GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Managing Employee Change Form

The Managing Employee Change Form must be completed when changing 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 operations of an institution, organization, or agency. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation such as president, vice-president, CEO, CFO, and board of directors.

The form should be completed in its entirety for every enrolling Provider, except those enrolling using the OPR enrollment type. Required fields **(*)**.

One form is required for each Medicaid ID.

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

*Provider Name	*Provider NPI	*Medicaid ID

2. Provide the following information on all managing employees of the provider. Please complete one form for each Managing Employee.

   a. What is the Relationship of this entity to the Provider's Organization?

☐ Board Member
☐ Corporate Officer
☐ Managing Employee
☐ Partner
☐ Shareholder

Title		***Last Name on your Tax ID/SSN**					
***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**				***Telephone Number**			
***Effective Date** *(MM/DD/YYYY)*				***End Date** *(MM/DD/YYYY)*			

3. Has this person been convicted of a criminal offense related to that person's 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 Descriptions**	***Conviction Date** *(MM/DD/YYYY)*	***Jurisdiction**

4. Has this person previously participated or currently participates as a provider in Puerto Rico Medicaid or any other state's Medicaid program or Medicare? ☐ **Yes** ☐ **No**

   If yes, provide the following information.

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

5. Has this person 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)*

6. Does this person 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)*

7. 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**	

8. Has this person 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	

9. Has this person 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	

10. Is this person related to the provider or any other disclosing entity as a spouse, parent, child, or sibling? ☐ **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 ☐ Ex-Spouse ☐ Stepparent ☐ Absent Parent ☐ Self ☐ Grandparent ☐ Son ☐ Daughter ☐ Child ☐ Sibling ☐ Other				

11. Does this person have or has this person ever had an association with another provider who currently has uncollected debt to Medicaid, CHIP or Medicare? ☐ **Yes** ☐ **No**
12. Does this person have or has this person ever had an association with another provider that has been or is subject to a payment suspension under a federal health care program? ☐ **Yes** ☐ **No**
13. Does this person have or has this person ever had an association with another provider that has been or is excluded by the HHS Office of Inspector General (OIG) from Medicaid, or CHIP?

    ☐ **Yes** ☐ **No**
14. Does this person have or has this person ever had an association with another provider that has had Medicare, Medicaid, or CHIP billing privileges denied, revoked, or terminated? ☐ **Yes** ☐ **No**

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).