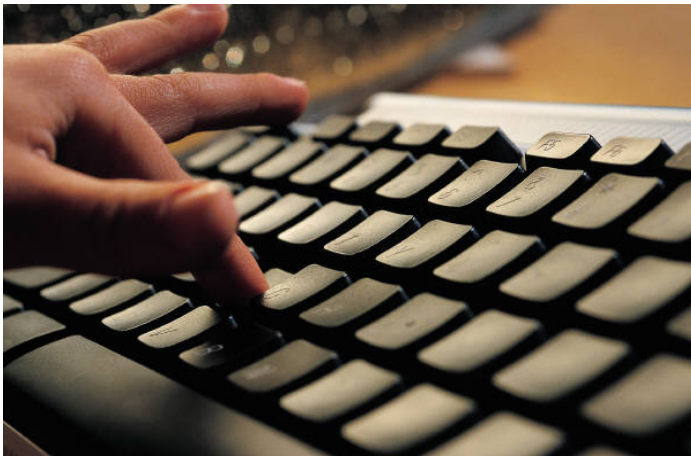


DMAP Disclosure Information



HP Enterprise Services



Disclosure Form Automation

According to the Code of Federal Regulations title 42, part 455, sections 100-106, all providers enrolled with the DMAP program must complete a disclosure form. This form must be submitted electronically. The proposed effective date is January 3, 2011.



Proposed Disclosure Statement



Delaware Medical
Assistance Program

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[Client Eligibility Including: TPL, Managed Care Enrollment, Lock-in, Plan Limitations and Client Service Limits](#)

[Claims Status Request](#)

[Check Write](#)

[Prior Authorization](#)

[DUR+ PA Criteria](#)

[Manage Profile](#)

[Household Case](#)

[Upload](#)

[Download](#)

[DMAP E-mail Registration](#)

[Provider Disclosure Statement](#)

[Inquiry](#)

[NDC Lookup](#)

Delaware Medical Assistance Program Provider Disclosure Statement

Provider Number 1205884030
Tax ID 99-9999999

This form will apply for all enrolled providers with this NPI and Tax ID combination. A separate form must be completed for any other NPI and Tax ID combinations.

[Please click here for terms and definitions used in the form](#)

Click on this link for terms and definitions

Name of Entity Mom and Pop's Pharmacy
Street 435 E. North Ruthiford Way
City/State/Zip Somecity, DE 99999
Phone (555) 354-9853

Is the above information your current Service Location? *

If your answer is "No", then please contact provider relations for assistance.

Doing Business as *

Questions 1 - 3 must be answered by all providers



Proposed Disclosure Statement

Question 1.

Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider been convicted of a criminal offense related to that person's involvement in any program under Medicaere, Medicaid or the Title XX services program since the inception of those programs? If yes, give the name(s) of person(s) and description(s) of offense(s).

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Name	Description



Proposed Disclosure Statement

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Question 3

Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? If yes, give the information below for each wholly owned supplier or subcontractor.

Name	Street	City	State	Zip	Description of Business Transaction
*					

Questions 4 - 6 to be answered by fiscal agents and by all providers EXCEPT individual practitioners.

Question 4.

Provide the name and address of each person with an ownership or control interest in the provider/fiscal agent or in any subcontractor in which the provider/fiscal agent has direct or indirect ownership of five percent or more.

Name	Street	City	State	Zip
* A.				
B.				
C.				
D.				
E.				
F.				



Proposed Disclosure Statement

Question 5.

Is any person named in question #4 related to another as spouse, parent, child, or sibling?

Note: Use the dropdowns to designate the relationship to the subcontractor listed above.

	Name	Relationship
*	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
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	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>

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Proposed Disclosure Statement

Question 6.

Does any person named in question #4 have an ownership or control interest in any other Medicaid provider or in 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, XVIII, or XX of the Act? If yes, give the name(s) of and address(es) of the Medicaid provider or entity.

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NOTE: designate relationship to each person in question #4 by using the dropdown provided

	Name	Street	City	State	Zip
*	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



Proposed Disclosure Statement

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Optional Remarks

Enter optional comments here (500 characters or less)

Whoever knowingly and willfully makes or causes to be made a false statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Name of Authorized Representative

Date (MM/DD/YYYY)

Title

Submit

Reset



Disclosure E-mail Notification – November 2, 1010

Attention All Providers:

Online Provider Disclosure Statement is coming soon!

Effective January of 2011, **ALL** providers will be required to submit a Provider Disclosure Statement. The statement must be submitted through the DMAP website. All providers will be responsible for the submission of their own Provider Disclosure Statement.

The go-live date for the 2011 Provider Disclosure Statement is January 3, 2011.

Providers will only have 35 days to complete the statement online. A provider will not be able to participate in DMAP if they do not complete the online Provider Disclosure Statement.

Sign up **NOW** at the link below to ensure online access to the Provider Interactive Services of the DMAP website. To receive up-to-date information via email, please sign up for email notifications at the second link below.

Provider Interactive Services:

<http://www.dmap.state.de.us/downloads/bulletins/Register.for.IS.pdf>

Email Notifications:

<http://www.dmap.state.de.us/downloads/bulletins/Register.for.listservs.pdf>

If you have any questions or need assistance, please contact

Provider Relations

at

1-800-999-3371

Further communications will be sent out via the DMAP Email Notification System. Information will also become available on the DMAP website.

The **DMAP Email Notification System** was created to inform the DMAP user community about DMAP policy updates and changes. Through the use of the email registration process, all DMAP website users can request to receive email notifications, change their information and areas of interest, and unregister if needed.

