



**UnitedHealthcare Disclosure of Ownership, Management and Control Interest Form
Addendum to Previous Group Disclosure Form/Roster Submission**

UnitedHealthcare Community Plan is required to collect disclosure of ownership, controlling interest and management information from care providers who participate in the Medicaid and/or the Children’s Health Insurance Program (CHIP) managed care network, pursuant to a Medicaid and/or CHIP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Care providers are required to disclose this information under 42 Code of Federal Regulations §455.100 – §455.106.

If a physician will have management responsibility, ownership or controlling interest of 5 percent or greater, or is related to an individual with an ownership/controlling interest in the group practice, she/he will need to complete the Medicaid Disclosure Form for an Individual Provider and you will need to submit an updated Group Disclosure Form.

If the physician has no management responsibility, ownership or controlling interest and is not related to any individual with an ownership/controlling interest in the group practice, please complete the following information. The form will be added to your group record on file. Please email a copy of this form with your notification letter to uhc_disclosures@uhc.com for physicians to be added to your Disclosure of Ownership Group Record.

Group Name	
Group Address	
Group Phone Number	
Group TIN	
Group NPI Number	

Care Provider Name (Last, First and Middle Initial)	Care Provider SSN	Care Provider DOB	Practice Address	NPI Number	CAQH Number (optional)	Medicaid ID (N/A or “Applied for” is acceptable)

Contact Name _____

Contact Signature _____

Contact Phone _____

Contact Email _____

Date _____