United Healthcare Community Plan

Provider Entity Disclosure of Ownership, Controlling Interest and Management Statement

UnitedHealthcare Community Plan ("UnitedHealthcare") is required to collect disclosure of ownership, controlling interest and management information from providers that participate in the Medicaid and/or the Children's Health Insurance Program (CHIP) managed care network pursuant to a Medicaid and/or CHIP contracts with the State Agency and the federal regulations set forth in 42 CFR Part §455.

Required information includes:
1) The identity of all owners and others with a controlling interest;
2) Certain business transactions as described in 42 CFR §455.105;
3) The identity of managing employees, agents and others in a position of influence or authority; and
4) Criminal conviction information for the provider, owners, officers, directors, agents and managing employees.
The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Providers participating in UnitedHealthcare's Medicaid and/or CHIP managed care networks must complete and submit the disclosure statement below in accordance with the terms of their participation agreement and as a condition of participation in Medicaid and/or CHIP. Failure to submit the requested information may result in claims denials, exclusion from UnitedHealthcare's network, or termination of an existing provider agreement.

This statement should be submitted with the initial contract and updated:
- Every three (3) years [annually in Louisiana]
- Upon renewal of the participation agreement
- At any time there is a revision to the information
- Within 35 days of a request for updated information.

Individual physician and health care professional members of a group practice that are credentialed (by UnitedHealthcare or a delegate) and contracted as a participating provider in UnitedHealthcare's Medicaid or CHIP managed care network must submit a signed Individual Provider Statement attesting to the requirements under these regulations at the time of credentialing, enrollment, or contracting as requested by UnitedHealthcare or by a delegate of UnitedHealthcare.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form.

Tips to Avoid Delays in Processing Your Disclosure Form

- ✓ **For any question answered with a "Yes" response, please fill out all subsequent fields.**
- ✓ **Every field must have a response. "N/A", "non-applicable" and "applied for" are acceptable.**
- ✓ **If fields are left blank, the form will be returned for corrections/completeness.**
- ✓ **If the form is unreadable due to illegible handwriting, the form will not be processed.**
- ✓ **All attachments must indicate which section they apply to.**

Contracted Provider Entity Information

Type of disclosing entity *Please choose one (1) category that indicates how the disclosing entity is structured per the IRS: ___ Partnership ___ Non-Profit ___ Corporation ___ Limited Liability Corporation (LLC) ___ Government/Public Entity ___ HCBS Provider ___Other: _____ **In which state(s) do you participate in Medicaid and/or CHIP?** _____	**Name of Person Completing the Form** **Title** **Phone Number** **Fax** **Email**
Legal Name ("**Provider Entity**"):	**DBA Name** (if different from Provider Entity Legal Name):

Complete Address

- Must include at least one street address
- Corporations must include the primary business ***and*** every business address (including P.O. Box addresses)
- Hospital systems must include address of the corporate headquarters

Street	**City**	**State**	**Zip**

Additional Addresses

Do you have additional addresses? ____**Yes** ____**No**

If **Yes**, please label the attachment "Additional Addresses". List **all** Practice/Business locations on the attachment.

Federal Tax ID#:	**Medicaid ID #**:	**National Provider ID (NPI) #**:
	____Applied for Medicaid ID ____Not Applicable	____Applied for NPI

As applicable, if Provider Entity is a provider group or facility, attach a roster of all individual providers/practitioners that bill under the provider group/facility TIN for Medicaid.
include: Provider name, address, NPI, date of birth, and social security number.

Do you have a roster to attach? ____**Yes** ____**No**

If **Yes**, please label the attachment with "Roster"

Section I: Identification of All Owners

Section I, Question 1: List all individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of 5% or more.

Refer to the Glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest

____**Yes** There are individual(s) and/or entity(ies) that have a 5% or greater ownership interest.

Individuals: List the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having a 5% or greater Ownership Interest in the Entity.

Entities: List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having 5% or greater Ownership Interest. (42 CFR§455.104(b)(1))

Note: If there are 1-3 owners, fill out the chart below. If there are 4 or more owners, you **must** attach a list with the required fields labeled "Section I, Question 1". Do you have a list to attach? ____**Yes** ____**No**

____**No** There is no individual or entity that has a 5% or greater ownership interest.

Note: If there are owners, but all have less than 5% ownership, select "No" above and include a comment in the chart below.

