Instructions for Louisiana Medicaid Ownership Disclosure Information Entity/Business

This is a multi-page form. Please review the instructions in their entirety before completing the form. ***Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.***

Refer to the web sites listed on the previous pages for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Enter your Provider Name at the top of each page in the space provided.

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.
Taxpayer ID Number – Enter the nine (9) digit Tax ID number for this provider.
National Provider Identifier (NPI) – Enter your ten (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Update to Current Enrollment, Re-Validation, Re-Enrollment or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.
Provider Type – Enter the Louisiana Medicaid Provider Type for this Entity/Business.
Primary Telephone Number(s) of Disclosing Entity/Business - Enter the area code and telephone number(s) at the street address of this Entity/Business.
Doing Business As (DBA) Name – Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the Entity/Business license.
Legal Name of Disclosing Entity/Business – Enter the legal name of the Entity/Business in the space labeled "Legal Name of Entity/Business."
Primary Disclosing Entity/Business Street Address, City, State, Zip - Enter the physical business street address of the Entity/Business requesting enrollment. Enter the city, state and zip code of the physical business street address.
Primary Disclosing Entity/Business Mailing Address/PO Box, City, State, Zip – Enter the mailing address or PO Box of the Entity/Business requesting enrollment. Enter the city, state and zip code of the mailing address.
Additional Post Office Boxes Not Identified Above – Enter any additional Post Office Boxes for the Entity/Business that are stand-alone or not associated with any business location.
Disclosing Entity/Business Telephone Number to Request Medical Records – Enter the area code and telephone number(s) that the Entity/Business uses to answer requests for medical records.
Disclosing Entity/Business Primary Fax Number – Enter the area code and fax number(s) of this Entity/Business.
Email Address of Entity/Business contact person - Enter the email address of the contact person who should receive official LDH notices.
Entity/Business Website – Enter the web address of the Entity/Business website if applicable.

A. **Is there a Corporate Office location for the disclosing Entity/Business?** Check the appropriate box.
DBA Name of Corporate Office – If the Entity/Business does have a corporate office location, enter the DBA Name of that office.
Corporate Office contact information – Enter the street address, mailing address/PO Box, additional PO boxes, phone number, fax number and email address for the corporate office.

B. **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below. Lists are not acceptable.
DBA Name of Additional Location – Enter the DBA name of the additional practice location.
Medicaid Provider # - Enter the Medicaid Provider number of the additional practice, if applicable.
Additional Location contact information – Enter the mailing address/PO Box, street address, additional PO boxes, phone number, fax number and email address for the additional location office. Continue identifying additional locations and the contact information in the spaces provided. If needed, please attach additional sheets if there are more than three additional locations.

C. **Identify how this disclosing Entity/Business is registered with the Internal Revenue Service – Select only 1 of the categories.** Multiple selections may result in a rejection for clarification.
Privately owned or Non-profit Providers Only – Identify the type of Entity/Business as it is registered with the Internal Revenue Service (IRS). Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of Entity/Business in the space(s) provided. Optional: May add comments in the space provided. Continue to Section II.
OR
Louisiana Government Providers Only – Identify the type of Entity/Business if Louisiana government owned. Select only one from among City and/or Parish, Department of Children and Family Services (DCFS), Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Villa, Other LDH agency, Local Education Agency (LEA), Louisiana State University (LSU), or Other State-owned entity. Check the appropriate box and complete the applicable fields.

D. **Is this disclosing Entity/Business publicly traded?** A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check the appropriate box.

E. **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?** Check the appropriate box. If yes, list all names and Tax IDs in the spaces provided. Attach additional pages if needed.

SECTION II – ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A. **Has this Entity/Business (since its existence) AND any entity/business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, 1) provide a written statement including the details on all occurrences and 2) attach all official legal documents, including any reinstatements.

