



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

Dear Applicant:

Thank you for your interest in enrolling in the New York State Medicaid Program.

Participation in the New York State Medicaid program is an important undertaking. Therefore, we want you to be aware of the following factors concerning your potential enrollment as a provider.

- **If your application is approved, the effective date of your enrollment will be specified by the Department.**
- **You will be at financial risk if you render service to Medicaid patients before successfully completing the enrollment process. Payment will not be made for any claims submitted for services, care or supplies furnished before the enrollment date authorized by the Department.**
- **Your signature on the application acknowledges that you have received, read and will comply with the policies and regulations of the Medicaid Program.**

Podiatry services are only reimbursed for the following instances:

- Medicaid beneficiaries under the age of 21 with the written referral of a physician, physician assistant, nurse practitioner or midwife.
- Medicaid beneficiaries who have Medicare coverage. You can bill for Medicare coinsurance and the deductible.

Podiatrists who provide services to New York State Medicaid beneficiaries are required to read the "Introduction to the New York State Medicaid Program" attached to the application. This material, outlining general procedures and policies governing the Medicaid Program, is to be detached from the application and kept by you as a reference which will assist you in maintaining compliance with Medicaid requirements.

Please do not send this material back with your application.

When you are enrolled in the program, you will receive a letter informing you of your acceptance and the effective date of your enrollment. You will also receive a package containing claim forms and instructions on how to obtain the appropriate Provider Manual which is available online at www.eMedNY.org. If you do not have internet access, you can obtain the appropriate Provider Manual by calling the eMedNY Call Center at (800) 343-9000. The Provider Manual contains New York State Medicaid policy, a list of information sources, and billing instructions. Click on Provider Manuals and scroll down and choose the appropriate manual. The Medicaid Update may also be accessed at www.eMedNY.org, click on Information, then DOH Medicaid Update Website.

As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including, but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, www.health.state.ny.us.

In addition, pursuant to 42 CFR §455.105 by enrolling in the Medicaid program, you are entering into an agreement with the NYS Department of Health by which you agree to and may be requested to provide the following information within 35 days upon request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5-year period ending on the date of the request.

New York State Medicaid Regulations allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

If you have any questions, please contact the EMedNY Call Center at (800) 343-9000.

Sincerely,

Fee for Service Provider Enrollment Bureau
Office of Health Insurance Programs

Enclosure

Podiatrist
EMEDNY-415101 (08/09)

Introduction to the New York State Medicaid Program

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Definitions: As referenced in this material.

Practitioner: Physician, Podiatrist, Physician's Assistant, Nurse Practitioner or Midwife.

Provider: Any individual or entity who has enrolled under the Medical Assistance Program to furnish medical care, services or supplies.

An Introduction to the Medicaid Program

Medicaid enrollment is a contractual agreement between a provider and the Department of Health (administrator of the Medicaid Program). The contractual agreement can be withdrawn by either party without cause by a written 30-day notice.

Medicaid is the largest third party insurer in the State of New York. By law it is the payer of last resort. Therefore, no claim for reimbursement shall be submitted to Medicaid unless the provider has investigated all other resources to ascertain the existence of third party insurance and has sought reimbursement from liable third parties.

By Enrolling in the Medicaid Program, a Provider Agrees To:

- ◆ comply with the rules, regulations and directives of the Department;
- ◆ comply with the disclosure requirements of the Department with respect to ownership and controlling interest, significant business transactions and involvement with convicted persons;
- ◆ accept payment under the Medicaid Program as payment in full for the services rendered;
- ◆ prepare and maintain legible contemporaneous medical records in English; and
- ◆ permit audits of all books and records relating to services furnished and payments received.

Responsibilities as a Practitioner:

- ◆ keep your provider information current; this includes notifying the Department of all changes in your service location, type of practice, including group participation, and if you wish to withdraw from participation;
- ◆ you are responsible for all services ordered and billed under your National Provider Identifier (NPI)/MMIS #;
- ◆ know who your employer is. As a physician or podiatrist, you can not be employed by a person or corporation not authorized by the New York State Education Department to practice medicine. As a physician's assistant or nurse practitioner you must comply with the requirements established by the Education Department governing your practice.
- ◆ you can not affiliate yourself with a provider who has been excluded from the Medicaid Program;
- ◆ to maintain complete legible records in English for six years from the date of payment;
- ◆ if you employ a billing service, the billing service must be enrolled in the Medicaid Program as a non-billing provider; and
- ◆ familiarize yourself with all Medicaid procedures and regulations currently in effect, and as they are issued.

