



**CMS Worksheet**

In order to comply with Federal law (42 CFR 420.200 – 420.206 and 455.100 – 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program. The Centers for Medicaid and Medicare Services (CMS) requires Coventry Health Care, Inc. and its subsidiaries and delegated credentialing entities to obtain this information to demonstrate that Coventry is not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. In order to comply with the CMS requirements, Coventry has requested that ActivHealthCare obtain the information below on each member provider.

Please complete the following information and return to the address below. This form is required if you wish to continue to participate with Coventry’s subsidiaries. You are also reminded that any changes to this information in the future must be reported to the health plan. Use the back of this form if you need space to continue your responses. If you have questions, please contact ActivHealthCare Credentialing Department at 1-800-635-0459 or 770-455-0040.

Name of Provider/Subcontractor: \_\_\_\_\_

Type of Provider/Subcontractor: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Primary Address: \_\_\_\_\_

Type of Ownership: \_\_\_\_\_ (Examples may include: partnership, corporation, government, limited partnership, corporate-owned, investor-owned, etc.)

List any person and their address that has a direct or indirect ownership interest of 5% or more in your entity.

\_\_\_\_\_  
\_\_\_\_\_

List any person and their address who is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds 5% of the total property and assets of the entity.

\_\_\_\_\_  
\_\_\_\_\_

If the entity is a corporation, please list the officers and directors of the entity and their address. If the entity is a partnership, please list the partners and their address.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any managing employees and their address. Managing employees are individuals such as general managers, business managers, administrators, or directors who exercise operational or managerial control over the entity or part thereof, or directly/indirectly conduct the daily operations of the entity, or part thereof.

\_\_\_\_\_  
\_\_\_\_\_

CHECK IF YOU HAVE LISTED ADDITIONAL INFORMATION ON THE BACK OF THIS FORM.

I certify that the information contained above is true, complete, and accurate.

Signed: \_\_\_\_\_ Print: \_\_\_\_\_

Date: \_\_\_\_\_ Title: \_\_\_\_\_

**Please return this form to: ActivHealthCare, P. O. Box 1368, Lilburn, GA 30048 or Fax to 770-455-6188.**