

**SOONERCARE  
AMBULATORY SURGICAL CENTER PROVIDER AGREEMENT**

Based upon the following recitals, the Oklahoma Health Care Authority (OHCA hereafter) and \_\_\_\_\_ (PROVIDER hereafter) enter into this Agreement:

\_\_\_\_\_  
(Facility's Name)

**ARTICLE I. PURPOSE**

The purpose of this Agreement is for OHCA and PROVIDER to contract for various health-care services to be provided to members in Oklahoma Medicaid, known as SoonerCare, programs.

**ARTICLE II. PARTIES AND DEFINITIONS**

**2.1 Oklahoma Health Care Authority**

- (a) OHCA is the single state agency that the Oklahoma Legislature has designated through 63 Okla. Stat. § 5009(B) to administer Oklahoma's Medicaid program, known as SoonerCare.
- (b) OHCA has authority to enter into this Agreement pursuant to 63 Okla. Stat. § 5006(A). OHCA's Chief Executive Officer has authority to execute this Agreement on OHCA's behalf pursuant to 63 Okla. Stat. § 5008(B).

**2.2 PROVIDER**

PROVIDER states that it is a distinct entity that operates exclusively for the purpose of providing outpatient surgical services and that it is certified by Medicare. **A copy of PROVIDER's certification must be submitted with this Agreement.**

**2.3** The parties agree that the **mailing** addresses for the parties to this Agreement are as follows:

Oklahoma Health Care Authority  
Legal Division  
Attention: Provider Contracting  
P.O. Box 54015  
Oklahoma City, Oklahoma 73154

\_\_\_\_\_  
Facility's Mailing Address

\_\_\_\_\_  
City, State, Zip Code

**2.4 DEFINITIONS**

- (a) **SoonerCare** means all OHCA medical benefit packages including Traditional, Choice, Insure Oklahoma, and Supplemental.
- (b) **Traditional** means a comprehensive SoonerCare package that pays providers for services on a fee-for-service basis.
- (c) **FFS** means fee-for-service.
- (d) **Member** means a person receiving health care benefits from a SoonerCare program.
- (e) **Supplemental** means a SoonerCare plan that provides medical benefits to supplement those services covered by Medicare (sometimes called "crossover".)
- (f) **Choice** means a medical home program where members choose a primary care provider for care coordination and primary care provider. All other services are reimbursed on an FFS basis, but services not rendered by the primary care provider may require a referral.
- (g) **Insure Oklahoma/Oklahoma Employer/Employee Partnership for Insurance Coverage Individual Plan (IO)** means a comprehensive SoonerCare package that requires members to share in the cost through premiums and co-payments. IO members choose a primary care provider who is paid a monthly rate for case management. IO reimburses all other member benefits on a FFS basis, but services not rendered by the primary care provider may require a referral.

### **ARTICLE III. TERM**

- 3.1** This Agreement shall be effective upon completion when: (1) it is executed by Provider; (2) all necessary documentation has been received and verified by OHCA; and (3) it has been accepted by OHCA. OHCA acceptance is complete only upon written notification to PROVIDER. The term of this Agreement shall expire April 30, 2012.
- 3.2** PROVIDER shall not assign or transfer any rights, duties, or obligations under this Agreement without OHCA's prior written consent except as otherwise provided in this Agreement and applicable Addenda.

### **ARTICLE IV. SCOPE OF WORK**

#### **4.1 General Provisions**

PROVIDER signing this Agreement agrees:

