GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Change of Ownership Form

The Puerto Rico Medicaid Program (PRMP) requires that provider and disclosing entities notify the PRMP within 35 days after any change in ownership in accordance with CFR 455.104. When the change is related to 100% ownership, a new application is required, and this form cannot be used. This form should be used only when change in ownership is less than 100%.

The form should be completed in its entirety for each ownership change. Required fields (*)

One form is required for each Medicaid ID.

1. **Provider Information** – This section is required.

*Provider Name	*Provider NPI	*Medicaid ID	*EIN/Tax ID

2. If reporting a change to current owners percentage, including termination of an owner, complete this section (if reporting new owners, go to step 3.)

*Current Owner Name	*Owner SSN	*Change of Ownership Date *(MM/DD/YYYY)*	*Current %	*New %

3. If reporting new ownership percentage between 5-100%, complete the following information: Is this entity an individual or a corporation?

☐ Individual (go to 3a)
☐ Corporation (go to 3b)

3a. Complete this section if you marked "Individual" above:

***% Interest**		***Last Name on Tax ID/SSN**			
Title		***First Name**		**Middle Name**	
***Last Name**			**Second Last Name**		
Suffix		***SSN**		***Birth Date** *(MM/DD/YYYY)*	
***Address Line 1**					
***Address Line 2**				***City**	
***State**		*** Country**		***Zip Code**	
***Email Address**					
***Effective Date** *(MM/DD/YYYY)*		***End Date** *(MM/DD/YYYY)*			

3b. Complete this section if you marked "Corporation" above:

***% Interest**		***Legal Name on Tax ID**			
***EIN**					
***Address Line 1**					
***Address Line 2**				***City**	
***State**		***Country**		***Zip Code**	
***Email Address**			***Effective Date** *(MM/DD/YYYY)*		

4. Has this entity/individual been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, Children's Health Insurance Program, or the Title XX services since the inception of these programs? ☐ **Yes** ☐ **No**

   If yes, provide the following information below.

***Offense Description**	***Conviction Date** *(MM/DD/YYYY)*	***Jurisdiction**

5. Has this entity/individual previously participated, or currently participates, as an owner or controlling interest in Puerto Rico Medicaid or any other state's Medicaid program or Medicare? ☐ **Yes** ☐ **No**

   If yes, provide the following information below.

***Program**	***State**

6. Has this entity/individual ever had their billing privileges revoked or had their participation in the program terminated for cause? ☐ **Yes** ☐ **No**

   If yes, provide the following information.

***Program**	***State**	***Date of Revocation** *(MM/DD/YYYY)*

7. Does this entity/individual have any outstanding debt with the Puerto Rico Medicaid Program, other Puerto Rico state agencies, other state Medicaid programs, or Medicare? ☐ **Yes** ☐ **No**

   If yes, provide the following information and attach documentation of the arrangements made to repay the debt.

***Program**	***State**	***Amount of Debt**	***Date** *(MM/DD/YYYY)*

8. Does any family or household member have any outstanding debt with any state or federal agency or program? ☐ **Yes** ☐ **No**

   If yes, provide the following information and attach documentation of the arrangements made to repay the debt.

Title		***First Name**		**Middle Name**			
***Last Name**				**Second Last Name**			
Suffix		***SSN**		***Birth Date** *(MM/DD/YYYY)*			
***Program**		***Amount of Debt**		***Date** *(MM/DD/YYYY)*			
***Address Line 1**							
Address Line 2							
***City**		***State**		***Country**		***Zip Code**	

9. Has this entity/individual had any healthcare-related adverse legal actions imposed by any state Medicaid program or any other federal agency or program? ☐ **Yes** ☐ **No**

If yes, provide the following information.

***Program**	***State**	***Action Imposed**	***Date of Action** *(MM/DD/YYYY)*
		☐ Criminal Conviction ☐ Administrative Sanction ☐ Program Exclusion ☐ Suspension of Payment ☐ Civil Monetary Penalty ☐ Assessment ☐ Program Debarment ☐ Criminal Fine ☐ Restitution Order ☐ Pending Civil Judgment ☐ Pending Criminal Judgment ☐ Judgment Pending Under False Claim Act	

10. Has this entity/individual had any non-healthcare-related adverse legal actions? ☐ **Yes** ☐ **No**

If yes, provide the following information.

***Program**	***State**	***Action Imposed**	***Date of Action** *(MM/DD/YYYY)*
		☐ Criminal Conviction ☐ Administrative Sanction ☐ Program Exclusion ☐ Suspension of Payment ☐ Civil Monetary Penalty ☐ Assessment ☐ Program Debarment	

11. For group providers only: Do any members of your group have a relationship to this entity? If so, please identify them below. If you are not enrolling as a group, please respond No to this question. ☐ **Yes** ☐ **No**

If yes, provide the following information.

Title		***First Name**		**Middle Name**	
***Last Name**				**Second Last Name**	
Suffix		***SSN**			
***Relationship** *(Select one)*	☐ Father ☐ Mother ☐ Parent ☐ Spouse				

***Relationship** *(Select one)*	☐ Ex-Spouse ☐ Stepparent ☐ Absent Parent ☐ Self ☐ Grandparent ☐ Son ☐ Daughter ☐ Child ☐ Sibling ☐ Other

12. Is this entity/individual related to any other person with ownership or control interest as a spouse, parent, child, or sibling? ☐ **Yes** ☐ **No**

    If yes, provide the information for whom the disclosing entity/individual completing this form is related to.

Title		***First Name**		**Middle Name**	
***Last Name**				**Second Last Name**	
Suffix			***SSN**		
***Relationship** *(Select one)*	☐ Father ☐ Mother ☐ Parent ☐ Spouse ☐ Ex-Spouse ☐ Stepparent ☐ Absent Parent ☐ Self ☐ Grandparent ☐ Son ☐ Daughter ☐ Child ☐ Sibling ☐ Other				

Authorized Signature

By signing this document electronically, I attest that all the information provided is true and accurate, and that I will notify the PRMP of any changes to the information contained**. Required fields (*)**

_____

***Signature of the person that is authorized to make this change**

Electronic signatures are allowed. Typed name is not acceptable as a signature.

_____ _____

Title ***Printed Name**

_____

Date *(Use date format MM/DD/YYYY)

Please provide the following contact information in the event we need to contact you regarding your request:

Contact Person Name: _____

Phone number: _____

E-mail address: _____

Upload this form through the Provider Secure Communication (PSC) portal at https://psc.prmmis.pr.gov/. Do NOT include Protected Health Information (PHI).