Name of Owner	**DOB** (mm/dd/yyyy)	**Complete Address (Street/City/State/Zip)**	** **SSN (individual) TIN (entity)** *List both as applicable*	**% Interest**
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		

Section II: Identification of All Individuals & Entities with a Controlling Interest

Section II, Question 1:

Does the Provider Entity have a **Board of Directors** or other governing body? ____**Yes** ____**No**

If Yes, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104(b)(1))

Note: If there are 1-2 directors, fill out the chart below. If there are 3 or more directors, you **must** attach a list with the required fields labeled "Section II, Question 1". Do you have a list to attach? ____**Yes** ____**No**

Name	**DOB** (mm/dd/yyyy)	**Complete Address (Street/City/State/Zip)**	** **SSN**
		Street **City** **State** **Zip**	
		Street **City** **State** **Zip**	

***SSN is required per 42 CFR § 455.104.**

Section II, Question 2:

Does the Provider Entity have any **Officers or Directors** (e.g., CEO, VP of Finance, etc.)? ____**Yes** ____**No**

If Yes, list all corporate officers and directors, including the name, date of birth (DOB), address, and Social Security Number (SSN) and applicable title or position (42 CFR §455.104(b)(1))

Note: If there are 1-2 officers/directors, fill out the chart below. If there are 3 or more officers/directors, you **must** attach a list with the required fields labeled "Section II, Question 2". Do you have a list to attach? ____**Yes** ____**No**

Name	**DOB** (mm/dd/yyyy)	**Complete Address (Street/City/State/Zip)**	**** SSN**	**Title**
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		

Section II, Question 3: Are there any other individuals or entities with a **Controlling Interest** in the Provider Entity (e.g., business partners, etc.)? ____**Yes** ____**No**

If Yes, list the name, address, date of birth (DOB) and Social Security Number (SSN) for each person having a Controlling Interest in the Provider Entity. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having a Controlling Interest. (42 CFR §455.104(b)(1))

Note: If there is 1 individual/entity, fill out the chart below. If there are 2 or more individuals/entities, you **must** attach a list with the required fields labeled "Section II, Question 3". Do you have a list to attach? ____**Yes** ____**No**

Name of Individual or Entity	**DOB** (mm/dd/yyyy)	**Complete Address (Street/City/State/Zip)**	**** SSN (individual) TIN (entity)**	**Title** *(as applicable)*
		Street **City** **State** **Zip**		

****SSN is required per 42 CFR § 455.104.***

Section III: Ownership & Controlling Interest in Other Disclosing Entities

Section III, Question 1: Do any of the individuals or entities *identified in **Section I*** as an owner have an Ownership or Controlling Interest in any **Other Disclosing Entity**? ____**Yes** ____**No**

Refer to the Glossary and Instructions to determine who should be listed as an Owner in Other Disclosing Entities

If Yes, list the name and the SSN or TIN of the Other Disclosing Entity in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3))

Note: If there are 1-2 owners, fill out the chart below. If there are 3 or more owners, you **must** attach a list with the required fields labeled "Section III, Question 1". Do you have a list to attach? ____**Yes** ____**No**

Name of Owner Listed in Section I	Name of Other Disclosing Entity	Other Disclosing Entity's SSN (individual) or TIN (entity)

Section IV: Ownership & Controlling Interest in Subcontractors

Section IV, Question 1:

Does the Provider Entity have a Direct or Indirect Ownership Interest of 5% or more in any **Subcontractor**? ____**Yes** ____**No**

Refer to the Glossary and Instructions to determine who should be listed as a Subcontractor

If Yes, does another individual or organization also have an **Ownership or Controlling Interest** in the same Subcontractor?

____**Yes** ____**No**

If Yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which the Provider Entity *also has* Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104(b)(1)&(2))

Note: If there are 1-2 subcontractors, fill out the chart below. If there are 3 or more subcontractors, attach a list with the required fields labeled "Section IV, Question 1". Do you have a list to attach? ____**Yes** ____**No**

Legal Name of Subcontractor			**Subcontractor TIN/SSN**
Name of *Other Individual/Entity with Ownership or Controlling Interest*			
***Other Individual/Entity's* Complete Address (Street/City/State/Zip)**	**Street** **City**	**State**	**Zip**
***Other Entity's* TIN**	***Other Individual's* SSN**	***Other Individual's* DOB** (mm/dd/yyyy)	**% Interest in Subcontractor**
Legal Name of Subcontractor			**Subcontractor TIN/SSN**
Name of *Other Individual/Entity with Ownership or Controlling Interest*			
***Other Individual/Entity's* Complete Address Street/City/State/Zip)**	**Street** **City**	**State**	**Zip**
***Other Entity's* TIN**	***Other Individual's* SSN**	***Other Individual's* DOB** (mm/dd/yyyy)	**% Interest in Subcontractor**