- (a) To provide outpatient surgical services to SoonerCare members pursuant to OAC 317:30-5-565 et seq.
- (b) To comply with all applicable statutes, regulations, policies, and properly promulgated rules of OHCA;
- (c) That the state has an obligation under 42 U.S.C. § 1396a(a)(25)(A) to ascertain the legal liability of third parties who are liable for the health care expenses of members under the care of PROVIDER. Because of this obligation, PROVIDER agrees to assist OHCA, or its authorized agents, in determining the liability of third parties;
- (d) That provision of ambulatory surgical center for purposes of this Agreement shall be limited to those services within the scope of the Oklahoma Medicaid State Plan reflected by properly promulgated rules. To the extent that services within the ambulatory surgical center are not compensable services under SoonerCare, the services may be provided but shall not be compensated by OHCA
- (e) To maintain all applicable licenses and/or certifications during the term of this contract. Should PROVIDER's licenses and/or certifications be modified, suspended, revoked, or in any other way impaired, PROVIDER shall notify OHCA within three business days of such action. In the event PROVIDER's license and/or certifications are modified, PROVIDER shall abide by the terms of the modified license and/or certifications. In the event of suspension, revocation, or other action making it unlawful for PROVIDER to provide ambulatory surgical services this Agreement shall terminate immediately. A violation of this paragraph, at the time of execution or during any part of the Agreement term, shall render the Agreement immediately void;
- (f) To maintain a clinical record system as follows:
  - (i) The system shall be maintained in accordance with written policies and procedures, which shall be produced to OHCA or its agent upon request;
  - (ii) PROVIDER shall designate a professional staff member to be responsible for maintaining the records and for ensuring they are completely and accurately documented, readily accessible, and systematically organized;
  - (iii) Each patient's record shall include, as applicable and in addition to other items set forth herein: member identification and personal, demographic and social data; evidence of consent forms; pertinent medical history; assessment of patient's health status and health-care needs; report of physical examination; brief summary of presenting episode and disposition; education and instruction to patient; all physician orders; diagnostic and laboratory test results; consultative findings; reports of treatments and medications; immunization records; preventive services; and other pertinent information necessary to monitor the patient. All entries must be legible, dated and include signatures of the physician and other health care professionals rendering the patient's care;
- (g) To render services in an appropriate physical location, which shall include barrier-free access, adequate space for provision of direct services, appropriate equipment, proper exit signs, and a safe environment for patients;
- (h) To train staff in handling medical and non-medical emergencies to ensure patient safety.

- (i) To have a preventive maintenance program to ensure essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition.
- (j) To develop and enforce policies and procedures in accordance with laws regarding communicable diseases. These policies and procedures shall include universal precautions. Including precautions related to Human Immunodeficiency Virus (HIV) serologically positive patients, which equal or exceed such standards established by the U.S. Occupational Safety and Health Administration;
- (k) To comply and certify compliance with 42 U.S.C. §§1395 cc(a)(1), 1395cc(f), and 1396a(w) which require SoonerCare providers to provide patients with information about patients' rights to accept or refuse medical treatment. PROVIDER shall educate staff and SoonerCare members concerning advance directives. PROVIDER shall include in each member's individual medical record documentation as to whether the member has executed an advance directive. PROVIDER shall not discriminate on the basis of whether an individual has executed an advance directive.

#### **4.2 Rights and Responsibilities Related to Member Co-payments and Collections**

- (a) Pursuant to 42 C.F.R. § 447.15, payments made by OHCA shall be considered payment in full for all covered services provided to a member, except for OHCA-allowed member co-payments.
- (b) PROVIDER shall not bill a member or attempt in any way to collect any payment from a member for any covered service, except for co-payments allowed by OHCA. This provision is in force even if PROVIDER elects not to bill OHCA for a covered service. Violation of this provision may result in suspension of payments, recoupement of OHCA reimbursements and/or contract action up to and including contract termination.
- (c) PROVIDER shall not require members to pay for services in advance, except for OHCA-allowed member co-payments.
- (d) PROVIDER may collect an OHCA allowed co-payment from a member for a covered service and may use any legal means to enforce the member's liability for such co-payment.
- (e) PROVIDER shall not deny covered services to eligible members because of their inability to pay a co-payment. Provision of a covered service to a member unable to pay a co-payment does not eliminate the member's liability for that co-payment.

