BlueCross BlueShield of New Mexico

PARTICIPATING PROVIDER INTEREST FORM
FACILITY/AGENCY/VENDOR

The attached packet contains the forms required in order to be considered for network participation with Blue Cross Blue Shield of New Mexico (BCBSNM). Please complete all applicable sections of the packet and return to NM Network Services by fax (preferred method) or by mail as indicated below.

The completed packet will be reviewed, and if accepted, the legal entity will receive a Medical Services Entity Agreement (MSEA) for signature, in the mail. Once a signed agreement is received, the credentialing process will be initiated. Upon approved credentialing status, provider will be added as a participating with the applicable lines of business and will be effective the date the provider is entered into the system. A fully executed copy of the agreement will then be sent to the legal entity.

If a provider is not accepted, a letter is sent to inform the provider they will not be added at this time, based on BCBSNM business needs.

Billing Information: Social Security Number and Federal Tax Identification Number must be completed in its entirety; the name that will appear on any reimbursement or Form 1099 will be that of the party to which payment is made. We will only make provider payments to the individual that rendered the service(s) and supplied a Tax Identification Number belonging to the named individual. To receive a Provider Record and/or join the BCBSNM network, please complete the Provider Record/Contracting form below and the W-9 Form.

Please Note: Your assigned BCBSNM internal provider record does NOT mean that your organization is participating or that a contract will be offered. Until your organization is credentialed and contract is executed with an effective date, all claims will be processed as out of network.

Please complete this packet and provide a copy of the following:

- Current State license
- Proof of Professional Liability Insurance and amounts
- Service or program description (if applicable)
- Most recent Accreditation report or copy of the Department of Health or CMS site visit (if not nationally accredited)
- Quality Assurance Program & annual evaluation of plan
- Licensure and/or certification of all applicable employees
- 147C (Corporation) is required. W-9 is only accepted if 147C is not available.
- Most recent CMS or Department of Health survey
- Medicare and/or Medicaid certification letters, if applicable
- Current liability insurance certificate including general, professional and workers compensation coverage
- Policies/procedures on credentialing of professional and clinical staff, including privileging if applicable
- Children, Youth and Families Department (CYFD) certification
- Department of Health (DOH) certification
- Current Clinical Laboratory Improvement Amendments (CLIA)
- Behavioral Health Areas of Expertise, if applicable
- Medicaid Provider Disclosure of Ownership and Control Interest Form **(Legal Entity only)**

Additional Requirements of Ambulatory Surgical Center:

1. Must be approved for reimbursement as an Ambulatory Surgery Center (ASC) under Medicare
2. Must have written referral agreement with at least one acute care hospital

Complete packet and return to:

FAX: 1-866-290-7718 (toll-free) or 505-816-2688 (local)
MAIL: Blue Cross Blue Shield of New Mexico
Attention: Network Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630
PHONE: Network Services at 1-800-567-8540 or 505-837-8800
WEBSITE: Additional forms and information can be found on our website at bcbsnm.com.

We look forward to assisting you in the future.

BlueCross BlueShield of New Mexico

PARTICIPATING PROVIDER INTEREST PACKET
FACILITY/AGENCY/VENDOR

Applying for:	**Requested Networks:**
☐ Provider Record only ☐ Provider Record and participation in the BCBSNM Network ☐ Participation in an additional BCBSNM Network only	☐ Commercial (HMO, PPO, POS, PAR, FEP) ☐ Medicaid ☐ Medicare Advantage ☐ Blue Preferred ☐ Blue Advantage HMO Network℠ ☐ Blue Community HMO Network℠

Are you associated with:

☐ IPA (Independent Physician Association) Name: _____

☐ PHO (Physician Hospital Organization) Name: _____

☐ Health System Name: _____ Employed by Health System Yes ☐ No ☐

Are you a:

☐ Federally Qualified Health Center (FQHC) ☐ Community Mental Health Center (CMHC)
☐ Rural Mental Health Clinic (RHC) ☐ Indian Health Services Facility ☐ Core Service Agency (CSA)

Please print:

Facility/Agency/Vendor Name: _____

Specialty: _____

NPI (National Provider Identifier) #: _____

Federal Tax ID Number: _____

Are you currently a Medicare provider? Yes ☐ No ☐ If yes, in what state_____
Medicare CMS Certification Number (CCN):

Are you currently a Medicaid provider? Yes ☐ No ☐ If yes, in what state_____
Medicaid number:

Physical Location: _____

Street: _____ Effective Date of this Address: _/__/___

City: _____ State: _____ Zip: _____

Scheduling Phone No:_____Other Phone No:_____ Fax No:_____

E-mail: _____Business Office Manager: _____

Does this facility provide screening mammography services? Yes ☐ No ☐ Scheduling Phone No:_____

Office Hours:

Mon___ to ___ | Tue ___ to ___ | Wed ___to___| Thu ___ to___| Fri___ to___| Sat___ to___ | Sun ___to ___|

Services performed at this location: _____

(Attach a separate sheet for any additional addresses **including office hours and services performed**)

Mailing Address (credentialing/correspondence):

Street/P.O. Box: _____

City: _____ State: _____ Zip: _____

Phone No: _____ Fax No: _____ Contact Person: _____

Billing Address (for payments, checks):

Street/P.O. Box: _____

City: _____ State: _____ Zip: _____

Phone No: _____ Fax No: _____ Contact Person: _____

Please describe your current service area:

Participation will require the provider to submit claims directly to Blue Cross and Blue Shield of New Mexico.
What system of filing will you use?

CMS-1500 ___ UB 04 ___ Other (explain) _____

Does your facility have wheelchair access? Yes ☐ No ☐

Has your company ever been listed on an OIG or other government sanction list? Yes ☐ No ☐

Have you ever been a BCBSNM participating provider before? Yes ☐ No ☐

List any languages spoken: _____

List any practice limitations: _____

List any limitations to weekly practice hours:_____

Place of Service (POS) Codes Billed (i.e. hospital- POS 21, surgery center-POS 24, etc.):_____

Please check all services provided:

☐ Licensed Medical-Surgical	☐ Emergency Medical	☐ Pediatric
☐ Obstetrical	☐ Critical Care Services	☐ Major Surgery
☐ Minor Surgical Procedures	☐ Licensed Ambulatory Surgical Facility	☐ Medicare Eligible Surgical Practices
☐ Perinatal Services	☐ Tertiary Pediatric Services	☐ Diagnostic Cardiac Catheterization Services
☐ Inpatient Psychiatric Services	☐ Residential Substance Abuse Treatment Centers	☐ Therapeutic Radiation
☐ Magnetic Resonance Imaging Center	☐ Diagnostic Radiology including x-ray, ultrasound, and CAT scan	☐ Renal Dialysis Center
☐ Mammography	☐Other: _____	☐Other:_____
☐ Lactation Counseling Services		

To the best of my knowledge, the information supplied on this document is accurate and complete.
Upon submission of this packet, provider hereby releases this information to Blue Cross and Blue Shield of New Mexico for the purpose of establishing a BCBSNM Provider Record.

I hereby represent and warrant that all information contained in this application is true, correct, and complete in all aspects. I understand and agree that any misrepresentation in this application by omission or affirmative statement shall be grounds for termination.

Print Name: _____ Title: _____

Signature: _____ Date: _____

BlueCross BlueShield of New Mexico

Behavioral Health Facility Areas of Expertise

Facility Name: _____

Service Address: _____

Directory Phone #: _____

NPI#: _____

Comments: _____

Services Provided			
Level of Care	**Age**	**Service**	**Y/N?**
Inpatient	Child	Mental Health	
		Substance Abuse	
		Detoxification	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Detoxification	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Detoxification	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Detoxification	
		Eating Disorder	
Residential	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
Partial Hospitalization	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	

Services Provided			
Level of Care	**Age**	**Service**	**Y/N?**
Partial Hospitalization	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
Intensive Outpatient (IOP)	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
Outpatient	Child	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adolescent	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Adult	Mental Health	
		Substance Abuse	
		Eating Disorder	
	Geriatric	Mental Health	
		Substance Abuse	
		Eating Disorder	
ECT	Inpatient	Adult	
		Geriatric	
	Outpatient	Adult	
		Geriatric	

Public Transportation Access: ☐ Yes ☐ No

TDD Capacity: ☐ Yes ☐ No

Wheelchair Accessibility: ☐ Yes ☐ No

Completed by: _____ Date: _____

Disclosure of Ownership and Control Interest Form

Purpose: In compliance with 42 CFR 457.935, 42 CFR §455.104, §455.105, and §455.106, providers/*disclosing entities* are required to disclose including, but not limited to, information regarding (1) the identity of all *persons with an ownership or control interest* in the provider/*disclosing entity*, or in any *subcontractor* in which the provider/*disclosing entity* has a direct or *indirect ownership* of 5 percent or more including the identity of *managing employees*, and *other disclosing entities*; (2) certain business transactions and *significant business transactions* between the provider/*disclosing entity* and *subcontractors*/*wholly owned suppliers*; and (3) the identity of any *person with an ownership or control interest* in the provider/*disclosing entity* or who is an *agent*, or a *managing employee* of the provider/*disclosing entity* that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs. **Any authorized/designated representative of the provider/*disclosing entity* may complete and sign this form on behalf of the provider/*disclosing entity*.**