Section V: Familial Relationships

Section V, Question 1: Are any of the individuals identified in Sections I, II, III or IV related to each other? ____**Yes** ____**No**

If Yes, list the individuals identified and the relationship to each other (e.g., spouse, sibling, parent, child) (42 CFR §455.104(b)(2))

Note: If there are 1-2 relationships, fill out the chart below. If there are 3 or more relationships, you **must** attach a list with the required fields labeled "Section V, Question 1". Do you have a list to attach? ____**Yes** ____**No**

Name of Individual #1:	Name of Individual #2:	Relationship

Section V, Question 2: **Provider Groups Only**: Are any provider members of the group related to the listed owners or those with a controlling interest? ____**Yes** ____**No**

If Yes, list the following information for each group provider member related to the listed owners and those with a controlling interest.

Note: If there are 1-2 relationships, fill out the chart below. If there are 3 or more relationships, you **must** attach a list with the required fields labeled "Section V, Question 2". Do you have a list to attach? ____**Yes** ____**No**

Name of group provider	Relationship	DOB (mm/dd/yyyy)	SSN**

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations*

Section VI, Question 1:

Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity **ever been convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program since the inception of those programs? ____**Yes** ____**No**

If Yes, list those persons and the required information below. (42 CFR §455.106)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VI, Question 1". Do you have additional documentation to attach? ____**Yes** ____**No**

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	**State of Conviction**
Complete Address (Street/City/State/Zip) **Street** **City** **State** **Zip**		
Matter of the Offense		
Date of Conviction (mm/dd/yyyy)	**Date of Reinstatement (mm/dd/yyyy)** *Enter N/A if not reinstated	

At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)

SSN is required per 42 CFR § 455.104.

Section VI, Question 2:
Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program? ____**Yes** ____**No**

If Yes, list those persons and the required information below. (42 CFR §455.436)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VI, Question 2". Do you have additional documentation to attach? ____**Yes** ____**No**

Name	
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**

Complete Address (Street/City/State/Zip)

Street

City **State** **Zip**

Reason for Sanction, Exclusion or Debarment

Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	**Date of Reinstatement (mm/dd/yyyy)** *Enter N/A if not reinstated	**List all States where currently excluded:**

Section VI, Question 3:
Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ____**Yes** ____**No**

If Yes, list those persons and the required information below.

Note: If providing additional documentation, attach a list with the required fields labeled "Section VI, Question 3". Do you have additional documentation to attach? ____**Yes** ____**No**

Name	
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**

Complete Address (Street/City/State/Zip)

Street

City **State** **Zip**

Reason for Termination

Date of Termination (mm/dd/yyyy)	**State that originated Termination**	**Date of Reinstatement (mm/dd/yyyy)** *Enter N/A if not reinstated	**Medicare billing privileges revoked?** ____**Yes** ____**No**

Section VII: Business Transaction Information

Section VII is not required at the time of supplying this form but may be required upon request of CMS. By signing this form, you are acknowledging that you will supply the following information within 35 days if requested by the Secretary of Health and Human Services or the Medicaid agency.

Section VII, Question 1: Business Transactions - Subcontractors

List the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) *See Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

Section VII, Question 2: Significant Business Transactions – Wholly Owned Suppliers

List the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2)) *See Glossary for definition*.

- Name of Supplier, Supplier's SSN (individual) or TIN (entity), and Supplier's Address

Section VII, Question 3: Significant Business Transactions – Subcontractors

List the information for Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2)) *See Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

Section VIII: Management & Control

Section VIII, Question 1: List all **Managing Employees** or anyone that exercises operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of the Provider Entity (e.g., general manager, business manager, administrator or dept. manager, etc.). *See Glossary for definition*

All Managing Employees must be listed. Include all Managing Employees' information including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104(b)(4))

Note: If there are 1-4 managing employees, fill out the chart below. If there are 5 or more managing employees, attach a list with the required fields labeled "Section VIII, Question 1". Do you have a list to attach? ____**Yes** ____**No**

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN**	Title
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		

****SSN is required per 42 CFR § 455.104.***

Section VIII, Question 2: Does the Provider Entity have any **Agents**? ____**Yes** ____**No**

If Yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity (e.g., purchasing agent, broker, etc.), including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104)

See Glossary for definition.

