CHANGE HEALTHCARE

# Wyoming Department of Health
# Medicaid Pharmacy Provider
# Change in % Ownership or Board Members

F. 307.426.4169 | M. PO Box 21719, Cheyenne, WY 82003

*Fax or mail form to CHC

## PHARMACY INFORMATION

Pharmacy Name (or Corporate Name for Chains): _____ Tax ID: _____

Change Affects (select one): ☐ Individual Pharmacy – Please list NPI: _____ ☐ Multiple pharmacies

## CHANGE TO EXISTING OWNERSHIP/CONTROL INFORMATION

Complete this form to submit Board Member changes or to remove any individuals or organizations whose ownership has dropped below 5% or to add any individuals or organizations who recently acquired (or whose ownership has increased to) 5% or more direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5% or more in the disclosing entity.

***This form is not to be used for buyouts, mergers, store closures and other similar changes in ownership. For these types of changes in ownership, please contact CHC.**

****Make copies of this page for each owner, board member, organization, etc., as needed. All fields are required.**

**A. Effective Date of Change:** ___/___/___ ☐ **Adding** ☐ **Removing**

**Ownership Type:** ☐ Owner ☐ Board Member (specify position) _____ ☐ Controlling Interest

Name (first, middle initial, last) / Organization: _____

% of Ownership: _____ SSN/FEIN: _____ Date of Birth (if applicable): ___/___/___

State, Country, County of Birth: _____
*(If applicable)* *State* *Country* *County (only required if born in U.S.)*

Physical Address: _____
*Address*

_____
*City* *State* *ZIP Code*

Has this person ever been sanctioned, debarred, suspended, excluded or convicted of a criminal offense related to Medicare, Medicaid or any other State or Federal health care program? If yes, select all that apply and attach any applicable documentation. YES ☐ NO ☐

☐ Sanctioned ☐ Debarred ☐ Suspended ☐ Excluded ☐ Convicted

Is this person the spouse, parent, child or sibling of a person with ownership or control interest? If yes, give name of person, relationship and indicate their percentage of ownership: YES ☐ NO ☐

Name: _____ Relationship: _____ % of Ownership: _____

**B.** Does the person/organization listed above in section A have ownership or controlling interest of 5% or more in **another** organization that bills for publicly funded health care programs? If yes, please list applicable businesses below. YES ☐ NO ☐

Legal Business Name: _____ Tax ID: _____ % of Ownership: _____

**C.** Is the enrolling pharmacy a subsidiary company or joint venture? If yes, fill in the following information about the parent company/joint business. YES ☐ NO ☐

Legal Business Name of Parent Company/Joint Business: _____

Address: _____
*Street Address*

_____
*City* *State* *ZIP Code*

Phone #: (_____) _____ - _____ Tax ID: _____

_____ _____
Authorized Contact Name Authorized Contact Title

_____ ___/___/___ (_____) _____ -
Authorized Signature Date Phone #