Utilization Monitoring Measures:

The Restricted Recipient Program (RRP) limits certain beneficiaries to specific providers in specific areas. The Department may restrict a beneficiary's access to services if it is found that the beneficiary has received duplicative, excessive, contraindicated or conflicting services, drugs or supplies. In such cases the Department may require that the beneficiary access specific types of medical care and services through a designated provider or providers.

The Medicaid Eligibility Verification System (MEVS) is a means to confirm that the beneficiary is eligible for benefits, identify the type of benefits for which they are eligible, and generate a service authorization. In addition, MEVS functions as an electronic gatekeeper by matching services ordered by a practitioner with services actually rendered. It has become increasingly necessary for practitioners to use MEVS in their transactions. Although it is not mandatory that you have an MEVS unit in your practice, it is highly recommended.

Utilization Threshold (UT) places limits on the number of services a Medicaid beneficiary may receive in a benefit year. When a beneficiary nears the threshold of annual visits (for example, the number of approved visits for physician services is ten) a letter is sent to the beneficiary to make them aware of the threshold. When given to the practitioner, the letter allows the practitioner, (physicians, physician's assistants or nurse practitioners) to assess services needed and if necessary, to request an extension of services, using a threshold override application.

The Drug Utilization Review Program (ProDur) maintains a full on-line record of each beneficiary's prescription history for a 90-day period. When a new claim is submitted by a pharmacy, the claim information is compared to the history. In the event that a potential problem is detected, the pharmacist receives an on-line warning or rejection notice. This system also aids in identifying duplications of medications prescribed. The pharmacist's can take appropriate action and contact the physician as necessary.

Payment Restrictions:

- ◆ Medicaid will not cover services rendered in the absence of an authorization from MEVS in accordance with Utilization Threshold requirements. In addition, Medicaid will not cover services that are rendered after the beneficiary has reached the Utilization Threshold established for a specific provider service type, without a threshold override.
- ◆ Medicaid will not cover services for which prior approval was required and not obtained; and

Medicaid will deny payments on behalf of a beneficiary to a fee-for-service provider if the beneficiary is enrolled in a managed care program. **The exception to this is family planning services.** A beneficiary is free to choose to receive family planning/reproductive health services from any enrolled provider, regardless of the beneficiary's managed care status.

Ordered Services:

Ordered services include:

- Pharmacy
- Durable Medical Equipment
- Transportation services
- Laboratory services
- Radiology services
- Hospital services

Ordered services are medically necessary services or items provided upon the written order of a qualified practitioner:

- ◆ the practitioner who writes the order is responsible for all ordered services, even though no direct payment is received by the practitioner; and
- ◆ all ordered services must be medically necessary and relate to the specific complaints and symptoms of the patient.

Sanctions:

Sanctions under the Medicaid Program may include exclusion from the Medicaid Program for a period of several years. This is the most serious sanction and results from committing an unacceptable practice. An unacceptable practice is conduct by a provider or person, which conflicts with any of the policies, standards or procedures of the Medicaid Program. Some examples include:

- ◆ knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;
- ◆ failing to maintain records necessary to fully disclose the extent of the care, services or supplies furnished (improper documentation);
- ◆ submitting bills or accepting payment for care, services or supplies rendered by a person suspended or excluded from participating in the Medicaid Program;
- ◆ providing services which are not medically necessary;
- ◆ accepting any type of bribe or kickback; and

- ◆ participating in fraudulent activities.

Ramifications of Exclusion From the Medicaid Program:

- ◆ Your name will be placed on Medicaid's list of excluded providers, and other individuals whose orders and services Medicaid will deny (PVR 292). It is circulated to all fillers of ordered services, stating that the Medicaid Program will not pay for services provided by providers or persons on this list.
- ◆ You may have difficulty in obtaining employment in a hospital or clinic.

Ramifications of Exclusion From the Medicaid Program (con't):

- ◆ You may also be excluded from the Medicare Program.
- ◆ Your name and cause for exclusion will be provided to other states, third party insurers, the Office of Professional Medical Conduct and Medicare, all of which may take further action.