#### **4.3 Payments from OHCA**

- a) OHCA shall pay PROVIDER for services in accordance with the appropriate part of OHCA's Provider Manual §317: 30-1-1-et seq., Coverage by category and limitations.
- b) PROVIDER agrees and understands that payment cannot be made by OHCA to vendors providing services under federally assisted programs unless services are provided without discrimination on the grounds of race, color, religion, sex, national origin or handicap.
- c) PROVIDER shall accept payment from OHCA by direct deposit to PROVIDER'S financial institution. OHCA shall make payment in accordance with the information supplied by PROVIDER on the attached electronic funds transfer (hereafter EFT) form. PROVIDER shall update direct deposit information as needed by sending a signed EFT form to OHCA.
- d) PROVIDER shall release any lien securing payment for any SoonerCare compensable service. This provision shall not affect PROVIDER's ability to file a lien for non-covered service or OHCA-permitted co-payment.
- e) Satisfaction of all claims will be from federal and state funds. Any false claims, statements, or documents, or any concealment of a material fact may be prosecuted.
- f) Payments will be made to PROVIDER within forty-five (45) days of submission of a "clean claim" as such term is defined at 42 C.F.R. § 447.45 (b). PROVIDER is entitled to interest in accordance with 62 Okla. Stat. § 41.4B (1991) for all payments not made within forty-five days after the clean claim has been submitted to OHCA or its claims payment agent.

- g) PROVIDER certifies with each claim for payment that that the services or products for which payment is billed by or on behalf of PROVIDER were medically necessary as defined by OAC 317:30-3-1(f) and were rendered by PROVIDER.

#### **4.4 Billing Procedures**

- (a) PROVIDER agrees all claims shall be submitted to OHCA in a format acceptable to OHCA and in accordance with OHCA regulations. Electronic and/or Internet submitted claims may receive priority handling.
- (b) If PROVIDER enters into a billing service agreement, PROVIDER shall be responsible for the accuracy and integrity of all claims submitted on PROVIDER's behalf by the billing service.
- (c) PROVIDER shall not use the billing service or any other entity as a factor, as defined by 42 C.F.R. § 447.10.
- (d) PROVIDER is responsible for verifying a member's appropriate eligibility by contacting OHCA's Eligibility Verification System (EVS).

### **ARTICLE V. LAWS APPLICABLE**

**5.1** The parties to this Agreement acknowledge and expect that over the term of this Agreement laws may change. Specifically, the parties acknowledge and expect (i) federal Medicaid statutes and regulations, (ii) state Medicaid statutes and rules, (iii) state statutes and rules governing practice of health care professions, and (iv) any other laws cited in this contract may change. The parties shall be mutually bound by such changes.

**5.2** As applicable, PROVIDER shall comply with and certifies compliance with:

- (a) Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq.;
- (b) Rehabilitation Act, 29 U.S.C. § 701 et seq.;
- (c) Drug-Free Workplace Act, 41 U.S.C. § 701 et seq.;
- (d) Title XIX of the Social Security Act), 42 U.S.C. § 1396 et seq.;
- (e) Civil Rights Act, 42 U.S.C. §§ 2000d et seq. and 2000e et seq.;
- (f) Age Discrimination Act, 42 U.S.C. § 6101 et seq.;
- (g) Americans with Disabilities Act, 42 U.S.C. § 12101 et seq.;
- (h) Oklahoma Worker's Compensation Act, 85 Okla. Stat. § 1 et seq.;
- (i) 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq., which (1) prohibits the use of federal funds paid under this Agreement to lobby Congress or any federal official to enhance or protect the monies paid under this Agreement and (2) requires disclosures to be made if other monies are used for such lobbying;
- (j) Presidential Executive Orders 11141, 11246 and 11375 at 5 U.S.C. § 3501 and as supplemented in Department of Labor regulations 41 C.F.R. §§ 741.1-741.84, which together require certain federal contractors and subcontractors to institute affirmative action plans to ensure absence of discrimination for employment because of race, color, religion, sex, or national origin;
- (k) The Federal Privacy Regulations and the Federal Security Regulations as contained in 45 C.F.R. Part 160 et seq. that are applicable to such party as mandated by the Health Insurance Portability and Accountability Act of (HIPAA), Public Law 104-191, 110 Stat. 1936, and HIPAA regulations at 45 C.F.R. § 160.101 et seq.;
- (l) Vietnam Era Veterans' Readjustment Assistance Act, Public Law 93-508, 88 Stat. 1578;
- (m) Protective Services for Vulnerable Adults Act, 43A Okla. Stat. § 10-101 et seq.;
- (n) Debarment, Suspension and other Responsibility Matters, 45 C.F.R. §§76.105 and 76.110;
- (o) With regard to equipment (as defined by O.M.B. Circular A-87) purchased with monies received from OHCA pursuant to this Agreement, 74 Okla. Stat. §§ 85.44(B) and (C), 45 C.F.R. §74.34, 42 C.F.R. 447.20 and 447.21.
- (p) Federal False Claims Act, 31 U.S.C. § 3729-3733; 31 U.S.C. § 3801.