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the Entity/Business address, Entity/Business telephone number, and the Entity/Business email address of the person completing this form. Finally, enter any additional Entity/Business telephone number(s) and Entity/Business email address(es).

SECTION V – OWNERSHIP INFORMATION

Medicaid requires that an Entity/Business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this Entity/Business. A separate form, Section V(b), is required for each owner, therefore, please make the necessary copies as a list of owners will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Owners are individuals and/or organizations having direct, indirect, or controlling ownership interest in this disclosing Entity/Business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing Entity/Business.
- Indirect ownership is defined as an ownership interest in an Entity/Business that has direct or indirect ownership in this disclosing Entity/Business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the Entity/Business.
    - To dissolve or transfer this disclosing Entity/Business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the Entity/Business:

- Whose personal assets are used to satisfy the Entity/Business creditors.
- Who join together to carry on an Entity/Business and expect to share in the profits and losses of the Entity/Business.
- Who report their share of profits and losses of the Entity/Business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION V(a) – INFORMATION ON ALL OWNERS

NEW FORMAT! Please read these directions in detail.

A. **Individuals & Entities/Businesses with Direct Ownership** –List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/ or controlling interest of 5% or greater in the disclosing Entity/Business. Add additional pages if needed.
NOTE: Section V(b) must be completed for each individual listed. Item B and Section V(c) must be completed for each entity/business listed.

B. **Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business** –
First column: List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business in the first column. The disclosing Entity/Business cannot list itself as an owner.
Second column: Name all owners of the entity/business listed in the first column.
Third column: Indicate the percent of ownership each owner has in the entity/business in the first column.
Fourth column: Indicate the percent ownership each owner has in the disclosing Entity/Business. This percent of indirect ownership in the disclosing Entity/Business is determined by multiplying the percentages of ownership in e

ach entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.
Add additional pages if needed.
NOTE: Section V(c) must be completed for each Entity/Business listed and Section V(b) must be completed for each individual listed.

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for **each and every individual owner named in Section V(a)**, whether the individual owns a direct or indirect stake in the disclosing Entity/Business. A list of all owners will not be accepted. **Make a copy of the blank form for each owner you report before you fill it out the first time.** For example, if you have five owners, you need to submit five completed Section V(b) forms.

A. **Individual Owner Information** – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this Entity/Business, the percentage of ownership of the Entity/Business, the Social Security Number (required), date of birth, current mailing address and physical address, telephone number and email address of the owner in the spaces provided.

B. **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?** – Read the question carefully and check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this owner a U.S. citizen?** Check the appropriate box. If no, provide the Alien Verification number.

D. **Does this owner reside outside the State of Louisiana?** – Check the appropriate box. If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the appropriate box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided. Attach additional pages if needed.

E. **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related (e.g. spouse, parent, child, sibling) in the spaces provided. Attach additional pages if needed.

F. **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

G. **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business participating in a Federal/State funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

H. **Has the individual owner named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. **Entity/Business Owner Information** – Enter the Entity/Business Name, the DBA Name, the Tax ID Number, the current street address of the primary location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided.

B. **Are there any business locations in addition to the location listed above?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location. Enter the DBA Name of the additional location, the Tax ID Number, the current street address of the additional location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided. Attach additional pages if needed.

C. **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?** Check the appropriate box. If yes, list all names and Tax IDs below. Attach additional pages if needed.

D. **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

E. **Is this Entity/Business and Tax ID listed in the Section I currently enrolled in a Federal/State funded healthcare program?** If yes, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments.

F. **Has this Entity/Business (since its existence) AND any Entity/Business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with, since the inception of those programs, as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, provide a written statement including the details on all occurrences. Attach all official legal documents, including any reinstatements.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

A separate VI(b) form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or manager control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

In the first table, enter the names of each agent, member or officer who is a part of management for the disclosing Entity/Business. In the second table, enter the names of each managing employee for the disclosing Entity/Business. Select the appropriate box to indicate if the individual is also an owner. If so, list their percentage of ownership. Add additional pages if needed.

