



## 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 2. 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](mailto:MTPRHelpdesk@Conduent.com).

<b>Section 1</b>	<b>Name of Provider Entity/Individual</b>		<b>EIN/SSN</b>	<b>NPI</b>	<b>Taxonomy</b>	
	<b>Address</b>		<b>City</b>	<b>State</b>	<b>ZIP Code</b>	
<b>Section 2</b>	<p>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.</p> <p>1. Provide the name and address of each person/corporation with current ownership or current controlling interest in the provider or in any subcontractor in which the provider has direct or indirect ownership of five percent or more.</p>					
	<b>First and Last Name</b>	<b>SSN/EIN</b>	<b>Birth Date, State and Country of Birth</b>	<b>Physical Location and Mailing Address, if different</b>		
	A.					
	B.					
	C.					
	<p>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. <b>Designate relationship to each person listed in question 1 using A, B, C, etc.</b></p>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Name</b>			<b>Relationship (e.g., Parent to C)</b>		
	<p>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.</p>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Name</b>		<b>Other Entity Name and Address</b>		<b>SSN /EIN</b>		



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Continued.

<b>Section 3</b>	Name of Entity/Individual	EIN /SSN	NPI	Taxonomy																																												
<b>Section 4</b>	<p><b>Question 2 and 3 to be answered by all providers</b></p> <p><b>Managing Employee</b> – 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.  <b>Agent</b> – any person who has been delegated the authority to obligate or act on behalf of a provider.</p> <p>2. Federal regulation requires that the following information be disclosed on all Managing Employees and Agents.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">Name</th> <th style="width: 10%;">SSN</th> <th style="width: 25%;">Birth Date, State and Country of Birth</th> <th style="width: 30%;">Address</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>3. Has the provider or any person who has ownership or controlling 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.</p> <div style="float: right; text-align: right;"> <input type="checkbox"/> Yes  <input type="checkbox"/> No         </div> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">Name</th> <th style="width: 10%;">SSN</th> <th style="width: 25%;">Birth Date, State and Country of Birth</th> <th style="width: 30%;">Description</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Name	SSN	Birth Date, State and Country of Birth	Address																									Name	SSN	Birth Date, State and Country of Birth	Description												
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<hr/> <b>PRINT OR TYPE</b> Name of Provider or Authorized Representative		<hr/> Title																																														
<hr/> Signature		<hr/> Date																																														