



## Ancillary Provider Disclosure Questions

Participating ancillary providers must complete and submit this form to accompany requests to add a new location or for the relocation of an existing location. Incomplete disclosures may result in delays in processing your requests.

Mail this completed form, along with your request and other supporting documentation, to:

**Horizon BCBSNJ Credentialing & Recredentialing Dept**  
**3 Penn Plaza East, PP-14C**  
**Newark NJ 07105-2200**

You may also email this completed form, along with your request and other supporting documentation, to [EnterprisePDM@horizonblue.com](mailto:EnterprisePDM@horizonblue.com).

Provider Name \_\_\_\_\_

Street Address \_\_\_\_\_

City State ZIP \_\_\_\_\_

Telephone Number \_\_\_\_\_

TIN \_\_\_\_\_

NPI \_\_\_\_\_

NJ Medicaid Provider Number \_\_\_\_\_

### Disclosure Questions

Please select the appropriate response to each question below. For all questions to which you respond "Yes," please provide an explanation of each case (including the date[s] of each incident and the final outcome).

1 Does your organization have any pending, settled, dropped or dismissed liability cases?

Yes

No

2 Has your organization (or any owner controlling 10 percent or more of your organization) ever been subjected to or is currently undergoing any of the following:

a Government disciplinary action such as, but not limited to, revocation of license or Medicare/Medicaid provider status?

Yes

No

b Medicare and/or Medicaid sanction within the last five years?

Yes

No

c Criminal or ethical investigation or conviction?

Yes

No

*(Continues)*

d Bankruptcy, insolvency or assignment for the benefit or creditor proceedings?

Yes

No

e Received any member complaints in the past 12 months?

Yes

No

**Affirmation of Information**

All information submitted by me on behalf of \_\_\_\_\_ an ancillary provider (the "provider") is true and correct to the best of my knowledge and belief. I understand that as an authorized representative of the provider, I have the right to review the information submitted in support of the provider's application. I understand that if any of this information is subsequently found to be false, misleading or incomplete, it could result in denial of the provider's application or termination of participation in the Horizon Blue Cross Blue Shield of New Jersey provider network, or any of its subsidiary or affiliate provider networks (hereafter collectively referred to as "Horizon BCBSNJ").

I understand and agree that I have the responsibility for producing adequate and accurate information for proper evaluation of the qualifications of the provider and for resolving any doubts about such qualifications. I also agree to provide information on an ongoing basis as requested and in accordance with any specific future request that is relevant to Horizon BCBSNJ's evaluation of the provider's application, credentials or qualifications, and that this statement in its entirety shall also apply then.

Name of Authorized Representative \_\_\_\_\_

Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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