whom you have had a business transaction totaling more than $25,000 during the most recent 12-month period.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID #	ADDRESS

IV. CRIMINAL OFFENSES

List each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XVIII, XIX or XX since the inception of those programs. Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have been convicted of a criminal offense.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID#	ADDRESS

OWNERSHIP AND CONTROL DISCLOSURE FORM (CONT'D)

V. SUSPENSION OR DEBARMENT

Have you, or any of your employees, or any individuals who have ownership and/or controlling interest in the disclosing entity ever been placed on the Federal Office of Inspector General Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medicare, Medicaid or Title XXVIII, XIX or XX service programs. If yes, list each person below. Attach additional pages as necessary. The current lists of excluded individuals can be found at: https://exclusions.oig.hhs.gov/ and https://www.sam.gov/portal/SAM/#1

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have been suspended, excluded, and debarred from participation in Medicare, Medicaid or other service programs.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID #	ADDRESS

VI. STATUS CHANGES

Is a change of ownership anticipated within the next year?	☐ YES	☐ NO
If yes, list date of change in operations.		
Is the facility operated by a management company or leased in whole or by part of another organization?	☐ YES	☐ NO
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year?	☐ YES	☐ NO
If yes, when?		

Any designated representative may complete and sign this form on the organization's behalf.

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 Plan/Network. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

Printed (or typed) NAME and
Title of person completing this form: _____ Date: _____

Signature: _____

Completely fill in the form above in Adobe Acrobat or Adobe Reader, and then electronically sign by clicking in the box above. You cannot make changes to this form once it has been electronically signed and you cannot save a partially completed form. If you do not have Adobe Reader or Adobe Acrobat, print this form and fill it in by hand. Signature stamps not accepted.