



DENTAL SERVICES

Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted to Envolve Dental, Inc., dba Centene Dental Services within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

Practice Information

Form with fields: Check one that describes you: Individual Practitioner, Group Practice, Disclosing Entity; Name of Individual Practitioner, Group Practice, or Disclosing Entity ("Provider"); DBA Name; Address; TIN or SSN; NPI.

Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the Provider (e.g. an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the Definition of “person with ownership or control interest” in the Instructions), list the name, address, date of birth (DOB) and Social Security Number (SSN) for each such individual.

Table with 6 columns: Name of Individual, Title, % Ownership, Address, DOB, SSN.

For entities with an ownership or control interest in the Provider, list the name, Tax Identification Number (TIN), and each address of each entity within the same state/market. (42 CFR 455.104) A full listing of all non-market disclosing entities is available upon request.

Table with 5 columns: Name of Entity, TIN, % Ownership, Primary Business Address, Business Locations Within the State.



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Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the Provider has an ownership or control interest of 5% or more? Yes No
If yes, list the name, address, DOB and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

Table with 4 columns: Name, DOB (if an individual), Address, SSN (if listing an individual) TIN (if listing an entity)

Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other? Yes No
If yes, list the individuals who are related to each other, and the type of relationship (spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

Table with 2 columns: Names, Type of relationship

Section IV: Convictions - Applicable to Providers Only

Has any person who has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? Yes No (verify through OIG Website)
If yes, please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Table with 4 columns: Name/Title, DOB, Address, SSN

Section V: Business Transactions – Applicable to Providers Only

Has the Provider had any financial transactions with any subcontractors totaling more than \$25,000 with any subcontractors during the previous 12 months? Yes No
Has the Provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous 5 years? Yes No
If yes, list the ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the previous twelve month period, and any significant business transactions between the Provider and any wholly owned supplier or between the Provider and any subcontractor during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Table with 3 columns: Name Supplier/Subcontractor, Address, Transaction Amount