NOTE: Section VI(b) must be completed for each individual listed unless individual has already been reported in Section V.

SECTION VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Make a photocopy of Section VI(b) for each managing employee/agent you report.

A. **AGENT– or – MANAGING EMPLOYEE –** Check a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, current physical address, telephone number and email address in the spaces provided.

B. **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? – C**heck the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this agent or managing employee a U.S. citizen?** Check the appropriate box. If no, provide Alien Verification number.

D. **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

E. **Has the agent or managing employee named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

F. **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION VII – AUTHORIZED REPRESENTATIVES

List the individuals who are authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms. Every person listed here must be either an owner or a managing employee as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a managing employee, or other (specify the title in the space provided).

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.
Title/Position of Authorized Representative – indicate the Authorized Representative's relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).
Signature of Authorized Representative – the authorized representative must sign the form. Signatures must be original and in blue ink (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.
Date of Signature – enter the date this agreement was signed.

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date. Please sign in colored ink (not black).

Reference Material for Louisiana Medicaid Ownership Disclosure Information
For an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:** http://url.ie/ywri

MAPIL Louisiana R.S., Title 46:437.1-14. http://url.ie/yw45

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://url.ie/yw46

Louisiana Update January/February 2009: http://url.ie/yw47

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://tinyurl.com/ne58pwb

Social Security Act 1128 a: http://tinyurl.com/3lnj2z9

Provider Name: _____

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number (Leave blank if applying for new number)	2	3	7	6	9	8	5

Taxpayer ID Number	7	2	1	0	7	4	0	0	8

National Provider Identifier (NPI)	1	9	0	2	3	6	9	3	1	7

This enrollment packet is for a ☐ New Enrollment ■ Update to Current Enrollment ☐ Re-Validation ☐ Re-Enrollment	☐ Change of Ownership (CHOW) _____ (Date of CHOW) _____ (Current Medicaid Provider Number)
Provider Type: n/a	Primary Telephone Number of Disclosing Entity/Business (504) 849-3521

Doing Business As (DBA) Name UnitedHealthcare Community Plan		Legal Name of Disclosing Entity/Business UnitedHealthcare of Louisiana, Inc.	
Primary Disclosing Entity/Business Street Address 3838 N. Causeway Blvd., Suite 2600	City Metairie	State LA	Zip 70002
Primary Disclosing Entity/Business Mailing Address/PO Box 3838 N. Causeway Blvd., Suite 2600	City Metairie	State LA	Zip 70002
Additional Post Office Boxes Not Identified Above N/A	City	State	Zip
Disclosing Entity/Business Telephone number to request medical records (999) 999-9999	Disclosing Entity/Business Primary Fax Number (504) 849-3570		
Email Address of Entity/Business contact person LA_UHC_CP@uhc.com	Entity/Business Website (if applicable) www.uhccommunityplan.com		

A. ☐ Yes ☐ No Is there a Corporate Office location separate from the primary location of the disclosing Entity/Business?

If yes, complete the section below.

DBA Name of Corporate Office			
Corporate Office Street Address	City	State	Zip
Corporate Office Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Corporate Office Phone Number ( ) -	Corporate Office Fax Number ( ) -		
Corporate Office Email address			

Provider Name: _____

Make a photocopy of this page if more space is needed to list additional locations

B. ☐ **Yes** ☐ **No** **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Lists are not acceptable.

2 If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Medicaid Provider #, if applicable		
UnitedHealthcare Community Plan			
Additional Location Street Address	City	State	Zip
8550 United Plaza Blvd., Suite 703	Baton Rouge	LA	70809
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
UnitedHealthcare Community Plan			
Additional Location Street Address	City	State	Zip
7305 Florida Blvd., Suite 20	Baton Rouge	LA	70806
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item E below

