Nor-Lea Hospital District

PHYSICIAN ACKNOWLEDGEMENT STATEMENT

Notice to Physicians:

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal laws.

Medicaid payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal laws.

Blue Cross/Blue Shield payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal laws.

All other Third Party Payor payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal laws.

_____ _____

Physician Signature Date

_____

Printed Name

Nor-Lea Hospital District

AUTHORIZATION TO OBTAIN
AND RELEASE INFORMATION

I have applied for appointment to the Medical Staff of Nor-Lea General Hospital. In that connection, I consent to complete disclosure of all relevant information pertaining to my professional qualification, moral character, physical and mental health, and I authorize you to make available to Nor-Lea General Hospital all such information in your files from any college, university, professional school, licensing authority, accreditation board, hospital, physician, dentist, malpractice insurance company, or any person or entity. I expressly waive any claim of privilege or privacy with respect to any information you release bearing on my admission to, retention, restriction or termination of staff privileges at Nor-Lea General Hospital, its Medical Staff, Credentials Committee, Administration and their agents, servants and all persons or entities supplying information to them from liability of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for staff privileges at Nor-Lea General Hospital
.

_____ _____

Signature **Date**

_____

Printed Name

Nor-Lea Hospital District

TO: _____ (Company)

As a condition of medical staff membership and the granting of privileges at Nor-Lea General Hospital (NLGH), the undersigned has agreed to provide this consent and request for the Company to release to NLGH as soon as feasible, notice of any change in the status of the undersigned's insurance coverage with the Company.

Therefore, by the execution of this request and release, I hereby consent and direct the Company to provide NLGH, its agents and representatives, notice, as soon as feasible, of any cancellation, restriction or change in the nature and extent of professional liability insurance coverage provided to me. I further agree that no claim of breach of contract, privacy or privilege, or any other claim for loss or damage, shall be made by me against the Company arising out of its compliance with the directive and request of this release. I expressly release and hold harmless _____ (Company) from any loss, claim or damage arising from its providing of information to NLGH about the status of my liability insurance coverage.

It is understood and agreed that the information which I have authorized to be released to NLGH may be released without prior notification or approval, and it is my specific request that this will be done as directed.

_____ _____

Signature **Date**

_____

Printed Name

Nor-Lea Hospital District

HEALTH STATEMENT

I do hereby certify that I have examined _____
(please print)
and consider him/her to be in satisfactory physical health and able to carry out the duties necessary in the performance of his/her profession. Any limitations or restrictions placed on this health care professional are as follows: _____
_____
_____
_____
_____

Comments: _____
_____
_____
_____

_____ _____
Attending Physician (please print name) Date

_____
Signature

Nor-Lea Hospital District

STATEMENT AND RELEASE OF APPLICANT FOR DELINEATION OF CLINICAL PRIVILEGES

In making application for clinical privileges as a member of the medical and dental staff of Nor-Lea Hospital District, I hereby state that I have received and read the bylaws and rules and regulations of the medical staff and other related policies and procedures of the hospital, and agree to abide by the terms thereof as they currently exist or as amended from time to time.

I fully understand that any significant omissions or erroneous information in this application may constitute cause for denial of clinical privileges or cause for summary suspension from the medical staff. I attest that this application is complete and that all information submitted herein is true to the best of my knowledge and belief.

I understand and agree that as an applicant for clinical privileges, I have the burden of producing adequate information for a proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I have not requested privileges for any procedure for which I am not qualified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

Signature of Applicant: _____ Date: _____

Printed Name: _____

HOSPITAL SERVICES CORPORATION
INSURANCE CREDENTIALING SERVICE
AUTHORIZATION AND RELEASE

Authority to Release: I hereby authorize my employer or practice and Hospital Services Corporation's Credentials Verification Service ("HSC") to make application to contracted health plans and managed care organizations for provider enrollment credentialing or re-credentialing. I understand that HSC will populate my provider enrollment applications using information provided to HSC by my employer or practice, or me. I release and discharge HSC, and their agents, officers, directors, or employees and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my provider enrollment applications.

Signature stamps are not acceptable.

_____	_____
Applicant Signature	Employer or Practice
_____	_____
Printed Name	Date

Hospital Services Corporation
Credentials Verification Services
P.O. Box 92200
Albuquerque, New Mexico 87199
Toll Free: (866) 908-0070
Facsimile: (505) 346-0287
Email: credentialing@nmhsc.com

Disclosure of Ownership and Control Interest Form

Purpose: In compliance with 42 CFR 457.935, 42 CFR §455.104, §455.105, and §455.106, providers/*disclosing entities* are required to disclose including, but not limited to, information regarding (1) the identity of all *persons with an ownership or control interest* in the provider/*disclosing entity*, or in any *subcontractor* in which the provider/*disclosing entity* has a direct or *indirect ownership* of 5 percent or more including the identity of *managing employees*, and *other disclosing entities*; (2) certain business transactions and *significant business transactions* between the provider/*disclosing entity* and *subcontractors*/*wholly owned suppliers*; and (3) the identity of any *person with an ownership or control interest* in the provider/*disclosing entity* or who is an *agent*, or a *managing employee* of the provider/*disclosing entity* that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs. **Any authorized/designated representative of the provider/*disclosing entity* may complete and sign this form on behalf of the provider/*disclosing entity*.**