Instructions for Completing the Ownership & Control Interest Disclosure Form

1) Read all definitions and instructions outlined throughout the form and then reference the definitions and instructions while completing the form. Terms with corresponding regulatory definitions are italicized and underlined throughout this form. Please review the applicable definition before responding to the question.
2) Definitions for Disclosure of Ownership and Control Interest Form - See Appendix A
3) Completion and submission of this statement/disclosure is a condition of participation as a credentialed or enrolled provider in the New Mexico Centennial Medicaid Managed Care Network or the State Children's Health Insurance Program (CHIP) network for services to members under Medicaid and CHIP benefit plans.
4) Answer all questions as of the current date i.e. request date.
5) If there is no information to include, indicate "None" or "Not applicable" (N/A) in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. Incomplete forms will be reported back to HSD.
6) If more space is needed, please attach additional sheets.
7) In any space requesting 'Name,' if it is the name of an individual, include First, Middle and Last.
8) Business & Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
9) Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.
10) This statement/disclosure should be submitted with your MCO application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A statement must also be provided within **35** calendar days of a request for this information.
11) Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

How to Determine Ownership or Control Percentages (42 CFR 455.102).

12) Indirect ownership interest. 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.
13) Person with an ownership or control interest. 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.

Disclosure of Ownership and Control Interest Form

NAME OF PROVIDER/*DISCLOSING ENTITY* **BEING CONTRACTED:**

NAME OF GROUP WHERE MEMBERS WILL BE SEEN:
TAX ID # OF PROVIDER/*DISCLOSING ENTITY*:

Section 1 –Disclosure Regarding *Managing Employees* (42 CFR 455.104(b) (4))

1) Does the provider/*disclosing entity* have any *managing employees*? ☐ **Yes** ☐ **No**
If **Yes**, provide the following details for any *managing employee* of the provider/*disclosing entity.*
See the definition of *managing employee*

NAME	SSN	Birthdate	Complete Address (street/city/state/zip)	NPI	Position

Section 2 – Criminal Offense Disclosure (42 CFR 455.106)

2) Has the provider, or any *person* (individual or entity) *who has ownership or controlling interest* in the provider/*disclosing entity*, or who is an *agent* or *managing employee* of the provider/*disclosing entity*, ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), or Title XX (Social Services Block Grants) since the inception of those programs? ☐ **Yes** ☐ **No** (verify exclusion through the applicable federal and state specific exclusion databases.)
If **Yes**, provide the following details and a description of offense(s). Use additional pages if necessary.

NAME	SSN/TIN	Birthdate	Description

Section 3 – Person(s) with Ownership or Control Interest Disclosure (42 CFR 455.104(b) (1))

3) Are there any *persons* (individual or entity) *with an ownership or control interest* in the provider/*disclosing entity*?
☐ **Yes** ☐ **No**
If **Yes**, provide the following details and include the title (for example, CEO, owner, board member etc.).
* For corporations/entities that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address.
See the definition of *person with an ownership or control interest* and *disclosing entity*

NAME	**TIN or SSN, as applicable	Birthdate	Title	Address (street/city/state/zip)	% Ownership Interest

Section 4A – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b) (1))

Disclosure of Ownership and Control Interest Form

4A) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ **Yes** ☐ **No**
If **Yes**, provide the following details about the *subcontractor*.
See the definition of the following terms: *subcontractor* and *indirect ownership interest*

Name of Subcontractor	****TIN or SSN,** as applicable	**Birthdate**	**Address (street/city/state/zip)**	**% Ownership Interest**

Section 4B – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b) (1))

4B) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ Yes ☐ No
If Yes, provide the information below about any *person (individual or entity) with an ownership or control interest*, in any *subcontractor* in which the provider/ disclosing entity has a 5 percent or more direct or *indirect ownership or control interest*.
See the definition of the following terms: *subcontractor* and *indirect ownership interest*

Name of Subcontractor (from section 4A)	**Name of Person(s) with an ownership or control interest in the *subcontractor***	****TIN or SSN,** as applicable **of Person(s) with an ownership or control interest in the *subcontractor***	**Birthdate of Person(s) with an ownership or control interest in the *subcontractor***	**Address (street/city/state/zip)of Person(s) with an ownership or control interest in the *subcontractor***	**% Ownership Interest**

Section 5A – Relationships Disclosure (42 CFR 455.104(b) (2))

5A) Are any of the individuals disclosed in Section 3 above related to each other as a spouse, parent, child, or sibling?
☐ **Yes** ☐ **No** If **Yes**, provide the following details:

NAME(From Section 3)	**Nature of Relationship (e.g., spouse)**	**Related to Name(From Section 3)**

Disclosure of Ownership and Control Interest Form

Section 5B – Relationships Disclosure (42 CFR 455.104(b) (2))

5B) Are any of the individuals disclosed in **Section 3** above related to any of the individuals disclosed in **Section 4B** as a spouse, parent, child, or sibling? ☐ **Yes** ☐ **No** (spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Use additional pages if necessary. If **Yes**, provide the following details:

NAME(From Section 3)	**Nature of Relationship (e.g., spouse)**	**Related to Name (From Section 4B)**

Section 6 – *Other Disclosing Entity* Disclosure (42 CFR 455.104(b) (3))

6.1) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any other Medicaid provider? ☐ Yes ☐ No ☐ N/A

6.2) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any *other disclosing 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 (Maternal and Child Health Services Block Grant), XVIII (Medicare), XX (Block Grants to States for Social Services) , or Title XXI (State Children's Health Insurance Program) of the Social Security Act? ☐ Yes ☐ No ☐ N/A

If Yes to Items 1 or 2 of this Section 6, provide the following details:

See the definition of the following terms: *other disclosing entity* and *ownership interest*

NAME (From Section 3)	**Name of *other disclosing entity or other Medicaid Provider***	**SSN and/or TIN**, as applicable **of the *other disclosing entity or other Medicaid Provider***

Section 7A – Business Transactions Disclosure (42 CFR 455.105)

7A) Business Transactions - Subcontractors: Has the provider/*disclosing entity* had any business transactions with a *Subcontractor* totaling more than $25,000 in the previous twelve (12) month period (12-month period ending as of the date on this request)? ☐ **Yes** ☐ **No** If **Yes**, provide the following details:

**See the definition of *subcontractor* **

Name of *subcontractor*	****TIN or SSN,** as applicable of *subcontractor*	**Birthdate**	**Address (street/city/state/zip)**	**Transaction Amount**

Disclosure of Ownership and Control Interest Form

Section 7B – Significant Business Transactions Disclosure (42 CFR 455.105)

7B) Significant Business Transactions: Has the provider/*disclosing entity* had any *Significant Business Transactions* with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending as of the date on this request)? ☐ **Yes** ☐ **No** If **Yes**, provide the following details:

See the definition of the following terms: *subcontractor*, *wholly-owned supplier*, and *significant business transactions*

Type of entity	**Name**	****TIN or SSN,** as applicable	**Birthdate**	**Address (street/city/state/zip)**	**Transaction Amount**
☐ Wholly Owned Supplier ☐ Subcontractor					
☐ Wholly Owned Supplier ☐ Subcontractor					

Section 8 – Attestation

8) Through signature below, I hereby certify that persons with ownership and control interest in the provider/*disclosing entity* or in a *subcontractor*, *agents*, *subcontractors*, *managing employees*, and any employees providing healthcare services as part of this application are screened with the applicable background check including, but is not limited to, verification against the applicable state and federal exclusion databases. I hereby represent and warrant that all information contained in this form is true, correct, and complete in all aspects. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract. I further understand completion of this form does not guarantee participation with the Managed Care Organization.

Name: _____ **Title:** _____
(Print or Type: First/Middle/Last) **(Print or Type)**

Signature: _____ **Date (MM/DD/YYYY):**_____
(Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)

Disclosure of Ownership and Control Interest Form

APPENDIX A

DEFINITIONS

#	Term/Words	Definition
1	*Agent*	**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2	*Disclosing entity*	**Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. * For purposes of completing the Medicaid Disclosure Form, solo practitioners and the group contracting entity are also treated as a "disclosing entity." **Group Providers - The contracting group entity should complete the Form on behalf of the group.
3	*Fiscal agent*	**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4	*Group of practitioners*	**Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
5	*Health Insuring Organization (HIO)*	Health insuring organization (HIO) has the meaning specified in § 438.2.
6	*Indirect ownership interest*	**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
7	*Managed care entity*	**Managed care entity** (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
8	*Managing employee*	**Managing employee** means 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.

Disclosure of Ownership and Control Interest Form

9	*Other disclosing entity*	Other disclosing entity means 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, XVIII, 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 XVIII); 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.
10	*Ownership interest*	Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in: a. The capital, the stock or the profits of the entity, or b. Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
11	*Person with an ownership or control interest*	Person with an ownership or control interest means a person or corporation that: a) Has an ownership interest totaling 5 percent or more in a disclosing entity; b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; e) Is an officer or director of a disclosing entity that is organized as a corporation; or f) Is a partner in a disclosing entity that is organized as a partnership?
12	*Prepaid ambulatory health plan (PAHP)*	Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.
13	*Prepaid inpatient health plan (PIHP)*	Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.
14	*Primary care case manager (PCCM)*	Primary care case manager (PCCM) has the meaning specified in § 438.2.
15	*Significant business transaction*	Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.
16	*Subcontractor*	Subcontractor means: a. An individual, agency, or organization to which a disclosing 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 (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

17	*Supplier*	Supplier means 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, a manufacturer of hospital beds, or a pharmaceutical firm).
18	*Termination*	Termination means – a) For a-- i. Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and ii. Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. b) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. c) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.
19	*Wholly owned supplier*	Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.