Principal Information Form (PIF-2)

Required for any person or entity that meets the definition of a "Principal" or "Subcontractor" as defined below.

A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.

A **Subcontractor** of the Provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal or Subcontractor.

All owners that have a 5 percent or more direct or indirect ownership interest in a provider that is assigned a high-categorical risk level must submit fingerprints for enrollment or revalidation in Texas Medicaid.

The Provider or provider's duly authorized representative must personally review each copy of this completed form and certify to the validity and completeness of the information provided by signing the Provider Agreement.

Check person or entity: ☐ Person ☐ Entity *If "**Entity**," please complete the following information.*	
Tax ID number as shown on the W9 IRS form:	**Legal name as shown on the W9 IRS form:**
Company Name:	
Address as shown on the W9 IRS form: Number Street Suite City State ZIP	
How is the entity organized to conduct business activities? *Examples include: Sole Proprietor (Unincorporated), Professional Association, General Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, Corporation, Nonprofit, Governmental*	
Do you conduct business under an assumed name? *If Yes, provide the assumed name below.*	☐ Yes ☐ No
Assumed Name:	

*If you selected "**Person**" above, please complete the following information.*

Last Name:	**First Name/Middle Initial:**

Maiden Name:	**List any other alias, name, or form of your name ever used:**

The following information must be completed by all Principals, Subcontractors, and Creditors. For additional names or addresses, attach pages as necessary.

Check principal or subcontractor: ☐ Principal ☐ Subcontractor

Physical Address:

Number	Street	Suite	City	State	ZIP

Accounting/Billing Address:

Number	Street	Suite	City	State	ZIP

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Billing agent ☐ Management company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose "Other," please explain:

Social Security Number:	**Federal Tax ID number:**

Specialty of practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare intermediary:** *(if applicable)*

Medicare provider number *(if applicable)*:	**Medicare effective date** (*mm/dd/yyyy*) *(if applicable)*:

Driver's license number:	**State:**	**Driver's license expiration date** (*mm/dd/yyyy*):

Date of birth (*mm/dd/yyyy*):		**Gender:**	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?		
☐ Yes ☐ No *If "Yes," provide the following information.*		
1.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (*mm/dd/yyyy*)**:**	**Expiration Date** (*mm/dd/yyyy*)**:**
2.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (*mm/dd/yyyy*)**:**	**Expiration Date** (*mm/dd/yyyy*)**:**
3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (*mm/dd/yyyy*)**:**	**Expiration Date** (*mm/dd/yyyy*)**:**
4.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (*mm/dd/yyyy*)**:**	**Expiration Date** (*mm/dd/yyyy*)**:**

Previous Physical address:					
Number	Street	Suite	City	State	ZIP
Previous Accounting address:					
Number	Street	Suite	City	State	ZIP

Your title in the provider organization for which enrollment is being sought:
Your duties to the provider organization (*attach additional sheets if necessary*)**:**

Your role in the provider organization: *Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official , Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Medical Director, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Subcontractor, or Unknown: (attach additional sheets if necessary)*
Effective date of your role in the provider organization (*mm/dd/yyyy*)**:**
Do you have a relationship with a separate provider? (*If "Yes," explain relationship below*) ☐ Yes ☐ No
Explain relationship with the separate provider:
List all TPIs, provider names, and physical locations under which you have billed or in which your were a principal. Include current and previous TPIs *(attach additional sheets if necessary)***:**

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(Attach additional sheets if necessary.)*

1.	**Name:**	**Social Security Number:**	**Date of Birth** (*mm/dd/yyyy*)**:**
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of Birth** (*mm/dd/yyyy*)**:**
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of Birth** (*mm/dd/yyyy*)**:**
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☐ No
If "Yes," fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (Attach additional sheets if necessary)	
Is your professional healthcare license or certification currently revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions? **Have you ever had your professional healthcare license or certification revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?** **Have you ever voluntarily surrendered a professional healthcare license or certification in lieu of disciplinary action?** *(You may be subject to a license or certification verification/status check with your licensing or certification board.)*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
If "Yes" was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (Attach additional sheets if necessary)	
Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program? **Do you currently have any outstanding debt or have you received notice of an unpaid amount due in relation to any State or Federally funded program?**	☐ Yes ☐ No ☐ Yes ☐ No
If "Yes" was answered to any of the questions, fully explain the details including date, and the state if applicable.	

"Convicted" means that:

(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
  (1) There is a post-trial motion or an appeal pending, or
  (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. §1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged or is there an outstanding warrant for your arrest?	☐ Yes ☐ No

If "Yes," fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)

Are you currently subject to court-ordered child support payments?	☐ Yes ☐ No

If "Yes," provide details.

Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No

If "Yes," provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)

Are you a citizen of the United States?	☐ Yes ☐ No

If "No," provide the country of which you are a citizen.

If you are not a citizen of the United States, do you have a legal right to work in the United States? *If "Yes," attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No