

PROVIDER ENROLLMENT DISCLOSURE FORM

Provider Name: _____

Provider NPI (only 1 per form): _____

Instructions: Circle “Y” for each “yes” response and “N” for each “no” response. Any “Yes” response requires additional documentation explaining the situation by item number, the name(s) of involved individual(s), the resolution if any, and any related timeframes.

A. Has the provider or any person with an ownership or controlling interest in the provider ever been convicted of crimes, including any form of suspended sentence, record expungement or pending appeals, in one or more of the following related areas:

- | | |
|---|-----|
| 1. Fraud, theft, embezzlement, extortion, income tax evasion, or insurance fraud | Y N |
| 2. Financial misconduct tied to delivery of health care not otherwise noted or breach of fiduciary responsibility | Y N |
| 3. Perjury | Y N |
| 4. Abuse or neglect of a patient, child, or elderly adult | Y N |
| 5. Obstruction of a criminal investigation | Y N |
| 6. Unlawful manufacture, distribution, prescription, or dispensing of any controlled substances | Y N |
| 7. Health care related crime, not otherwise listed | Y N |

B. Has the provider or any person with an ownership or controlling interest in the provider ever had the following situations apply:

- | | |
|--|-----|
| 8. Failed to grant immediate access and/or provide payment information | Y N |
| 9. Failed to provide disclosure information | Y N |
| 10. Revocation or suspension of a license to provide health care, including any license surrender while formal disciplinary actions were pending | Y N |
| 11. Revocation or suspension of accreditation | Y N |
| 12. Suspension, exclusion, debarment, or sanction from participation by a Federal or State health care program or procurement program | Y N |
| 13. Current payment suspension with Medicare or another State Medicaid agency | Y N |
| 14. Judgement under the False Claims Act | Y N |
| 15. Current overpayment with Medicare or another State Medicaid agency exceeding \$1,500 | Y N |

I declare and affirm under the penalties of perjury that this document has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further declare and affirm under the penalties of perjury that any claim to be submitted pursuant to this document will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct. Failure to appropriately disclose information is

reason to deny an application to be a provider with South Dakota Medicaid or terminate an existing provider agreement with South Dakota Medicaid.

Completed by: _____ Date: _____
(Signature of Individual Provider for Individual's Enrollment)

Printed Name: _____