**5.3** The explicit inclusion of some statutory and regulatory duties in this Agreement shall not exclude other statutory or regulatory duties.

- 5.4 All questions pertaining to validity, interpretation, and administration of this Agreement shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed or product is provided.
- 5.5 The venue for legal actions arising from this Agreement shall be in the District Court of Oklahoma County, State of Oklahoma

#### **ARTICLE VI. AUDIT AND INSPECTION**

- 6.1 As required under 42 C.F.R. 431.107, PROVIDER shall keep such records as are necessary to disclose fully the extent of services provided to members and shall furnish records and information regarding any claim for providing such service to OHCA, the Oklahoma Attorney General's Medicaid Fraud Control Unit (MFCU hereafter), and the U.S. Secretary of Health and Human Services (Secretary hereafter). PROVIDER agrees to keep records to disclose the services it provides for six years from the date of service. PROVIDER shall not destroy or dispose of records, which are under audit, review or investigation when the six-year limitation is met. PROVIDER shall maintain such records until informed in writing by the auditing, reviewing or investigating agency that the audit, review or investigation is complete.
- 6.2 Authorized representatives of OHCA, MFCU, and the Secretary shall have the right to make physical inspection of PROVIDER's place of business and to examine records relating to financial statements or claims submitted by PROVIDER under this Agreement and to audit PROVIDER's financial records as provided by 42 C.F.R. § 431.107. If PROVIDER fails to submit records to OHCA or its agent within reasonable specified timeframes, all SoonerCare payments to PROVIDER may be suspended until records are submitted.
- 6.3 Pursuant to 74 Okla. Stat. § 85.41, OHCA and the Oklahoma State Auditor and Inspector shall have the right to examine PROVIDER's books, records, documents, accounting procedures, practices, or any other items relevant to this Agreement.
- 6.4 PROVIDER shall submit, within thirty-five days of a request by OHCA, MFCU, or the Secretary, all documents, as defined by 12 Okla. Stat. § 3234, in its possession, custody, or control concerning (i) the ownership of any subcontractor with whom PROVIDER has had business transactions totaling more than twenty-five thousand dollars during the twelve months preceding the date of the request, or (ii) any significant business transactions between PROVIDER and any wholly owned supplier or between PROVIDER and any subcontractor during the five years preceding the date of the request.
- 6.5 PROVIDER shall provide OHCA with information concerning PROVIDER's ownership in accordance with 42 C.F.R. § 455.100 et. seq. This Agreement shall not be effective until OHCA receives the ownership information requested in the Disclosure of Ownership and Controlling Interest Form which is attached to and made part of this Agreement. Ownership information shall be provided to OHCA at each Agreement renewal and within twenty days of any change in ownership. Ownership information is critical for determining whether a person with an ownership interest has been convicted of a program- crime under Titles V, XVIII, XIX, XX and XXI of the federal Social Security Act, 42 U.S.C. § 301 et seq. PROVIDER shall also furnish ownership information to OHCA upon further request.