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service

Select only one (1) – multiple selections may result in a rejection for clarification

Privately Owned or Non-profit Providers Only

☐ **Sole Proprietorship**

☐ **Partnership/Limited Liability Partnership**: How many members are identified with this partnership? _____

■ **Corporation:** Revenue greater than or equal to $5M annually Yes Revenue less than $5M annually _____

In the (current) Articles of Incorporation: How many stakeholders/individual owners are identified? 1

How many Board of Director members are identified? 0

How many officers are identified? 0

☐ **Limited Liability Corporation (LLC)**

In the (current) Articles of Organization: How many members are identified? _____

How many managing employees are identified? _____

☐ **Non-profit:** How many members are appointed to the governing board? _____ (Must attach IRS verification showing the non-profit status)

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**

☐ **DCFS**

☐ **LDH**

☐ OBH ☐ OPH
☐ OAAS ☐ OCDD
☐ Villa ☐ Other _____

☐ **LEA (Local Education Agency)**

☐ **LSU**
Hospital -_____

☐ **Other State-owned entity:** _____

D. ☐ Yes ☐ No Is this disclosing Entity/Business publicly traded? See instructions.

E. ☐ Yes ☐ No Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name Southeast Health Plan of Louisiana, Inc.	Tax ID (no change in Tax ID)
Name Community Health Network of Louisiana	Tax ID (no change in Tax ID)
Name	Tax ID
Name	Tax ID
Name	Tax ID

Provider Name: _____

SECTION II – DISCLOSING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

A. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:

☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item A below

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. ☐ **Yes** ☐ **No** **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, provide the details in the fields below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	UnitedHealthcare Community Plan	72-1074008	LA	2376985

SECTION IV - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Scott	D		Waulters		

Social Security Number	Date of Birth	Job Title
[redacted]		Chief Executive Officer

The person completing this form is (please check one):

☒ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002

Entity/Business Telephone Number	Entity/Business Email Address
(504) 849-3521	LA_UHC_CP@uhc.com
Additional Entity/Business Telephone Number(s)	**Additional Entity/Business Email Address(es)**
(999) 999-9999	N/A

Provider Name: _____

NEW FORMAT! PLEASE REFER TO THE INSTRUCTIONS FOR DETAILED EXPLANTIONS!

Make a photocopy of this page if more space is needed to list owners in items A and B

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals & Entities/Businesses with Direct Ownership

List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/or controlling interest of 5% or greater in the disclosing Entity/Business.

*Fill out Section V(b) for each **Individual**. Fill out both item B and Section V(c) for each **Entity/Business** listed below.*

Individuals or Entities/Businesses with ownership	% of ownership
1. UnitedHealthcare, Inc.	100%
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business

List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business. Identify the owners of that Entity/Business and their % of ownership below.* The disclosing Entity/Business cannot be listed as an owner.

*Fill out Section V(b) for each **Individual** and Section V(c) for each **Entity/Business** listed below.*

Entity/Business/Organization with a direct ownership interest listed in item A	Owners of the Entity/Business identified on the left.	% of ownership in Entity/Business identified on the left	% of ownership in the disclosing Entity/Business
1. N/A	a.		
	b.		
	c.		
	d.		
2.	a.		
	b.		
	c.		
	d.		
3.	a.		
	b.		
	c.		
	d.		
4.	a.		
	b.		
	c.		
	d.		
5.	a.		
	b.		
	c.		
	d.		

