Medicaid Disclosure Form Attestation – Individual

PURPOSE

This form may be used when the following conditions are met:

1. Individual Provider has submitted a complete Medicaid Disclosure Form – Individual within the last 365 days; AND
2. Individual Provider has reviewed the form that was previously submitted for continued accuracy; AND
3. There are no changes, additions, or deletions to any of the information previously disclosed.

WHAT IF A PROVIDER DOES NOT COMPLETE A MEDICAID DISCLOSURE

The Federal Rules and the Medicaid Provider Manual independently require providers to provide the information requested in this form. SWMBH is required to collect this information by its contracts in addition to the governing laws. Completion and submission of a Provider Disclosure Form is a condition of participation in SWMBH's provider network. ***Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.***

42 CFR §455.104(e) Consequences for failure to provide required disclosures. *Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.*

HOW OFTEN DOES THE MEDICAID DISCLOSURE FORM HAVE TO BE COMPLETED

The Medicaid Disclosure Form must be submitted at the following intervals:

1) Credentialing;
2) Initial contracting;
3) Annual contract renewal;
4) Within 35 days of a request for updated information from SWMBH;
5) Within 35 days of any changes to the information or change in ownership.

Individual Provider Information

Instructions

Please fill out the entire section. ***Every field must be complete***. If fields are left blank, the form will not be processed and will be returned for corrections/completions. If the form is unreadable due to illegible handwriting, the form will not be processed.

<table>
<tr><td colspan="2" rowspan="5">Please choose appropriate category:
☐ Individual Member of a Medical Group
☐ Individual Contracted Provider
☐ Sole Proprietor
☐ HCBS Provider
☐ Other:

Group Affiliation? ☐ Yes ☐ No
If Affiliated with a Group, do you have a Private Practice as well? ☐ Yes ☐ No ☐ NA</td><td colspan="2">Name of Person Completing the Form</td></tr>
<tr><td colspan="2">Title</td></tr>
<tr><td colspan="2">Phone Number</td></tr>
<tr><td colspan="2">Fax</td></tr>
<tr><td colspan="2">Email</td></tr>
<tr><td colspan="4">Legal Name of Individual (“Individual Provider”): Name of Group (if applicable):</td></tr>
<tr><td colspan="4">Physical Address
STREET CITY STATE ZIP</td></tr>
<tr><td colspan="4">+Additional Addresses (list all Practice locations – attach a separate sheet if necessary):</td></tr>
<tr><td>SSN #:</td><td>*Medicaid ID #:</td><td>*National Provider ID (NPI) #:</td><td></td></tr>
<tr><td colspan="2">*If billing under an Entity: Federal Tax Identification #:</td><td colspan="2">*If billing under an Entity: Billing Entity’s NPI #:</td></tr>
<tr><td colspan="2">*If billing under an Entity: Billing Entity’s Medicaid ID#:</td><td colspan="2"></td></tr>
</table>

These fields cannot be left blank; “N/A” non-applicable and “applied for” are acceptable responses.
Individual providers please use social security number; field cannot be left blank: “N/A” non-applicable and “applied for” are acceptable responses

+ Please list “consumers’ homes” or “public community locations” if services are provided in these locations

PROVIDER ATTESTION

By signing below, I hereby certify that on [date] _____, I reviewed the attached Medicaid Disclosure Form – Individual that was submitted by me on [date] _____ _____. The information contained in that form continues to be accurate and no additions, deletions, corrections, or changes are necessary at this time. I understand that additions or changes to the information submitted must be submitted by me within 35 days of the change. Additionally, I understand that misleading, inaccurate, or incomplete data may result in denial of participation, denial of claims, and contract termination. (Individual Provider must sign).

Previously submitted Disclosure Form MUST BE ATTACHED

_____ _____

Signature Title

_____ _____

Printed Full Name Date

Phone Number: _____ Fax Number: _____

Email: _____

Please indicate all Organizations with whom your entity holds a contract:

Southwest Michigan Behavioral Health: ☐

Barry County Community Mental Health Authority: ☐

Riverwood Center (Berrien County): ☐

Pines Behavioral Health (Branch County): ☐

Summit Pointe (Calhoun County): ☐

Woodlands Behavioral Health Network (Cass County): ☐

Kalamazoo County Community Mental Health and Substance Abuse Services: ☐

Community Mental Health and Substance Abuse Services of St. Joseph: ☐

Van Buren Community Mental Health: ☐