



Alaska Medicaid Clinical Coverage Review Request Disclosure Form

In an effort to ensure fair, balanced, objective, and scientific rigor in requests, presentations or testimony to the Alaska Medicaid DUR, P&T, or other advisory Committees (hereafter *Committee(s)*), workgroups, and/or the Alaska Medicaid Clinical Review team, all individuals presenting information to the State of Alaska Medicaid Program are expected to disclose any real or apparent conflict(s) of interest that they may have which may be viewed as having a direct bearing on the subject matter of program discussions/activities. This pertains to relationships with pharmaceutical companies, device manufacturers, or other business entities or corporations whose products or services are related to the subject matter of the Alaska Medicaid program. All presenters who are not employee representatives of pharmaceutical or device manufacturers will be asked to complete this form prior to their testimony, including health care providers.

What is a potential Conflict of Interest?

A financial interest may include, *but is not limited to*, being a shareholder in the organization, being on retainer with the organization, having research or honoraria paid by the organization, or receiving other forms of remuneration (i.e. monetary or services) from an organization. An affiliation may include holding a position on an advisory committee or some other role or benefit to a supporting organization. Health care providers and other public individuals must disclose if a pharmaceutical or device manufacturer solicited support.

Conflicts of interest may unduly impact the integrity of the Medicaid program and inappropriately increase the federal and state dollars used to fund the program.

Topic: _____

Please check one of the following:

I do NOT (nor does any immediate family member) have any real or apparent conflicts of interest due to affiliation with any company or manufacturer whose product(s) may be evaluated in conjunction with Committee deliberations.

I DO (or an immediate family member does) have real or apparent conflicts of interest due to affiliation with a company or manufacturer whose product(s) may be evaluated in conjunction with Committee deliberations. [You must attach a description of the nature of the potential or actual conflict of interest as a separate document.]

I understand that providing false information or statements in an effort to influence a federally funded program may be subject to enforcement actions under federal law (including but not limited to 42 USC 1320a-7b(b), Anti-Kickback) and applicable state law. I understand that the Alaska Medicaid program may use the CMS Open Payments database (42 USC 1320a-7h) in their review process, but I am responsible for accurate reporting on this form for each request made. <https://oig.hhs.gov/fraud/enforcement>

Signature	Printed Name	Date
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- Enrolled Alaska Medicaid Provider; NPI: _____
- Private individual; state of residence: _____

Can you answer ‘yes’ to any of the following questions? Answering ‘yes’ does not prevent you from providing information to the Alaska Medicaid program; however, sufficient disclosure must be provided.

Topic:	Initial	
1. Were you asked to provide oral or written support for a particular product or service to the Alaska Medicaid program by an organization or other individual? <i>Comments:</i>	Yes	
	No	
2. Do you currently receive consulting fees or have you been paid for advisory board participation? <i>Comments:</i>	Yes	
	No	
3. Are you employed by a pharmaceutical or device manufacturer? <i>Comments:</i>	Yes	
	No	
4. Have you ever received any grant support from the industry directly related to the topic? <i>Comments:</i>	Yes	
	No	
5. Are you receiving any gifts or services as a result of your testimony today? <i>Comments:</i>	Yes	
	No	
6. Do you have any other current or recent (within the last 36 months) financial arrangement or affiliation with any organization that may have a direct interest in the business before the Alaska Medicaid Advisory Committees or Clinical Review Teams? <i>Comments:</i>	Yes	
	No	

Please attach any additional comments or clarifications as needed.

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Signature

Printed Name

Date

- Enrolled Alaska Medicaid Provider; NPI: _____
- Private individual; state of residence: _____