*The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

Provider Name: ____

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION N/A

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
N/A					

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required)	Date of Birth
		- -	/ /

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
Mailing Address/PO Box	City	State	Zip Code

Telephone Number	Email address
- -	

B. ☐ Yes ☐ No Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☐ Yes ☐ No Is this owner a U.S. citizen? If no, provide Alien Verification ___________________________

D. ☐ Yes ☐ No Does this owner reside outside the State of Louisiana?

☐ Yes ☐ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?
If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☐ Yes ☐ No Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: N/A

F. ☐ **Yes** ☐ **No** **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

G. ☐ **Yes** ☐ **No** **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: N/A

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name	Legal Name of Entity/Business	Tax ID Number (required)
N/A	UnitedHealthcare, Inc.	41-1922511

Entity/Business Street Address – Primary Location	City	State	Zip
9800 Health Care Lane	Minnetonka	MN	55343-4522

Entity/Business Mailing Address/PO Box	City	State	Zip
9800 Health Care Lane	Minnetonka	MN	55343-4522

Additional Post Office Boxes Not Identified Above	City	State	Zip
N/A			

Telephone Number	Fax Number
(952) 936-1709 -	( ) -

Email address of Entity/Business contact person	Entity/Business Website (if applicable)
N/A	N/A

B. ☐ **Yes** ☒ **No** **Are there any business locations in addition to the location listed above?**

☐ If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	**City**	**State**	**Zip**
Additional Location Street Address	**City**	**State**	**Zip**
Additional Post Office Boxes Not Identified Above	**City**	**State**	**Zip**
Additional Location Phone Number	**Additional Location Fax Number**		
( ) -	( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	**City**	**State**	**Zip**
Additional Location Street Address	**City**	**State**	**Zip**
Additional Post Office Boxes Not Identified Above	**City**	**State**	**Zip**
Additional Location Phone Number	**Additional Location Fax Number**		
( ) -	( ) -		
Additional Location Email address			

C. ☐ **Yes** ☒ **No** **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: UnitedHealthcare, Inc.

D. ☐ Yes ■ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name		Subcontractor Business Owner Name		
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address	City	State	Zip Code	
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address		City	State	Zip Code
Telephone Number - -	Email address			

E. ■ Yes ☐ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
UnitedHealthcare of Louisiana, Inc.	UnitedHealthcare Community Plan	72-1074008	LA	2376985

Provider Name: _____

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: UnitedHealthcare, Inc.

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. **F. Has this Entity/Business (since its existence) – AND –** **Any Entity/Business affiliated with the same Tax ID number – AND –** **Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:**	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: UnitedHealthcare of Louisiana, Inc.

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. Joseph A. Ochipinti	☐ Yes ☐ No	0
2. Thomas C. Choate	☐ Yes ☐ No	0
3. Nyle B. Cottington	☐ Yes ☐ No	0
4. Michael J. Balcer	☐ Yes ☐ No	0
5. Peter M. Gill	☐ Yes ☐ No	0
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1. Scott D. Waulters (Chief Executive Officer)	☐ Yes ☐ No	0
2. Karl A. Lirette (Chief Operations Officer)	☐ Yes ☐ No	0
3. Julie C. Morial (Chief Medical Officer)	☐ Yes ☐ No	0
4. Tatyana Kotlovskiy (Chief Financial Officer)	☐ Yes ☐ No	0
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Joseph	A		Ochipinti		

Title/Job Position within this Entity/Business	% ownership	S[redacted] Security N[redacted]mber ([redacted]d)	Date of Birth
President & CEO	-0-	[redacted] - [redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002
Physical Address	**City**	**State**	**Zip Code**
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002

Telephone Number	Email address
504-849-1527	joseph_ochipinti@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Joseph A. Ochipinti

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Thomas	C		Choate		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
495 N. Keller Road, Suite 200	Maitland	FL	32751
Physical Address	**City**	**State**	**Zip Code**
495 N. Keller Road, Suite 200	Maitland	FL	32751

Telephone Number	Email address
407-659-7224	thomas_choate@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Thomas C. Choate

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: UnitedHealthcare of Louisiana, Inc.

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Nyle	Brent		Cottington		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
9800 Health Care Lane	Minnetonka	MN	55343
Physical Address	**City**	**State**	**Zip Code**
9800 Health Care Lane	Minnetonka	MN	55343

Telephone Number	Email address
(952) 979-6133	brent_cottington@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Nyle B. Cottington

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: UnitedHealthcare of Louisiana, Inc.

