Alabama Medicaid Agency Change of Ownership Information Reporting Change of Ownership Information

Medicaid requires the owner of a Medicaid-enrolled facility or group to report any change of ownership (CHOW) to Medicaid within 30-days of the change or sale. Timely receipt of this information assists the Medicaid Agency in completing a provider's CHOW. Please note that a provider's enrollment must be active and in good standing to complete a change of ownership.

Providers who accept the previous owner's Medicaid agreement must complete the change of ownership form and submit the following documents: Electronic Funds Transmittal (EFT) Form; W-9; sales agreement/bill of sale; and Disclosure Forms for any owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. Also, please attach a detailed statement of the course of action you are pursuing. The above mentioned forms are located on the Medicaid website at www.medicaid.alabama.gov in the Forms section under the Provider, Provider Enrollment tabs. The completed documentation must be mailed to the Enrollment & Sanctions Unit, Program Integrity Division, Alabama Medicaid Agency, 501 Dexter Avenue, P O Box 5624, Montgomery, Alabama 36104. If you are accepting the previous owner's agreement, it is not necessary for you to complete an application.

Providers who <u>do not</u> accept the previous owners Medicaid agreement must complete a new application. To submit a new application, visit our website at <u>www.medicaid.alabama.gov</u>.

Note: For all hospital CHOWs, please indicate in your detailed statement and on the form below whether the hospital will be a public or private entity after CHOW completion.

For questions concerning CHOWs, please contact the Enrollment & Sanctions Unit at (334) 242-5141.

CHECKLIST

Please make sure all documents are attached.

Change of Ow	vnership Form
Disclosure for with 5% or more co.	rms (For any owners, officers, directors, agents, managing employees and shareholders introlling interest.)
completion to facilita	EFT are not made by Medicaid until CHOW completion. Any EFT changes prior to CHOV ate payment of funds directly to the new owner will have to be submitted via the Medicaid tall by the old owner with agreement by the new owner.)
W-9	
Sales Agreem	ent or Bill of Sale
Detailed state	ment of the course of action being taken
Othor	

Alabama Medicaid Agency Change of Ownership Information This form is to be completed and returned to the Medicaid Agency as specified on previous page.

Currently enrolled facility or group providers who will experience a change in ownership or a change in tax number must complete the information below.

Effective or Anticipa	ted date of change:		
Reason for change:	□CHANGE OF OWNERSHIP	□MERGER	□OTHER
Previous Owner's I	nformation		
Facility Name			
Alabama Medica	id Provider Number		
NPI Number			
Tax ID Number			
Contact Name			
Contact Telephor	ne Number		
of ownership (CHO		ne information you	nanges made as the result of the chang provide below will be reflected in our , please indicate this as well.
New Owner's Infor	mation		
Facility Name			
Pu	blic ■ Private ■ (for hospitals	s only-must check on	e)
NPI Number			
Tax ID Number			
Payee Address _			
Mailing Address			
Contact Name			
Contact Telephor	ne Number		
Contact Email A	ddress		
Name of Authorized Ro	epresentative (typed or printed legibly)	Title	
Signature		Date	