Ownership Update
Provider Disclosure Statement
Montana Healthcare Programs

Use this form to request changes in current ownership. Changes to Tax ID, require reenrollment. Use additional pages if necessary, following the format of appropriate sections. Disclose all information as it should appear on the provider record. Sign page 3. This form will replace all data on file, please ensure it is correct.

Return all pages of this form via mail, fax, or encrypted e-mail to Provider Relations, P.O. Box 4936, Helena, MT 59604; 406-442-4402 (Fax); or MTPRHelpdesk@Conduent.com.

Section 1

Name of Provider Entity/Individual	EIN/SSN	NPI	Taxonomy

Address	City	State	ZIP Code

Section 2

At least one person must be added as owner, and up to 24 persons can be added. If you need additional fields, please download an additional form and attach.

1. Provide the name and address of each person/corporation with current ownership or current controlling ing interest in the provider or in any subcontractor in which the provider has direct or indirect ownership of five percent or more.

First and Last Name	SSN/EIN	Birth Date, State and Country of Birth	Physical Location and Mailing Address, if different
A.			
B.			
C.			

1a. Is any person named in question 1 related to another as spouse, parent, child, or sibling? If yes, provide name of person and relationship. **Designate relationship to each person listed in question 1 using A, B, C, etc.** ☐ **Yes** ☐ **No**

Name	Relationship (e.g., Parent to C)

1b. Does any person named in question 1 have an ownership or controlling interest in any other provider that is publicly funded? If so designate the individual and other entity below along with any other business location / mailing address. ☐ **Yes** ☐ **No**

Name	Other Entity Name and Address	SSN /EIN

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Continued.

Section 3

Name of Entity/Individual	EIN /SSN	NPI	

Section 4

Question 2 and 3 to be answered by all providers

Managing Employee – 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 operations of an institution, organization, or agency. (42 CFR section 455.101) Managing Employees are in a position to exert influence over the conduct of the provider's operations and includes officers, governing boards, or board of directors.
Agent – any person who has been delegated the authority to obligate or act on behalf of a provider.

2. Federal regulation requires that the following information be disclosed on all Managing Employees and Agents.

Name	SSN	Birth Date, State and Country of Birth	Address

3. Has the provider or any person who has ownership or controllinging interest in the provider or in any subcontractor 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 of person and description of offense.

☐ **Yes**
☐ **No**

Name	SSN	Birth Date, State and Country of Birth	Description

PRINT OR TYPE
Name of Provider or Authorized Representative

Title

Signature

Date