Instructions For Completing the Ownership & Control Interest Disclosure Form

1) Read all definitions and instructions outlined throughout the Form and then reference the definitions and instructions while completing the Form. Terms with corresponding regulatory definitions are italicized and underlined throughout this Form. Please review the applicable definition before responding to the question.
2) Definitions for Disclosure of Ownership and Control Interest Form - See Appendix A
3) Completion and submission of this Statement/Disclosure is a condition of participation as a credentialed or enrolled provider in the New Mexico Centennial Medicaid Managed Care Network or the State Children's Health Insurance Program (CHIP) network for services to members under Medicaid and CHIP benefit plans.
4) Answer all questions as of the current date i.e. request date.
5) If there is no information to include, indicate "None" or "Not applicable" (N/A) in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. Incomplete Forms will be reported back to HSD.
6) If more space is needed, please attach additional sheets.
7) In any space requesting 'Name,' if it is the name of an individual, include First, Middle and Last.
8) Business & Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
9) Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.
10) This Statement/Disclosure should be submitted with your MCO application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A Statement must also be provided within 35 calendar days of a request for this information.
11) Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

How to Determine Ownership or Control Percentages (42 CFR 455.102).

12) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
13) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Disclosure of Ownership and Control Interest Form

NAME OF PROVIDER/*DISCLOSING ENTITY* **BEING CONTRACTED:**

NAME OF GROUP WHERE MEMBERS WILL BE SEEN:
TAX ID # OF PROVIDER/*DISCLOSING ENTITY*:

Section 1 –Disclosure Regarding *Managing Employees* (42 CFR 455.104(b)(4))

1) Does the provider/*disclosing entity* have any *Managing Employees*? ☐ **Yes** ☐ **No**
If **Yes**, provide the following details for any *managing employee* of the provider/*disclosing entity.*
**See the definition of *managing employee*

NAME	SSN	Birthdate	Complete Address (street/city/state/zip)	NPI	Position

Section 2 – Criminal Offense Disclosure (42 CFR 455.106)

2) Has the provider, or any *person (*(individual or entity) *who has ownership or controlling interest* in the provider/*disclosing entity*, or who is an *agent* or *managing employee* of the provider/*disclosing entity*, ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), or Title XX (Social Services Block Grants) since the inception of those programs? ☐ **Yes** ☐ **No** (verify exclusion through the applicable federal and state specific exclusion databases.)
If **Yes**, provide the following details and a description of offense(s). Use additional pages if necessary.

NAME	SSN/TIN	Birthdate	Description

Section 3 – Person(s) with Ownership or Control Interest Disclosure (42 CFR 455.104(b)(1))

3) Are there any *persons* (individual or entity) *with an ownership or control interest* in the provider/*disclosing entity*?
☐ **Yes** ☐ **No**
If **Yes**, provide the following details and include the title (for example, CEO, owner, board member etc).
* For corporations/entities that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address.
**See the definition of *person with an ownership or control interest* and *disclosing entity*

NAME	**TIN or SSN, as applicable	Birthdate	Title	Address (street/city/state/zip)	% Ownership Interest

Disclosure of Ownership and Control Interest Form

Section 4A – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b)(1))

4A) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ **Yes** ☐ **No**
If **Yes**, provide the following details about the *subcontractor*.
**See the definition of the following terms: *subcontractor* and *indirect ownership interest,*

Name of Subcontractor	****TIN or SSN,** as applicable	**Birthdate**	**Address (street/city/state/zip)**	**% Ownership Interest**

Section 4B – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b)(1))

4B) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ Yes ☐ No
If Yes, provide the information below about any *person (individual or entity) with an ownership or control interest*, in any *subcontractor* in which the provider/ disclosing entity has a 5 percent or more direct or *indirect ownership or control interest*.
**See the definition of the following terms: *subcontractor* and *indirect ownership interest,*

Name of Subcontractor (from section 4A)	**Name of Person(s) with an ownership or control interest in the *subcontractor***	****TIN or SSN,** as applicable**of Person(s) with an ownership or control interest in the *subcontractor***	**Birthdateof Person(s) with an ownership or control interest in the *subcontractor***	**Address (street/city/state/zip)of Person(s) with an ownership or control interest in the *subcontractor***	**% Ownership Interest**

Section 5A – Relationships Disclosure (42 CFR 455.104(b)(2))

5A) Are any of the individuals disclosed in Section 3 above related to each other as a spouse, parent, child, or sibling?
☐ **Yes** ☐ **No** If **Yes**, provide the following details