#### **ARTICLE VII. CONFIDENTIALITY**

- 7.1 PROVIDER agrees that member information is confidential pursuant to 42 U.S.C. § 1396a(7), 42 C.F.R. § 431:300-306, and 63 Okla. Stat. § 5018. PROVIDER shall not release the information governed by these requirements to any entity or person without proper authorization or OHCA's permission.
- 7.2 PROVIDER shall have written policies and procedures governing the use and removal of patient records from PROVIDER's facility. The patient's written consent shall be required for release of information not authorized by law, which consent shall not be required for state and federal personnel working with records of members.
- 7.3 PROVIDER agrees to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically 45 C.F.R. Part 164.

**ARTICLE VIII. TERMINATION**

- 8.1 This Agreement may be terminated by three methods: (i) Either party may terminate this Agreement for cause with a thirty-day written notice to the other party; (ii) either party may terminate this Agreement without cause with a sixty-day written notice to the other party; or (iii) OHCA may terminate the contract immediately (a) to protect the health and safety of members, (b) upon evidence of fraud, or (c) pursuant to Paragraph 4.1(e) above.
- 8.2 In the event funding of SoonerCare from State, Federal or other sources is withdrawn, reduced, or limited in any way after the effective date of this Contract and prior to the anticipated Agreement expiration date, this Agreement may be terminated immediately by OHCA.
- 8.3 In the event of termination, PROVIDER shall provide any records or other assistance necessary for an orderly transition of SoonerCare members' health care.

**ARTICLE IX. OTHER PROVISIONS**

- 9.1 The representations made in this memorialization of the Agreement constitute the sole basis of the parties' contractual relationship. No oral representation by either party relating to services covered by this Agreement shall be binding on either party. Any amendment to this Agreement shall be in writing and signed by both parties, except those matters addressed in Article 2.3 and Article 4.3 (C), which require PROVIDER's signature only.
- 9.2 Attachments to this Agreement which are made part of the Agreement and incorporated by reference are (i) PROVIDER's Affidavit, (ii) Disclosure of Ownership and Controlling Interest Form, (iii) Electronic Funds Transfer Authorization, and (iv) Provider Application Form.
- 9.3 If any provision of this Agreement is determined to be invalid for any reason, such invalidity shall not affect any other provision, and the invalid provision shall be wholly disregarded.
- 9.4 Titles and subheadings used in this Agreement are provided solely for the reader's convenience and shall not be used to interpret any provision of this Agreement.
- 9.5 OHCA does not create and PROVIDER does not obtain any license by virtue of this Agreement. OHCA does not guarantee PROVIDER will receive any patients, and PROVIDER does not obtain any property right or interest in any SoonerCare member business by this Agreement.

\_\_\_\_\_  
Authorized Representative's Signature                      Date

\_\_\_\_\_  
Print Authorized Representative Name

\_\_\_\_\_  
Provider's FEIN (Federal Employer Identification Number)

\_\_\_\_\_  
Date



## SOONERCARE PROVIDER APPLICATION FOR BUSINESS

- Application must be typed or printed in black ink. **All information must be completed or marked "N/A".**
- When completing this application, keep in mind the questions pertain to the organization named in the agreement.
- Provide evidence of current professional liability (malpractice) insurance policy.
- Enrollment in the VFC Program is required for those who provide primary care for members under 18 years of age.
- If you have any questions regarding this application, please contact Provider Enrollment at (800)522-0114, option 5 or locally at (405)522-6205, option 5.

