

**MAGNOLIA HEALTH PLAN**  
**Disclosure of Ownership And Control Interest Statement**

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

**Practice Information**

Check one that most closely describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity	
Name of Individual, Group Practice, or Disclosing Entity:	
DBA Name:	
Address:	
Federal Tax Identification Number:	Provider CAQH #:

**Section I**

<p><u>For individuals</u>, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.</p> <p><u>For entities</u>, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)</p>			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

**Section II**

<p>Are any of the individuals listed above related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)</p>	
Names	Type of relation

**Section III**

<p>Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)</p>			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

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**Section IV**

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?  Yes  No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

**Section V**

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors?  Yes  No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

**Section VI**

Have you identified your status (under Practice Information 1) as a Disclosing Entity?  Yes  No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title (or indicate if authorized Agent)**

\_\_\_\_\_  
**Name (please print)**

\_\_\_\_\_  
**Date**

Please return the form by fax to 866-480-3227 or by mail to:

**Magnolia Health Plan**  
**Attn: Network Development and Contracting**  
**111 East Capitol St. Ste. 500**  
**Jackson, MS 39201**