DISCLOSURE STATEMENT: INDIVIDUAL PRACTITIONERS AND GROUPS OF PRACTITIONERS

Federal and State law require this form to be completed by any individual practitioner or group of practitioners with a contractual arrangement with Horizon NJ Health relating to the managed Medicaid and NJ FamilyCare programs. Horizon must provide this form to DMAHS upon request. Please direct any questions regarding this form to your legal counsel and refer to the New Jersey Medicaid HMO Contract as well as 42 CFR 455.100, et seq.

FORM SUBMISSION

Submit this form, along with other credentialing documentation, through our online Enrollment Tool (which can be accessed through the Join Our Networks webpage), or mail it to:

Horizon BCBSNJ Credentialing & Recredentialing Department
3 Penn Plaza East, PP-14C
Newark NJ 07105-2200

I. IDENTIFYING INFORMATION OF THE PROVIDER

Name of Disclosing Provider and D/B/A ______________________________

Street Address of Disclosing Provider and D/B/A ______________________________

City of Disclosing Provider and D/B/A______________________________

County of Disclosing Provider and D/B/A______________________________

State of Disclosing Provider and D/B/A______________________________

Zip Code of Disclosing Provider and D/B/A______________________________

Telephone Number of Disclosing Provider and D/B/A______________________________

NJ Medicaid Provider Number of Disclosing Provider and D/B/A______________________________

II. DISCLOSURE BY PROVIDER: INFORMATION RELATED TO BUSINESS TRANSACTIONS

A. 42 C.F.R. §455.105(b)(1) requires disclosure of ownership information for any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
Has this individual practitioner or group practice had business transactions with a subcontractor totaling more than $25,000 during the past 12-month period?

No

Yes

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If you selected “Yes,” provide the following information. Include additional pages as necessary.

Name 1 ______________________________

Address 1 ______________________________

Ownership 1 ______________________________

Name 2 ______________________________

Address 2 ______________________________

Ownership 2 ______________________________

B. 42 C.F.R. §455.105(b)(2) requires disclosure of significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5 years. “Significant business transaction” means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of a provider's total operating expenses.

Has this individual practitioner or group practice had significant business transactions with a wholly owned supplier and/or a subcontractor during the past 5 years?

No

Yes

If you selected “Yes,” provide the following information. Include additional pages as necessary.

Name of Parties to Transaction 1 ______________________________

Amount of Transaction 1 ______________________________

Date of Transaction 1 ______________________________

Nature of Transaction 1 ______________________________

Name of Parties to Transaction 2 ______________________________

Amount of Transaction 2 ______________________________

Date of Transaction 2 ______________________________

Nature of Transaction 2 ______________________________

III. DISCLOSURE OF INFORMATION ON PERSONS CONVICTED OF CRIMES

42 C.F.R. §455.106(a) requires identification of any person who has ownership or control interest in the provider, or is a director, officer, agent or managing employee of the provider, and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs.

Has any person with ownership or control interest in the provider, or who is a director, officer, 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, CHIP, or the Title XX services program since the inception of those programs?

No

Yes

If you selected “Yes,” provide the following information. Include additional pages as necessary.

Person 1 Name ______________________________

Person 1 Address ______________________________

Person 1 Date of Birth ______________________________

Person 1 Social Security Number ______________________________

Tax Identification Number (TIN) ______________________________

Person 2 Name ______________________________

Person 2 Address ______________________________

Person 2 Date of Birth ______________________________

Person 2 Social Security Number ______________________________

Tax Identification Number (TIN) ______________________________

IV. ATTESTATION

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this Disclosure 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 provider already participates, a termination of its agreement or contract with Horizon NJ Health, as appropriate.

Name of Authorized Representative ______________________________

Title of Authorized Representative ______________________________

Date of Signature ______________________________

Signature of Authorized Representative ______________________________