OWNERSHIP/CONTROL INFORMATION, CONTINUED

At least one person must be added as owner, and up to 24 persons can be added. If you need additional fields, please download and print them at http://medicaidprovider.hhs.mt.gov/providerpages/enrollment.shtml and attach additional pages to the paper enrollment package when they are completed.

*Ownership

_____ *Owner _____ Agent _____ Managing Employee _____ Subcontractor

*Last Name _____ *First Name _____ MI _____

*Date of Birth _____ *Social Security No. _____

*Country of Birth _____

State of Birth (Only required if country of birth is U.S.) _____

Physical Address

*Address _____

Address 2 _____

*City _____ *State _____ *ZIP _____ - _____

County _____ (Only required for in-state Business.)

Mailing Address (If different from the Physical Address.)

*Address _____

Address 2 _____

*City _____ *State _____ *ZIP _____ - _____

County _____ (Only required for in-state Business.)

*Telephone _____ Extension _____

Montana Provider Number (Enter the owner's or managing employee's most recent provider number, if applicable.)

_____

*Are you the spouse, parent, child, or sibling of a person with ownership or control interest?

_____ Yes _____ No Name _____

*Have you ever been sanctioned, debarred, suspended, excluded, or convicted of a criminal offense related to Medicare/Medicaid or any other State or Federal program?

_____ Yes _____ No

If yes, enter explanation. _____

_____