Prevention:

Preventive measures can be taken to protect yourself and your practice against problems with the Medicaid Program. Preventive measures include:

- ◆ physicians, beware of “storefront clinics”, where a physician’s assistant is acting as the primary care provider and you only have to be on-site a few hours a week;
- ◆ practice your own medicine; for example, do not be pressured by either a partner or a beneficiary to prescribe medications or services unless you feel that they are medically necessary;
- ◆ be wary where a provider number is required before employment is offered;
- ◆ be responsible for the services you order; and
- ◆ do not sign blank prescription or order forms.

Documentation:

Documentation will be one of the most important means to protect yourself. All care, services and supplies must be fully documented in the medical record, be legible and in English. Guidelines for documentation include:

- ◆ the full name, address and medical assistance number of each beneficiary examined;
- ◆ the date of the visit;
- ◆ the chief complaint or reason for the visit;
- ◆ the beneficiary’s pertinent medical history as appropriate to the visit, and findings obtained from any physical exam that day;
- ◆ a diagnostic impression;
- ◆ a recording of any progress including the response to treatment;
- ◆ a notation of all medication dispensed, administered or prescribed with the precise dosage and regimen for each medication;
- ◆ a description of any X-rays, laboratory tests, electrocardiograms or other diagnostic tests and a notation of the results;
- ◆ a notation of any referrals, and a statement as to the reason;
- ◆ a statement as to whether or not the beneficiary is expected to return;
- ◆ a chart entry giving the medical necessity for any ancillary diagnostic procedures; and
- ◆ all other books, records or documents necessary to fully disclose the extent of the care, services and supplies provided.

These are the basic tenets of medical chart documentation.

MMIS Provider Manual Reference:

For complete procedures and requirements governing the Medicaid Program, you may reference the Medicaid Management Information System (MMIS) Provider Manual. The manual provides detailed guidance on policies, billing and payment and is available at <http://www.emedny.org/>.

Provider Expectations:

Providers can expect:

- ◆ to be treated with respect by the Department;
- ◆ to have available to them information regarding the Medicaid Program and policy;
- ◆ timely payment for services rendered, in accordance with the rules and regulations of the Medicaid Program;
- ◆ that enrollment in the Medicaid Program does not mandate them to render services to all Medicaid beneficiaries who request care. However, no person shall be denied benefits or be subject to discrimination based on race, color, national origin, age, sex, religion or handicap.
- ◆ to have access to the Telephone Verification System for information on beneficiary eligibility status through MEVS or by calling 1-800-997-1111;
- ◆ that within its capacity the Medicaid Program will make reasonable response to requests for assistance in all aspects of the program;
- ◆ assistance in researching claim denials or billing problems through the fiscal agent;
- ◆ that all patient records submitted under their National Provider Identifier (NPI)/MMIS # will be treated as confidential; and
- ◆ to be afforded the right to a hearing if the Department determines that they have engaged in unacceptable practices.

Practitioner Telephone Reference Guide for New York State Medicaid

CONTACTS	DESCRIPTION	TELEPHONE NUMBER(S)
Computer Science Corporation – Fiscal Agent for Medicaid		
Provider Relations	All billing problems regarding: UT's, pend/denied claims, claim status, etc.	(800) 343-9000
Threshold Override Applications	Used to increase service limits for a beneficiary	(800) 343-9000
On-Site Visits	To arrange billing seminars with regional staff	(800) 343-9000
Department of Health		
Billing	NYS review for pend/denied claims	(800) 342-3005 or (518) 473-4029
Co-Payments	Beneficiaries financial responsibility towards medical services	(518) 473-2160 (800) 343-9000
Eligibility for Beneficiaries		Beneficiary's County
MEVS (Medicaid Eligibility Verification System)	Phone Verification Help Desk	(800) 997-1111 (800) 343-9000
Enrollment	Issues for providers regarding: address changes, specialties, status of application, locator code changes, etc.	(800) 343-9000
Fraud (to report a case of suspected fraud)	Provider: Beneficiary – Upstate/New York City	(518) 486-9057 (877) 873-7283
Managed Care	PCP's/HMO's	(800) 206-8125
MANS (Medicaid Automated Name Search)	Used to locate a beneficiary's ID # and for provider check amounts	(518) 447-9504
Prior Approval		(800) 342-3005 or (518) 474-8161
QMB (Qualified Medicaid Beneficiary)	Limited Medicaid payments for approved Medicare services	Refer to Local County DSS
Restricted Recipient		(518) 474-6866
Unresolved Issues/General Medical Policy Inquiries		(518) 473-2160

MEDICAID PROVIDER ENROLLMENT PODIATRIST FORM CHECKLIST

THE FOLLOWING INFORMATION MUST BE PROVIDED TO PROCESS YOUR ENROLLMENT APPLICATION.