NAME(From Section 3)	**Nature of Relationship (e.g., spouse)**	**Related to Name(From Section 3)**

Disclosure of Ownership and Control Interest Form

Section 5B – Relationships Disclosure (42 CFR 455.104(b)(2))

5B) Are any of the individuals disclosed in **Section 3** above related to any of the individuals disclosed in **Section 4B** as a spouse, parent, child, or sibling? ☐ **Yes** ☐ **No** (spouse, parent, child, sibling? If yes, give the name(s) of person(s) and relationship(s). Use additional pages if necessary. If **Yes**, provide the following details

NAME(From Section 3)	**Nature of Relationship (e.g., spouse)**	**Related to Name(From Section 4B)**

Section 6 – *Other Disclosing Entity* Disclosure (42 CFR 455.104(b)(3))

6.1) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any other Medicaid provider? ☐ Yes ☐ No ☐ N/A

6.2) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any *other disclosing 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 (Maternal and Child Health Services Block Grant), XVIII (Medicare), XX (Block Grants to States for Social Services) , or Title XXI (State Children's Health Insurance Program) of the Social Security Act? ☐ Yes ☐ No ☐ N/A

If Yes to Items 1 or 2 of this Section 6, provide the following details:

**See the definition of the following terms: *other disclosing entity* and *ownership interest,*

NAME (From Section 3)	**Name of *other disclosing entity or other Medicaid Provider***	**SSN and/or TIN**, as applicable **of the *other disclosing entity or other Medicaid Provider***

Section 7A – Business Transactions Disclosure (42 CFR 455.105)

7A) Business Transactions - Subcontractors: Has the provider/*disclosing entity* had any business transactions with a *Subcontractor* totaling more than $25,000 in the previous twelve (12) month period (12-month period ending as of the date on this request) ? ☐ **Yes** ☐ **No** If **Yes**, provide the following details

**See the definition of *subcontractor*

Name of *subcontractor*	****TIN or SSN,** as applicable of *subcontractor*	**Birthdate**	**Address (street/city/state/zip)**	**Transaction Amount**

Disclosure of Ownership and Control Interest Form

Section 7B – Significant Business Transactions Disclosure (42 CFR 455.105)

7B) Significant Business Transactions: Has the provider/*disclosing entity* had any *Significant Business Transactions* with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending as of the date on this request) ? ☐ **Yes** ☐ **No** If **Yes**, provide the following details

**See the definition of the following terms: *subcontractor, wholly-owned supplier,* and *significant business transactions*

Type of entity	Name	**TIN or SSN, as applicable	Birthdate	Address (street/city/state/zip)	Transaction Amount
☐ Wholly Owned Supplier ☐ Subcontractor					
☐ Wholly Owned Supplier ☐ Subcontractor					

Section 8 – Attestation

8) Through signature below, I hereby certify that persons with ownership and control interest in the provider/*disclosing entity* or in a *subcontractor*, *agents*, *subcontractors*, *managing employees*, and any employees providing healthcare services as part of this application are screened with the applicable background check including, but is not limited to, verification against the applicable state and federal exclusion databases . I hereby represent and warrant that all information contained in this form is true, correct, and complete in all aspects. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract. I further understand completion of this form does not guarantee participation with the Managed Care Organization.

Name:_____ **Title:**_____
(Print or Type: First/Middle/Last) **(Print or Type)**

Signature:_____ **Date (MM/DD/YYYY):**_____
(Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)

Disclosure of Ownership and Control Interest Form

APPENDIX A

DEFINITIONS

#	Term/Words	Definition
1	***Agent***	**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2	***Disclosing entity***	**Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. * For purposes of completing the Medicaid Disclosure Form, solo practitioners and the group contracting entity are also treated as a "disclosing entity." **Group Providers - The contracting group entity should complete the Form on behalf of the group.
3	***Fiscal agent***	**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4	***Group of practitioners***	**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).
5	***Health Insuring Organization (HIO)***	Health insuring organization (HIO) has the meaning specified in § 438.2.
6	***Indirect ownership interest***	**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. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
7	***Managed care entity***	**Managed care entity** (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
8	***Managing employee***	**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.

9	*Other disclosing entity*	Other disclosing entity **means any other Medicaid disclosing entity and 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. This includes:** 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.**
10	***Ownership interest***	**Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in: **a.** The capital, the stock or the profits of the entity, or **b.** Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
11	***Person with an ownership or control interest***	**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) Is 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.
12	***Prepaid ambulatory health plan (PAHP)***	Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.
13	***Prepaid inpatient health plan (PIHP)***	Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.
14	***Primary care case manager (PCCM)***	Primary care case manager (PCCM) has the meaning specified in § 438.2.
15	***Significant business transaction***	**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.
16	***Subcontractor***	**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.

17	*Supplier*	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).**
18	***Termination***	**Termination** means – a) For a-- i. Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and ii. Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. b) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. **c)** The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.
19	***Wholly owned supplier***	**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.