OKLAHOMA MEDICAID INFORMATION	
<b>SECTION I</b>	<p>Are you currently or have you ever been enrolled in the Oklahoma Medicaid Program?  <input type="checkbox"/> Yes, I am currently enrolled.    <input type="checkbox"/> Yes, I was in the past. Go to Section II.    <input type="checkbox"/> No. Go to Section II.</p> <p>If <b>currently enrolled</b>, please check one of the following:</p> <p><input type="checkbox"/> Change of ownership.  Change Effective Date _____ Current Provider ID _____</p> <p><input type="checkbox"/> Additional service location.  Effective Date _____ Current Provider ID(s) _____  <small>(If the first 9 digits are the same, only list once.)</small></p> <p><input type="checkbox"/> Renewal    <input type="checkbox"/> Other _____  Effective Date _____ Provider ID _____</p>
PROVIDER INFORMATION	
<b>SECTION II</b>	<p><input type="checkbox"/> Corporation    <input type="checkbox"/> Estate/Trust    <input type="checkbox"/> Government Owned    <input type="checkbox"/> Limited Liability Company  <input type="checkbox"/> Not-for-Profit    <input type="checkbox"/> Partnership    <input type="checkbox"/> Public Service Corporation    <input type="checkbox"/> Sole Proprietor</p> <hr/> <p>DBA (<i>Doing Business As</i>) Name _____ NPI (<i>National Provider Identifier</i>) _____</p> <p>First DOS (<i>Date of Service</i>) _____ Medicare Number _____ Medicare Certification Date _____</p> <p>License Number (<i>Attach a copy of current license</i>) _____ Original Issue Date _____ DEA Number _____</p> <p>Are you enrolled in the Vaccine for Children (VFC) Program?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    VFC # _____</p>
ADDRESS INFORMATION	
<b>SECTION III</b>	<p>Service Location Address (<i>PO Box is not acceptable</i>) _____ Pay To (<i>If different from Mailing on Section 2.2 of the agreement</i>) _____</p> <p>City _____ State _____ Zip _____ 4 digit zip _____ City _____ State _____ Zip _____ 4 digit zip _____</p> <p>(_____) _____ (_____) _____ (_____) _____ (_____) _____</p> <p>Phone _____ Fax _____ Phone _____ Fax _____</p> <p>Contact Name _____ Contact Phone _____ Fax _____</p> <p>E-mail Address _____</p>
PAYMENT AND TAX REPORTING INFORMATION	
<b>SECTION IV</b>	<p>FEIN (<i>Federal Employer Identification Number</i>) _____</p> <p>IRS (<i>Internal Revenue Service</i>) Legal Name _____  <small>(Must match with IRS Form SS4 or IRS Letter 147C. A copy should be attached.)</small></p> <p>If you are a Sole Proprietor and do not have a FEIN, SSN (Social Security Number) can be used instead.</p> <p>SSN _____</p> <p>Name as it appears on Social Security Card _____  <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span><i>Last</i></span> <span><i>First</i></span> <span><i>Middle</i></span> </div></p>
<p>_____</p> <p>Print Authorized Representative Name      Authorized Representative Signature      Date</p>	

**\* If you are an eligible primary care provider and choose to enroll as a group Choice and/or O-EPIC Provider, please complete the applicable attachment(s).**

## **General Information Pertaining to Disclosure of Ownership and Control Interest Statement**

***PRIVACY ACT STATEMENT: THIS PROVIDES INFORMATION AS REQUIRED BY THE PRIVACY ACT OF 1974.***

The primary use of the Disclosure of Ownership and Controlling Interest Form is to facilitate tracking of providers sanctioned by the Oklahoma Health Care Authority (OHCA) and/or the Department of Health and Human Services (DHHS), Office of Inspector General. Completion and submission of this form is a condition of participation, certification or re-certification under any of the programs established by Titles V, XVIII, and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the appropriate state agency under any of the above-titled programs. A full and accurate disclosure of ownership and financial interest is required. Direct or indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity.

### **GENERAL INSTRUCTIONS**

Please answer all questions as of the current date. If additional space is needed, use an attached sheet referencing the item number to be continued.

### **OHCA's REQUEST FOR SOCIAL SECURITY NUMBERS**

OHCA understands that individuals have concerns about disclosing social security numbers (SSNs). For this reason, we are providing the following information.

### **WHY WE REQUEST SSNs**

Federal Medicaid regulations require that any entity that contracts to provide services to SoonerCare (Oklahoma Medicaid) members must supply OHCA with full and complete information related to each person with an ownership or control interest in the entity. The SSN is required by the regulation and there is no substitute allowed. You can find the regulation at 42 United States Code § 1320a-3.