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Michael	NMN		Balcer		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chief Financial Officer	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
10 Cadillac Drive, #200	Brentwood	TN	37027
Physical Address	**City**	**State**	**Zip Code**
10 Cadillac Drive, #200	Brentwood	TN	37027

Telephone Number	Email address
(615) 372-3471	michael_balcer@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Michael Balcer

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: UnitedHealthcare of Louisiana, Inc.

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Peter	NMN		Gill		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Treasurer	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
9900 Bren Road East	Minnetonka	MN	55343
Physical Address	**City**	**State**	**Zip Code**
9900 Bren Road East	Minnetonka	MN	55343

Telephone Number	Email address
(952) 936-3203	peter.gill@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Peter Gill

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Scott	D		Waulters		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)
Chief Executive Officer	-0-	[redacted]

Mailing Address/PO Box	City	State	Zip Code
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002
Physical Address	**City**	**State**	**Zip Code**
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002

Telephone Number	Email address
(504) 849-3521 -	swaulters@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Scott D. Waulters

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☒ No	Been denied malpractice insurance?
☐ Yes ☒ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ☐ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: UnitedHealthcare of Louisiana, Inc.

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Karl	Anthony		Lirette		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chief Operations Officer	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002
Physical Address	**City**	**State**	**Zip Code**
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002

(504) 849-3523	Email address
	Karl.lirette@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Karl A. Lirette

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: UnitedHealthcare of Louisiana, Inc.

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Julie	Claire	Morial	Morial		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)
Chief Medical Officer	-0-	[redacted]

Mailing Address/PO Box	City	State	Zip Code
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002
Physical Address	**City**	**State**	**Zip Code**
3838 N. Causeway Blvd., Suite 2600	Metairie	LA	70002

Telephone Number	Email address
(504) 849-3539	julie_morial_md@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Julie C. Morial, MD

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: UnitedHealthcare of Louisiana, Inc.

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Tatyana	NMN		Kotlovskiy		

Title/Job Position within this Entity/ Business	% ownership	S[redacted]mber (required)	Date of Birth
Chief Financial Officer	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
8550 United Plaza Blvd., Suite 703	Baton Rouge	LA	70809

Physical Address	City	State	Zip Code
8550 United Plaza Blvd., Suite 703	Baton Rouge	LA	70809

Telephone Number	Email address
(504) 849-1514	tkotlovskiy@uhc.com

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: UnitedHealthcare of Louisiana, Inc.

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Tatyana Kotlovskiy

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1. Scott D. Waulters, Interim Chief Executive Officer	☐ Owner ■ Managing employee ☐ Other _____
2.	☐ Owner ☐ Managing employee ☐ Other _____
3.	☐ Owner ☐ Managing employee ☐ Other _____
4.	☐ Owner ☐ Managing employee ☐ Other _____
5.	☐ Owner ☐ Managing employee ☐ Other _____
6.	☐ Owner ☐ Managing employee ☐ Other _____
7.	☐ Owner ☐ Managing employee ☐ Other _____
8.	☐ Owner ☐ Managing employee ☐ Other _____
9.	☐ Owner ☐ Managing employee ☐ Other _____
10.	☐ Owner ☐ Managing employee ☐ Other _____

Please sign in blue ink (not black)

Scott D. Waulters
Printed Name of Authorized Representative

Signature of Authorized Representative
(sign in blue ink)

Interim Chief Executive Officer
Title/Position

April 18, 2019
Date of Signature

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Scott D. Waulters	Scott D. Waulters
Printed Name of Authorized Representative	Signature of Authorized Representative *(sign in blue ink)*
Interim Chief Executive Officer	April 18, 2019
Title/Position of Authorized Representative	Date of Signature