Note: If there are 1-2 agents, fill out the chart below. If there are 3 or more agents, attach a list with the required fields labeled "Section VIII, Question 2". Do you have a list to attach? ____**Yes** ____**No**

Name	**DOB (mm/dd/yyyy)**	**Complete Address (Street/City/State/Zip)**	**SSN****
		Street **City** **State** **Zip**	
		Street **City** **State** **Zip**	

****SSN is required per 42 CFR § 455.104.***

Through signature below, **I hereby certify that I have the authority to legally bind the entity** and that any employees or contractors providing services pursuant to a contract with UnitedHealthcare Community Plan are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities and any applicable state, federal or other governmental exclusion or sanction databases and that the information provided herein is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

**Signature must be a wet signature or an e-signature from a state-approved source (ex. Adobe Sign)*
**If fields are left blank, the form will be returned for corrections/completeness.*

Signature _____ Title (indicate if authorized Agent) _____

Full Name (please print) _____ Date _____

Phone Number _____ Fax Number _____ Email Address _____

Instructions for Disclosure of Ownership/Controlling Interest and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Identification of All Owners:
Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more in your entity. If the Owner is a corporation, please list the primary business address as well as every business location and P.O. Box address. Date of Birth and SSN* must be included for each individual owner.

Section II: Identification of All Individuals & Entities with a Controlling Interest:
Please list the required information for each individual or organization that has a Controlling Interest in your entity. Individuals with a Controlling Interest include officers and directors of a corporation, as well as the governing board (*see Glossary for definition*). Date of Birth and SSN* must be included for each individual with controlling interest.

Section III: Ownership & Controlling Interest in Other Disclosing Entities:
If any of the individuals or entities listed in Section I and/or Section II as having ownership or controlling interest in this entity also have ownership or controlling interest of 5% or more in any other entities, identify those entities in Section III. This information is to identify shared and interconnected ownership and controlling interests.

Section IV: Ownership & Controlling Interest in Subcontractors:
If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership or a Controlling Interest of 5% or more in that same Subcontractor, please identify the Subcontractor and provide the required information for the additional individuals and entities.

Section V: Familial Relationships:
Report whether any of the persons listed in Sections I, II, III and/or IV are related to each other and identify the parties and their relationship. Relationships must be disclosed if the parties are spouses, parent/child, or siblings.

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:
List your own criminal convictions, exclusions, sanctions, debarments and terminations, ***and*** for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all necessary databases to verify this information.

Section VII: Business Transaction Information:
The following is not required at this time, but will need to be provided within 35 days of request from the Secretary of Health and Human Services or the Medicaid agency:
1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transaction*** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any ***Significant Business Transaction*** between your entity and any Subcontractor during the past 5 years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

Section VIII: Management & Control:
1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
Date of Birth and SSN* must be included for each Managing Employee and Agent.

CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

**Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.*

GLOSSARY

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

***Direct Ownership Interest*:** An individual or entity that possesses equity in the capital, the stock, or the profits of the disclosing entity. Ownership Interest also includes an interest in any mortgage, deed of trust, note, or other obligations (42 CFR §455.101).
In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported (42 CFR §455.102).

***Indirect Ownership Interest*:** An individual or entity that has an ownership interest in an entity that has a direct or indirect ownership interest in the disclosing entity (42 CFR §455.101).
The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported (42 CFR §455.102).

***Controlling Interest*:** An individual or entity that has: (1) An officer or director of a disclosing entity that is organized as a corporation; or (2) A partner in a disclosing entity that is organized as a partnership (42 CFR §455.101)

***Other Disclosing Entity*:** any other Medicaid disclosing entity and 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, XV III, 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 XV III); (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 (42 CFR §455.101).

***Significant Business Transaction*:** any business transaction or series of related that, during any one fiscal year, exceeds the lesser of $25,000 or five percent (5 %) of a Provider Entity's total operating expenses (42 CFR §455.101).

***Subcontractor*:** (a) an individual, agency, or organization to which a Provider 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 to obtain space, supplies, equipment, or services provided under the Medicaid agreement (42 CFR §455.101) (42 CFR §455.101).

***Supplier*:** 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, manufacturer of hospital beds, or pharmaceutical firm) (42 CFR §455.101).

***Wholly Owned Supplier*:** a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity (42 CFR §455.101).

***Agent*:** any person who has been delegated the authority to obligate or act on behalf of a Provider Entity (42 CFR §455.101).

***Managing Employee*:** 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 (42 CFR §455.101).