### **WHO IS REQUIRED TO PROVIDE A SSN**

If the contracting entity is an individual or a sole proprietorship, the individual or sole proprietor;

If the entity is a partnership, each partner;

**If the entity is organized as a corporation, each officer and director of the corporation; this includes limited liability corporations and non-profit corporations.**

Any person that has an ownership interest of 5% of more in an entity; and

Any person that owns all or part interest in a mortgage, deed of trust, note, or other obligations secured (in whole or part) by the entity or its property or assets, if the security interest equals 5% of more of the total property and assets of the entity.

Entities operated by a unit of government, e.g. state agencies, county hospitals, public schools, etc., are generally not required to supply SSNs.

### **WHAT OHCA DOES WITH SSNs**

The federal government maintains a database of providers who have been excluded from participating in the Medicaid program. OHCA searches this database using SSNs to ensure that none of the individuals have been excluded from Medicaid. If any of those individuals are excluded, OHCA will not be able to contract with the entity.

SSNs are handled by a limited number of enrollment staff who are trained to keep the information confidential. These staff members enter the SSNs into the entity's provider record in our Medicaid Management Information System (MMIS). The federal government periodically sends OHCA a file of providers added to the exclusion list and we run this file against the SSNs stored in the system.

OHCA's treatment of SSNs is akin to its treatment of member and provider identification numbers which are not disclosed to the public. OHCA's MMIS is highly secure and meets HIPAA requirements for the handling of personal health information. OHCA conducts regular security tests and audits of the system. In addition, only a limited number of OHCA staff can view SSNs in the MMIS.

**Failure to submit requested information will result in a refusal by the State agency to enter into a contract with any such institution or in termination of existing contracts.**

## DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

**Item I. Identifying Information**

- (a) Name of Individual, Facility or Organization: \_\_\_\_\_
- (b) DBA Name: \_\_\_\_\_
- (c) Federal Tax Identification Number (TIN) OR Social Security Number: \_\_\_\_\_
- (d) Check the entity type that best describes the structure of the enrolling provider entity. Check **only one** box.
- For-Profit Corporation       Non-Profit Corporation       Partnership       Government Owned       Sole Proprietorship
- (e) Is this entity chain affiliated?       No       Yes

**Item II. Ownership and Control Information**

(a) List the name, title, address, and SSN for each office and/or individual who has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. List the name, Tax ID (TIN), and address of any organization, corporation, or entity having direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more in the provider entity. Attach additional pages as necessary to list all officers, owners, management and ownership entities.

Name	Title	Address, City, Zip	SSN/TIN	Percentage

(b) List those persons named in Item II (a) that are related to each other (spouse, parent, child, or sibling).

Name	Relationship	SSN

(c) List the name, title, address and social security number of each person with an ownership or control interest in **any subcontractor** in which the disclosing entity has direct or indirect ownership of 5% or more.

Name	Title	Address, City, Zip	SSN	Percentage

(d) List the name, address and TIN of **any other disclosing entity** in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or control interest of at least 5% or more.

Name	Title	Address, City, Zip	SSN	Percentage

## DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

**Item III. Criminal Offenses**

(a) List the name, title, SSN and address of each officer and/or individual **who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity** and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Title	Address, City, Zip	SSN (or TIN if organization)
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(b) List the name, title, social security number and address of any individual who has an ownership or controlling interest in the disclosing entity and has been suspended or debarred from participation in Medicare, Medicaid or Title XX program since the inception of those programs.

Name	Title	Address, City, Zip	SSN
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**Item IV. Status Changes**

(a) Has there been a change in ownership or control within the last year or is a change of ownership or control anticipated within the year?

No                       Yes

(b) Is this facility operated by a management company or leased in whole or party by another organization?

No                       Yes

**If "Yes", list date of change in operations:** \_\_\_\_\_

(c) Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last year?

If "Yes", when? \_\_\_\_\_

Previous No. of Beds \_\_\_\_\_ Current No. of Beds \_\_\_\_\_ Date of change \_\_\_\_\_

(d) Has there been a change in administrator, Director of Nursing or Medical Director within the last year?

