
**MAINE INTEGRATED HEALTH MANAGEMENT SOLUTION
OWNERS & BOARDS
PROVIDER MAINTENANCE FORM (MIHMS_MF_0006)**

The purpose of this form is to make modifications to a paper enrollment application. This form is to update any information regarding owners and board members.

Complete this form if you need to do any of the following:

- Add one or more new owners or board members
- Remove one or more existing owners or board members
- Update the information on file for one or more existing owners or board members

If modifications need to be made to service location(s) refer to Maine Integrated Health Management Solution SERVICE LOCATIONS Provider Maintenance Form MIHMS_MF_0007.

If modifications need to be made to rendering provider(s) refer to Maine Integrated Health Management Solution RENDERING PROVIDERS Provider Maintenance Form MIHMS_MF_0008.

Please print or type all information so that it is legible. Use only blue or black ink. Do not use pencil.

Failure to provide accurate, complete information could result in delayed processing of your application and/or incorrect claim reimbursement.

Note that an asterisk (*) following a question or field label in this form indicates required information.

If you are not changing ownership or board member information for your enrollment or have otherwise received this form in error, contact the MaineCare Provider Enrollment Unit at 1-866-690-5585.

SECTION 1. IDENTIFYING INFORMATION

1. What is your NPI or API? *

2. What is your tax ID? *

Note: Supply at least one of the following numbers. You may provide both.

FEIN _____ SSN _____

3. Name *

Note: For individuals, supply the name in this field in the format LastName, FirstName. For groups, supply the name in this field in the format Group Name. For facilities, agencies, or organizations, supply the name in this field in the format FAO Name. Ensure the name is spelled correctly.

SECTION 2. OWNERS AND BOARD MEMBERS

Part A. General Information

In accordance with Form CMS-1513 (Disclosure of Ownership and Control Interest Statement), you must provide the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of five percent (5%) or more in the disclosing entity.

If you are maintaining owner or board member information for multiple owners or board members, you must provide a copy of this Section (pages 2-7) for each owner or board member. Unless otherwise indicated, all fields in all parts are required.

All fields except FEIN, End Date, and Address 2 are required when supplying information about a person who is an owner or a board member.

All fields except End Date and Address 2 are required when supplying information about an organization that is an owner. FEIN is required when providing information about an organization.

1. Are you adding, removing (or terming out), or updating information for an owner or board member?

- Adding an owner or board member
- Removing (or terming out) an existing owner or board member
- Updating information for an existing owner or board member

2. Does the following information apply to an owner or a board member? *

- Owner Board member

3. Name, Tenure, and Address Information

First and Last Name * _____

FEIN or SSN * _____

Begin Date * _____

End Date _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program (42 CFR 45)? *

- Sanctioned Excluded Convicted None of these

2. Does any owner or board member have ownership or control interest in other organizations that bill Medicaid for services? If so, please specify.

For each organization that qualifies, provide the indicated information below. If you need additional space for this list, you may attach a separate page. For the attached page, label it at the top margin with Section 2, Part B, #2—Medicaid Billing Organizations.

Business Name * _____

NPI or Medicaid Number * _____

FEIN or SSN * _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

Part C. Business Questions

1. Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX? *
 Yes
 No

2. (Title XVIII providers only) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? *
 Yes
 No

3. Has there been a change in ownership or control within the last year? *
 Yes, on this date: _____
 No

4. Do you anticipate any change of ownership or control within the year? *
 Yes, on or about this date: _____
 No

5. Do you anticipate filing for bankruptcy within the year? *
 Yes, on or about this date: _____
 No

6. Is this facility operated by a management company, or leased in whole or part by another organization? *
 Yes, the change in operations occurred on this date: _____
 No

7. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? *
 Yes
 No

8. Is this facility chain affiliated? *

Yes No

If Yes, complete the following fields, where the address fields refer to the address of corporation:

Name * _____

FEIN * _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

9. If the answer to the previous question is No, was this facility ever affiliated with a chain? *

Yes No

If Yes, complete the following fields, where the address fields refer to the address of corporation:

Name * _____

FEIN * _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

10. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years? *

Yes No

If Yes, complete the following fields:

Year of change * _____

Current beds * _____

Prior beds * _____

SECTION 3. DOCUMENTATION

In addition to this application, you must also complete, in their entirety, the documents that are included in your enrollment application packet. Be sure to label each document with the NPI and tax ID supplied in Section 1. To successfully complete the remainder of your enrollment application, follow the instructions included on the documents.

SECTION 4. SIGNATURE AND SUBMISSION

Read the following statements and, if you are in agreement with them, sign and date where indicated below. Your application is incomplete without your signature.

- I certify that the information contained herein is true, correct, and complete.
- If I become aware that any information in this form is not true, correct, or complete, I agree to notify the Medicaid Provider Enrollment Unity of this fact immediately.
- I authorize the Medicaid Provider Enrollment Unit to verify the information contained herein.
- I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.

Provider's signature

Today's date