# PROMISe™ Application for Clinic/Outpatient Dept. Reimbursement Rate

## Specialty 01/183- Hospital Based Medical Clinic – *Outpatient Services*

1. Type of Provider: ☐ Hospital Clinic/Outpatient Dept. ☐ Hospital Satellite Clinic
   ***Please Note:*** **A separate application is required for each clinic/outpatient dept. and /or satellite clinic.**

2. **Requested Effective Date**: yyyy/mm/dd – Example: (2004/07/03):

   ___ ___ ___ ___ / ___ ___ / ___ ___

3. Enter Name of Hospital:_____

4. National Provider Identifier Number: __ __ __ __ __ __ __ __ __ __ (10 digits)

   Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

5. Hospital Provider Number (if Enrolled): ___ ___ ___ ___ ___ ___ ___ ___ ___

6. **Clinic/Outpatient Dept. Name and Address Information**:

   **Name:**

   **Addresses:**

**Service Location Address:**

Street Address: _____

City: _____ Email: _____

State: ____ ____ Zip Code: ___ ___ ___ ___ ___-___ ___ ___ ___ Phone No.: (_____)_____

Do you bill for a mobile unit from this location? ☐ **Yes** ☐ **No**
Mobile Medical Unit? ☐ Yes ☐ No
Mobile Dental Unit? ☐ Yes ☐ No

Mail-To ☐ Pay-To ☐ Home Office ☐

Street Address: _____

City: _____ Email: _____

State: ____ ____ Zip Code: ___ ___ ___ ___ ___-___ ___ ___ ___ Phone No.: (_____)_____

Mail-To ☐ Pay-To ☐ Home Office ☐

Street Address: _____

City: _____ Email: _____

State: ____ ____ Zip Code: ___ ___ ___ ___ ___-___ ___ ___ ___ Phone No.: (_____)_____

_____

7. Do you have an outpatient clinic/dept.? ☐ Yes ☐ No

8. Do you have a current fee schedule for billing all third party and private payers? ☐ Yes ☐ No

9. What is your lowest charge per visit?

.

10. Include a statement confirming the procedure the clinic follows for a patient referral process that ensures follow-up treatment by other physicians or appropriate specialists:

_____

_____

_____

11. List the physicians who staff the clinic:

_____ _____

_____ _____

12. Does the clinic/outpatient dept. provide comprehensive medical services for a minimum of forty (40) hours per week? ☐ Yes ☐ No

13. Is a licensed physician present in the clinic/outpatient dept. at all times during scheduled hours of operation to perform medical services? ☐ Yes ☐ No

14. Do your clinic/outpatient dept. physicians have the authority to independently admit patients to the hospital?

☐ Yes **☐ No

If **NO, how is this accomplished?

_____

_____

15. Is the clinic/outpatient dept. operated by the hospital either directly or under contract with private physicians or corporations?

☐ Yes **☐ No

If **NO, how is the clinic/outpatient dept. operated?

_____

_____

16. Is there a CLIA certificate and a Dept. of Health Lab license associated with this address?

**☐ Yes CLIA Certification #_____

DOH Lab Certification#_____

☐ No

If **YES, Please provide a copy of the CLIA and Dept. of Health Lab Certification.

**17. I certify that the information on this application is true to the best of my knowledge.**

_____ _____

SIGNATURE DATE

_____

HOSPITAL ADMINISTRATOR

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database.

## Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure Forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider.

**Disclosing entity** means a Medicaid provider (other than an individual practitioner or a group of practitioners), or a fiscal agent.

**Other Disclosing entity** means any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

b. Any Medicare intermediary or carrier; and

c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

**Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not the share common facilities, common supporting staff, or common equipment).

**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity.

Note: The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example:

If you own 10 percent of the stock in Corporation A, which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

If you own 20 percent of the stock in Corporation A, which owns 50 percent of the stock in Corporation B which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

**Managing employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

**Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**Person with an ownership or control interest** means a person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a disclosing entity.

b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.

c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.

d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

Note: The percentage of ownership of a mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example:

If you own 10 percent of a note secured by 60 percent of the disclosing entity's assets, you would have a 6 percent interest in the disclosing entity's assets.

e. Is an officer or director of a disclosing entity that is organized as a corporation; or,

f. Is a partner in the disclosing entity that is organized as a partnership.

**Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

**Subcontractor** means**:**

a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Supplier** means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

**Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

# OWNERSHIP AND CONTROL INTEREST DISCLOSURE

**Note: Ownership and Control Interest information is required in accordance with the Federal Regulations at 42 CFR, Part 455.**

Name of disclosing entity: _____

13-digit PROMISe™ Provider Number: _____

Contact Name (for questions on this form): _____

Contact Phone: (_____) _____ - _____ Contact Email Address: _____

## Section I: Managing Employee or Agent Disclosure

**A.** Please enter the full name, address, social security number, and date of birth of any person who is a managing employee or agent of the disclosing entity.

The following individual is a: ☐ **Managing Employee** ☐ **Agent**

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP) or a state health care program?

