MagellanRx Disclosure Form

The federal regulations set forth in 42 CFR 455.104, 455.105, 455.106 require you to fill out this form if you are enrolling, recredentialing, re-contracting your Pharmacy or Pharmacy Chain, or if there have been significant changes to the information required on this form (e.g., a change in ownership).

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Please retain a copy for your files and return the original with the application.

Note: Each pharmacy participating in a Pharmacy Services Administration Organization (PSAO) MUST fill out its own form.

Please answer all questions as of the current date. If a question is not applicable, please respond N/A for that question.

NO QUESTIONS SHOULD BE LEFT BLANK

I. Identifying Information

Name of person completing form:	Phone of person completing form:
Legal Name of Pharmacy or Pharmacy Chain:	
DBA Name of Pharmacy:	

Address(es): If you are a small chain (10 or fewer stores) list each location. If you are a large chain, provide your corporate address. If more space is needed, please attach additional sheets.

Street Address	City	State	Zip

Federal Tax Identification Number	Pharmacy NCPDP# (If you are a small chain (10 or fewer stores) list each NCPDP. If a large chain, provide your chain code.	Pharmacy NPI# (If you are a small chain (10 or fewer stores) list each NPI. If a large chain, provide your chain code.

MagellanRx Disclosure Form

II. Information Regarding Ownership, Control And Management

(a) Ownership/Control: Provide the information requested below on any individual(s) or entity having an ownership interest of 5% or greater or control interest in this Pharmacy or Pharmacy Chain. Ownership and control may be "direct" (an individual who owns 5% of the pharmacy) or "indirect" (an individual who owns 5% of the company that owns the actual Pharmacy or Pharmacy Chain.) For corporate entities, please include, as applicable, any primary business address, every business location, and any P.O. Box on a separate page.

Individual: List name, title, home address, date of birth (DOB), Social Security Number (SSN), and percentage of ownership.

Entity: Corporation name, business address, and Tax Identification Number (TIN).

Name of individual/entity	DOB	Address	SSN/TIN	% Ownership	Title

(b) Management/Agent Relationship: List the name, title, home address, date of birth (DOB), and Social Security Number (SSN) for Pharmacy's or Pharmacy Chain's Managing Employees, Pharmacist In Charge, and Agents.

Name	DOB	Address	SSN	Title

(c) Ownership of Subcontractors: Provide the name, address, and TIN for any subcontractor that the Pharmacy or Pharmacy Chain has ownership interest of 5% or greater.

Name of Subcontractor	Address	TIN

III. Relationship of the Parties

Are any of the individuals listed in **Section II (a)** and/or **(b)** related to each other?

☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of Relation

MagellanRx Disclosure Form

Are any of the individuals listed in Section II (a) related to someone with a controlling or ownership interest of 5% or more in any subcontractor(s) providing services to the Pharmacy or Pharmacy Chain? A subcontractor is a company that performs business functions related to the provision of pharmacy services, i.e., billing agent.

☐ Yes ☐ No

If yes, provide detail below.

Name	Name of Subcontractor	TIN	Name of Related Individual	Relationship

IV. Related Healthcare Entities and Subcontractors

Does the Pharmacy, Pharmacy Chain, or any of the individuals or entities listed in **Section II (a)** have a controlling or ownership of 5% or more in any health care providers or contractors?

☐ Yes ☐ No

If yes, provide the following information about the subcontractor.

Name	TIN	Address	% Ownership	Name of person/entity with control/ownership

V. Convictions, Debarment, Exclusions, and Terminations[1]

Have any of the individuals or entities on the Section II (a) or (b) been "convicted"[2] of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, TRICARE, or the Title XX services program since the inception of those programs?

☐ Yes ☐ No

If yes, provide detail below.

Name	Date	Type of Conviction

Have any of the individuals or entities on the **Section II (a) or (b)** ever been **"debarred"[3]** or otherwise excluded from participation in Federal Government Contracts including under provisions of Executive Order 12549?

☐ Yes ☐ No

If yes, provide detail on next page.

MagellanRx Disclosure Form

Name	Length of Debarment	Reason for Debarment

Have any of the individuals or entities on the **Section II (a) or (b) ever been "Suspended,"[4] "Excluded,"[5]** or **"Terminated"[6]** from participation in Federal programs, including Medicare, Medicaid, CHIP, or TRICARE or under Executive Order 12549?

☐ Yes ☐ No

If yes, provide detail below.

Name	Date	Reason for Exclusion or Termination

Has any person or entity in **Section II (a) or (b)** ever had Civil Monetary Penalties (CMPs) assessed against them? A CMP is a fine assessed by a governmental agency that manages a federal pharmacy program.

☐ Yes ☐ No

If yes, provide detail below.

Name	Reason for CMP	Date	Amount

Has any person or entity in **Section II (a) or (b)** ever been subject to any other disciplinary or legal action relating to his/her participation in a state or federal health care program?

☐ Yes ☐ No

If yes, provide detail below.

Name	Type of Action	Date

[1] In answering these questions, please refer to state licensing board information as well as the Federal Debarment List located at www.sam.gov or for a listing of federally debarred and suspended individuals/entities and the Federal List of Excluded Individuals/Entities (LEIE) database at https://oig.hhs.gov/exclusions/exclusions_list.asp.

[2] "Convicted" means a judgement, conviction, finding of guilt, or entry of nolo contendere plea in any Federal, State, or local court regardless of pending post-trial motions, pending appeals, or whether the conviction has been expunged. "Convicted" also includes individuals or entities participating in a first offender or deferred adjudication program where conviction has been withheld. 42 CFR 1001.2

[3] "Debarred" means an individual is not allowed to participate in contracts paid for by the Federal Government, whether or not those contracts are in the pharmacy healthcare area.

[4] "Suspended" means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court were not reimbursed.

[5] "Excluded" means that a person or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS, OIG) that they may no longer work with any federally-funded healthcare program.

[6] "Terminated" means a person or entity lost the right to bill a State's Medicaid or CHIP program for a cause related to fraud or abuse.

VI. Significant Business Transactions

In the past 12 months, has the Pharmacy or Pharmacy Chain had any financial transaction with any subcontractors totaling more than $25,000? (42 CFR 455.105)

☐ Yes ☐ No

If yes, list the ownership of the subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve-month period.

Name of Subcontractor	Address	Owner

Has the Pharmacy or Pharmacy Chain had any significant business transactions with any subcontractor or wholly owned suppliers over the previous five years?

☐ Yes ☐ No

If yes, please provide details below.

Name Supplier/Subcontractor	Address	Transaction Amount

I certify that information provided herein is true and accurate. Additions or other changes to the information must be submitted immediately upon revision. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation. I further understand that this Disclosure Form constitutes part of the Provider Agreement with Magellan Rx and that failing to provide full and accurate information, including providing immediate notice of any change relating to this information, will constitute a breach of the Provider Agreement. I certify that the Pharmacy or Pharmacy Chain will comply with legal requirements, including but not limited to, the requirements of 45 CFR Part 76.

Signature of Authorized Pharmacy Representative (Required) _____ Date _____

Printed Name _____ Title _____