**If "Yes", please check box below and list date.**

Administrator             Director of Nursing             Medical Director            Date: \_\_\_\_\_

Name of new Administrator, Director of Nursing or Medical Director: \_\_\_\_\_

(e) Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?             No             Yes

**If "Yes", when?** \_\_\_\_\_



## ELECTRONIC FUNDS TRANSFER (EFT) INSTRUCTION

Electronic Funds Transfer (EFT) is the required payment method to deposit funds for claims approved for payment directly into a provider's bank account. These funds can be credited to either checking or savings accounts. EFT avoids the risks associated with mailing and handling paper checks; ensuring funds are directly deposited into a specified account.

The following notification is provided in compliance with Automated Clearing House (ACH) guidelines:

"Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. The effective date for EFT under the Oklahoma Medicaid Program is Wednesday (or Thursday) of each week.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request maybe refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer's needs.

In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date."

Complete the Electronic Funds Transfer Authorization Agreement and attach a voided check. If a check is not available, attach a letter from your financial institution indicating the bank transit routing and account number. The document must be on bank letter head and signed by a bank official.

**Deposit slips are not acceptable.**

Contact Information:

- **Provider Enrollment, Fee for Service** (800)522-0114, option 5 or local (405)522-6205, option 5.
- **SoonerCare**, please contact your provider representative directly.
- **Website address**, [www.okhca.org](http://www.okhca.org).

<u>For OHCA use only</u>	
DE: _____	V: _____
Date: _____	Date: _____

**STATE OF OKLAHOMA  
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT**

Complete all sections below. A voided check must be attached to the completed EFT Authorization Agreement. If a check is not available attach a letter from your financial institution indicating the bank transit routing and account number. The document must be on bank letter head and signed by a bank official. **Deposit slips are not acceptable.**

- NOTICE**
- EFT and Tax ID payments must be reported to the same individual or business.
  - If you are an individual provider and your payments report to a Group FEIN and EFT, please complete Group Appendix A instead of EFT.

**Type of Authorization:** (Check one)

- New Enrollment or Additional Location
- Change Account Number for Financial Institution
- Correct Account or Bank Transit Number
- Change of ownership *(must also complete a new enrollment packet)*
- Change in employment, group association, practice, business structure, billing agent, tax ID, etc..., please consult Provider Enrollment for Fee for Service contract or provider representative for SoonerCare contract. *(See contact information on EFT Instruction, page 1.)*

**Provider Information**

Provider ID <i>(One number per form. If new leave blank)</i>	Provider Name		
Service Location Address	City	State	Zip
Contact Name	Contact Phone Number		

**Financial Institution Information**

Financial Institution:	Phone Number: ( )
Transit Routing number:	Account Number:
Type of Account: <i>(Check one)</i>	<input type="checkbox"/> Checking <input type="checkbox"/> Savings

**OHCA Information**

Agency Name: Oklahoma Health Care Authority	Agency Number: 807
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I hereby authorize the State of Oklahoma Treasury, hereinafter called Treasury, to initiate credit entries for the checking or savings account indicated on the voided check and the financial institution named above, hereinafter called depository, to credit any amount(s) due to this medical provider by the State of Oklahoma. This authority is to remain in full force and effect until Treasury has received written notification from this provider of its termination in such time and manner as to afford Treasury and depository a reasonable opportunity to act on it.

**Signature *(Individual provider must sign personally.)***

Individual	<p>Provider Signature _____ Date _____</p>
Entity/Business	<p style="text-align: center;"><b>CERTIFICATION</b></p> <p>I hereby certify that I have the authority to enter into this agreement or initiate this action on behalf of the above-named entity. I further understand and acknowledge that it is unlawful to make a claim knowing the claim to be false and that such false claims is deemed Medicaid fraud under Title 56 § 1005;1006.</p> <p>Print Authorized Representative Name _____ Signature _____ Date _____</p>