   ☐ **Yes (Provide details below)** ☐ **No**

2. Description of Offense: _____

_____

_____

_____

_____

*Attach separate sheet, if necessary*

****COPY SECTION I A TO ADD ADDITIONAL MANAGING EMPLOYEES/AGENTS****

## Section II: Ownership and Control

**If the provider is organized as a corporation, partnership, estate trust or is a government entity that is organized as a corporation, complete this section.**

In completing this section, an individual with at least 5% direct or indirect ownership interest includes individuals that have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity and individuals who own an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

**INDIVIDUALS WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY**

**A.** Please enter the full name, social security number, date of birth, and address of individuals with an ownership or control interest in the disclosing entity and all officers, partners, and directors.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. If the individual listed above is an officer or director, what position does the individual hold?

☐ **President** ☐ **Chairman** ☐ **Member**
☐ **Vice President** ☐ **Vice Chairman**
☐ **Secretary** ☐ **Director**
☐ **Treasurer** ☐ **Officer**

2. a. Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____ Relationship: _____
*Attach separate sheet, if necessary*

## Section II: (cont.)

b. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____ Relationship: _____

*Attach separate sheet, if necessary*

3. Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

*Attach separate sheet, if necessary*

4. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

5. Description of Offense: _____

_____

_____

_____

_____

*Attach separate sheet, if necessary*

****COPY SECTION II A TO ADD ADDITIONAL INDIVIDUALS****

## Section II: (cont.)

**CORPORATE ENTITIES WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY**

**B.** Please enter the full name, tax identification number, and primary business address of corporate entities that have at least 5% direct or indirect ownership interest in the disclosing entity.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. Please enter the percentage and ownership type that the corporate entity listed above has in the disclosing entity.

   ☐ **Direct:**_____% ☐ **Indirect:**_____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

2. Please enter any additional business locations and PO Boxes for the corporate entity listed above.

   Address: _____ Suite/Apt: _____

   _____ _____ _____ _____
   (City) (State) (Zip Code) (+4)

   *Attach separate sheet, if necessary*

3. Does the corporate entity listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____

   Address: _____ Suite/Apt: _____

   _____ _____ _____ _____
   (City) (State) (Zip Code) (+4)

   *Attach separate sheet, if necessary*

****COPY SECTION II B TO ADD ADDITIONAL CORPORATE ENTITIES****

## Section II: (cont.)

**OWNERSHIP OR CONTROL INTEREST IN SUBCONTRACTORS**

**C.** Please enter the full name, date of birth, and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

   ☐ **Direct:**_____% ☐ **Indirect:**_____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

   c. Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

   ☐ **Direct:**_____% ☐ **Indirect:**_____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

   d. Is the individual listed above the spouse, parent, child, or sibling of any other individuals with at least 5% direct or indirect ownership or control interest in the disclosing entity?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____ Relationship: _____

   e. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____ Relationship: _____

## Section II: (cont.)

f. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

g. Description of Offense: _____

_____

_____

_____

_____

*Attach separate sheet, if necessary*

****COPY SECTION II C TO ADD ADDITIONAL INDIVIDUALS****

**D.** Please enter the full name, tax identification number, and primary business address of any corporate entity with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. Please enter the percentage and ownership type that the corporate entity listed above has in the subcontractor.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

****COPY SECTION II D TO ADD ADDITIONAL CORPORATE ENTITIES****

## Section II: (cont.)

**E.** Please enter the full name, tax identification number, and primary business address of all subcontractors in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

****COPY SECTION II E TO ADD ADDITIONAL SUBCONTRACTORS OF THE DISCLOSING ENTITY****

**OWNERSHIP OR CONTROL INTEREST IN OTHER ENTITIES**

**F.** Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

****COPY SECTION II F TO ADD ADDITIONAL ENTITIES****

**SIGNIFICANT BUSINESS TRANSACTIONS**

**G.** Has the disclosing entity had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?

☐ **Yes (Provide details below)** ☐ **No**

Name of Supplier/Subcontractor: _____

Social Security Number or Federal Tax ID: _____ Date of Birth: _____
(Individuals only)

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

****COPY SECTION II G TO ADD ADDITIONAL SIGNIFICANT BUSINESS TRANSACTIONS****

## Section III: Non-Profit Organization Disclosure (Not Organized as a Corporation)

***If the disclosing entity is a non-profit organized as a corporation, please complete Section II***

**A.** Please enter the full name, address, social security number, and date of birth of any person who is a director (board member) or officer of the disclosing entity.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. What position is held by the individual listed above?

| | | |
|---|---|---|
| ☐ **President** | ☐ **Chairman** | ☐ **Member** |
| ☐ **Vice President** | ☐ **Vice Chairman** | |
| ☐ **Secretary** | ☐ **Director** | |
| ☐ **Treasurer** | ☐ **Officer** | |

2. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XX (CHIP), or a state health care program?

3. ☐ **Yes (Provide details below)** ☐ **No**

Description of Offense: _____

_____

_____

_____

_____

*Attach separate sheet, if necessary*

****<u>COPY SECTION III TO ADD ADDITIONAL INDIVIDUALS</u>****