NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Participating Provider Owner/Manager Disclosure Certification

Instructions

In accordance with the New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts section B(9)(l), providers are required to have an officer, director or partner of the Provider execute the following certification within 5 days of executing a new agreement with a Medicaid Managed Care Organization (MCO). The MCO must retain this document with the applicable contract for validation during operational surveys.

Questions regarding this certification can be directed to BMCCSProgInt@health.ny.gov.

Certification Category (Choose one): ☐ Participating Provider Certification ☐ Subcontractor Certification

Section A Participating Provider Information

Participating Provider Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

FEIN or SSN: _____

Section B Officer, Director or Partner Information (if different from above)

First Name: _____ Last Name: _____ Middle Initial: _____ Suffix: _____

Title: _____

Phone Number: _____ Email Address: _____

Section C Managed Care Organization(s)

Name of the Managed Care Organization the Participating Provider has an agreement with to provide services to Medicaid beneficiaries:

MCO Name: Independent Health Association, Inc.

Anticipated Contract Term: _____ To: _____

Date of Execution: _____

Section D Questions

In order to complete the Participating Provider Owner/Manager Disclosure Certification form, you must certify each of the following statements:

The person signing below, declares, affirms and certifies (hereinafter certification) that the information entered as part of this form is true and that:

1. That the Participating Provider named on this form is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of the New York State Department of Health related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Participating Provider. This includes 18 NYCRR § 515.2, except to the extent that any reference in the regulation establishing rates, fees and claiming instructions will refer to the rates, fees and claiming instructions set by the Managed Care Organization(s) named on this form. ☐ I Certify
2. That all care, services or medical supplies for which the provider submits claims for payment have been provided. ☐ I Certify
3. That payment requests are submitted in accordance with applicable law. ☐ I Certify

Section E Certification

IMPORTANT: Making a false statement in this certification may subject you to criminal prosecution for a misdemeanor or felony under the New York State Penal Law.

The person signing below, declares, affirms and certifies (hereinafter certification) that the information entered as part of this form is true and that:

1. he/she is the certifying official/provider whose name and contact information appears above;
2. the certifying official/provider has undertaken due diligence and conducted all reasonable inquiry prior to making any of the statements in this certification and has sufficient knowledge to complete this form; and
3. the certifying official/provider acknowledges that this certification is being made in order to comply with the requirements outlined in the questions answered above.

Signature _____ Date _____