MC-Rx
Powered by ProCare Rx

DISCLOSURE STATEMENT

If this form is being completed by an Individual Provider the signature at the end of the form must be the written signature of the Provider. Otherwise, the signature at the end of the form must be the written signature of an Authorized Representative of the Participating Pharmacy who must be a partner, president or secretary of the Disclosing Entity.

Item I. Identifying Information

(a)	Do you practice as ☐ an individual pharmacy provider ☐ a disclosing entity
(b)	Name of Individual, facility or Organization:
(c)	DBA Name:
(d)	Address:
(e)	Federal Income Tax Identification Number (TIN) OR Social Security Number:
(f)	Is this entity chain affiliated? ☐ Yes ☐ No

Item II. Ownership and Control Interest Information for Disclosing Entity 42 C.F.R. §§ 455.100-104

(a) List the name, title, address, and SSN for each **office and/or individual** who has any ownership or controlling interest in this Disclosing Entity. The office/individual's ownership or controlling interest is an ownership interest of 5% or more of this Disclosing Entity. List the name, Tax ID (TIN), and address of any **organization, corporation, or entity** having any ownership or controlling interest in this Disclosing Entity. The ownership or controlling interest is an ownership interest of 5% or more in this Disclosing Entity. Attach additional pages as necessary to list all officers, owners, management, and ownership entities. Use an additional sheet if necessary.

Name	Title	Personal Address	SSN/TIN	% owned

(b) List those persons named in Item II (a) that are related to each other (spouse, parent, child or sibling). 42 C.F.R. § 455.104. Use an additional sheet if necessary.

Name	Relationship	SSSN

(c) List the following information for each person with an Ownership or Control Interest in any Subcontractor that this disclosing entity has a direct or indirect ownership of 5% or more of 42 C.F.R. § 455.104. Use an additional sheet if necessary.

Name	Title	Personal Address	SSN/TIN	% owned

(d) List the following information for any other disclosing entity in which a person with an Ownership or Controlling Interest in this disclosing entity, has an Ownership or Control Interest of at least 5% or more. 42 C.F.R. § 455.104. Use an additional sheet if necessary.

Name	Title	Personal Address	SSN/TIN	% owned

Item III. Business Transaction Information. 42 C.F.R. §455.105.

(a) List the ownership of any subcontractor with whom this Provider has had business transactions totaling more than $25,000 during the previous 12-month period. 42 C.F.R. §455.105. Use an additional sheet if necessary.

Name	Title	Personal and/or Business Address	Contracted Date

(b) List any significant business transactions between this Provider and any wholly owned supplier, or between this Provider and any Subcontractor, during the previous 5-year period. 42 C.F.R. §455.105.

Item IV. Managing Employee

Provide detailed information regarding the identity of any person who is an agent or managing employee of the Provider. Use an additional sheet if necessary.

Name	Title	Personal Address	SSN

Item V. Criminal Offenses and Exclusions 42 C.F.R. §§ 455.100, 106

A. If you are filling out this form as an individual provider, giving information about yourself, please answer the following questions:

(1) (a) Have you personally have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services programs since the inception of those programs?

☐ No ☐ Yes

(b) Has some connected to your practice (i.e. and office manager or director) 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?

☐ No ☐ Yes

If you answered yes above, please provide the following information for each person convicted of a criminal offense. Use an additional sheet if necessary.

Name	Title	Personal Address	SSN/TIN

(2) If you answered Item I (a) at the beginning of this form as an individual AND your practice is incorporated, please list the name and addresses of the corporations Officers and Board of Directors in the spaces below. Use an additional sheet if necessary.

Name	Title	Personal Address	SSN/TIN

B. If you are filling this form out as an Authorized Representative of a Disclosing Entity, providing information about the business entity, please answer the following question:

Have you or any Director, Officer, Agent, managing employee, or other individual or organization having ownership or control interest in this provider been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid or Title XX services program since the inception of those programs?

☐ No ☐ Yes

If you answered yes above, please provide the following information for each individual or entity.

Name	Title	Personal Address	SSN/TIN

Item VI. Status Changes – For Disclosing Entities Only

(a) Has there been a change in ownership or control interest 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 partly by another organization?

☐ No ☐ Yes

If Yes, list date of change in operations:

(c) 1. Is this facility chain affiliated? If yes list the name, address of parent corporation and EIN#

☐ No ☐ Yes

Name	Business Address	EIN #

2. If your answer to 1. above is "No", was this facility ever affiliated with a chain? If yes list the name, address of parent organization and EIN #

☐ No ☐ Yes

Name	Business Address	EIN #

Item VII. Board of Directors or Board of Governors

List the name, title, personal address, social security number, and percentage of interest for each of the Board of Directors or Board of Governors of this provider. Use an additional sheet if necessary.

Name	Title	Personal Address	SSN/TIN	% owned

MC-21 LLC d/b/a MC-Rx may refuse to enter into, renew, or terminate an agreement with this Provider if it is determined that this entity did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106

PRINT NAME OF PROVIDER

Signed By: _____ Date: _____

Name: _____ NCPDP: _____

Title: _____ NPI: _____