PRIOR CONDUCT QUESTIONNAIRE

Confidential Information

ADDITIONAL QUESTIONS REGARDING PRIOR CONDUCT—All responses must be thorough and complete. If there is not sufficient space available for a response, you may attach additional sheets to this form. Failure to fully respond or to provide accurate and detailed information can result in a delay in the processing of your application or can result in the denial of your request for enrollment or reinstatement request. Providers must complete this form and submit to MVP within 5 days of becoming aware of misconduct.

Applicant Name: _____

New York State Provider ID #:_____ NPI #:_____

I. A. Prior Medicare History (Federal Program, Title XIX)

1. Have you ever been excluded, terminated and/or suspended by Medicare?

Yes_____ No_____

If yes:

(a) Date of exclusion, termination or suspension. ___/___/___
MM/DD/YY

(b) Cause of exclusion, termination or suspension (you must be specific and provide full details).
_____

_____

(c) Were you reinstated? Yes_____ No_____

If yes, provide a copy of your reinstatement letter.

(d) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your exclusion, termination or suspension will not be repeated. (See reinstatement instructions with application for examples)

2. Have you ever been restricted by agreement or sanctioned by Medicare which did not result in a exclusion, termination or suspension?

Yes_____ No_____

(a) Identify date and type of action. _____

_____

(b) Identify reason for restriction or sanction. _____

_____

(c) Are you currently participating in Medicare without any restrictions or sanctions?

Yes_____ No_____

(d) Date the restriction or sanction ended? ___/___/___
MM/DD/YY

B. Prior Medicaid History (State Program, Title XVIII)

1. Have you ever been excluded, terminated and/or suspended by Medicaid in any state?

Yes_____ No_____

If yes:

(a) Date of exclusion, termination or suspension. ___/____/___
MM / DD / YY

(b) Cause of exclusion, termination or suspension (you must be specific and provide full details).

_____

_____

(c) Were you reinstated? Yes_____ No_____

If yes, provide a copy of your reinstatement letter.

(d) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your exclusion, termination or suspension will not be repeated. (See reinstatement instructions with application for examples)

2. Have you ever been denied enrollment by Medicaid in any state?

Yes_____ No_____

If yes:

(a) Identify state(s), date of denial and reason. _____

_____

(b) Submit a copy of your denial letter.

3. Have you ever been restricted by agreement or sanctioned by Medicaid which did not result in an exclusion, termination or suspension?

Yes_____ No_____

(a) Identify date and type of action. _____

_____

(b) Identify reason for restriction or sanction. _____

_____

(c) Are you currently participating in Medicare without any restrictions or sanctions?

Yes_____ No_____

(d) Date the restriction or sanction ended? ___/____/___
MM/DD/YY

II. A. 1. Have you ever been convicted of stealing from any federally or state funded Medicaid/Medicare Program? (Medicaid/Medicare Fraud)

Yes_____ No_____

If yes:

(a) What was the date and location of the conviction? _____

(b) What were the causes that resulted in the conviction? _____

_____

(c) Provide a copy of your conviction papers.

(d) Are you currently on probation?

Yes_____ No_____

If yes, provide a copy of your probation papers and a current status report.

(e) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your conviction will not be repeated. (See reinstatement instructions with application for examples)

B. 1. Have you ever been convicted of public assistance or welfare fraud?

Yes_____ No_____

If yes:

(a) Identify the state and date of the conviction. _____

(b) What penalty was imposed as a result of the conviction? _____

_____

C. 1. Have you ever been convicted of any crime relating to the furnishing of or billing for medical care, services or supplies or which is considered an offense involving fraud, theft, against public administration, or against public health and morals, other than previously listed on this form?

Yes_____ No_____

If yes:

(a) Identify the state(s) and date of conviction. _____

(b) What penalty was imposed as a result of the conviction? _____

_____

III. A. 1. Has your medical license or registration ever been revoked and/or suspended in any state?

Yes_____ No_____

If yes:

(a) Identify the state(s) and the date of revocation and/or suspension. _____

_____

(b) Identify the causes for the revocation and/or suspension. _____

_____

(c) Has your license been restored? Yes_____ No_____

(d) Date your license was restored. ___/___/___
MM/DD/YY

(e) Are you currently on probation? Yes_____ No_____

(f) Date you expect probation to end ___/___/___
MM/DD/YY

(g) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to the revocation, termination or suspension of your medical license will not be repeated. (See reinstatement instructions with application for example)

B. 1. Has your medical license or registration ever been surrendered in any state?

Yes_____ No_____

If yes:

(a) Identify state(s) and date your license was surrendered. _____

(b) Identify the reason you surrendered your license. _____

_____

(c) Date your license was re-issued ___/___/___
MM/DD/YY

C. 1. Has your license and/or registration ever been placed on probation or have you entered into any type of agreement by any licensing authority in any state?

Yes_____ No_____

If yes:

(a) Identify state(s) and date(s) of action. _____

(b) Identify reason for the action. _____

_____

(c) List any restrictions placed on your license. _____

_____

(d) If currently on probation, attach a letter which indicates you are currently in compliance with all terms of your probation.

IV. A. 1. Are there any pending proceedings that could result in any sanction in any state?

Yes_____ No_____

If yes:

(a) Identify all sanctions that may result from the pending action:

Medicare:

_____ termination from Medicare
_____ denial of enrollment by Medicare
_____ suspension from Medicare
_____ restriction by agreement from Medicare
_____ conviction of Medicare fraud

Medicaid:

_____ termination from Medicaid
_____ denial of enrollment by Medicaid
_____ suspension from Medicaid
_____ restriction by agreement from Medicaid
_____ conviction of Medicaid fraud

Other:

_____ conviction for stealing
_____ conviction for welfare fraud or public assistance fraud
_____ license or registration revoked
_____ license or registration suspended
_____ license or registration surrendered
_____ license or registration restricted by probation
_____ license or registration restricted by agreement

B. 1. Expected date in which a decision should be rendered. ___/____/___
MM/DD/YY

MVP Health Plan, Inc. is collecting this information per the New York State Department of Health Standard Clauses effective March 1, 2011, Section B, #9, which are part of your contract with MVP Health Plan, Inc.

I certify that the answers provided are correct.

Full name (please print):_____

Signature: _____ Date: _____
MM / DD / YY