FAILURE TO SUBMIT REQUIRED INFORMATION MAY RESULT IN YOUR APPLICATION BEING RETURNED TO YOU AND WILL DELAY THE ENROLLMENT PROCESS.

REQUIRED FIELDS TO BE COMPLETED ON THE ENROLLMENT FORM

- TYPE OF APPLICATION*
- NATIONAL PROVIDER IDENTIFIER (NPI)
- SOCIAL SECURITY NUMBER
- CORRESPONDENCE ADDRESS
- PAY TO ADDRESS
- SERVICE ADDRESS
- TYPE OF PRACTICE
- PLACE OF SERVICE
- MEDICARE INFORMATION
- ALL YES/NO QUESTIONS MUST BE ANSWERED**
- PROVIDER'S ORIGINAL SIGNATURE

*IF REINSTATEMENT IS CHECKED PLEASE SEE REQUIRED DOCUMENTATION ON PAGE 2 OF 2 OF THIS CHECKLIST.

**IF YES ANSWERED TO ANY OF THE FOUR QUESTIONS, YOU MUST COMPLETE THE PRIOR CONDUCT QUESTIONNAIRE AVAILABLE AT WWW.EMEDNY.ORG. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES.

REQUIRED DOCUMENTATION TO BE SUBMITTED

SUBMIT A COPY OF YOUR CURRENT LICENSE/REGISTRATION CERTIFICATE

- NEW YORK STATE PODIATRIST MUST SUBMIT A COPY OF THEIR NYS EDUCATION DEPARTMENT LICENSE/REGISTRATION RENEWAL CERTIFICATE
- OUT OF STATE PODIATRIST MUST SUBMIT A COPY OF THEIR LICENSE DOCUMENTATION FROM THEIR STATE'S LICENSING AGENCY.

DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM

SUBMIT A COPY OF YOUR MEDICARE APPROVAL LETTER

IF YOU ARE REPORTING A FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):

- SUBMIT A COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN.

IF EMPLOYED BY A FACILITY OR CLINIC AND ENROLLING FOR E-PRESCRIBING SUBMIT A WRITTEN STATEMENT TO THAT EFFECT.

SUBMIT THE OFFICE OF MEDICAID INSPECTOR GENERAL (OMIG) PROVIDER COMPLIANCE CONFIRMATION (IF APPLICABLE). FOR MORE INFORMATION, GO TO THE OMIG WEBSITE, COMPLIANCE SECTION AT WWW.OMIG.STATE.NY.US.

IF SALARIED/CONTRACT:

- IF EMPLOYED BY A FACILITY OR CLINIC, ATTACH A WRITTEN STATEMENT FROM THE FINANCIAL DIRECTOR, CLARIFYING IF THE SALARY IS INCLUDED IN THE FACILITY'S MEDICAID RATE.

REINSTATEMENTS

AN APPLICATION IS CONSIDERED TO BE A REINSTATEMENT IF THE APPLICATION WAS PREVIOUSLY EXCLUDED/TERMINATED FROM THE MEDICAID PROGRAM AS A RESULT OF COMMITTING AN UNACCEPTABLE PRACTICE, DISCIPLINE ACTION TAKEN AGAINST THEIR LICENSE, INDICTMENT, CONVICTION OR MEDICARE EXCLUSION.

IF YES ANSWERED TO ANY OF THE FOUR QUESTIONS, YOU MUST COMPLETE THE PRIOR CONDUCT QUESTIONNAIRE AVAILABLE AT WWW.EMEDNY.ORG. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES. IF YOU ANSWER YES TO THE FIRST OF THE YES/NO QUESTIONS BECAUSE YOU WERE EXCLUDED, TERMINATED, SANCTIONED, OR RESTRICTED BY AN AGREEMENT FROM ANY MEDICAID PROGRAM AND/OR MEDICARE PROGRAM YOU MAY BE REQUESTED TO SUPPLY INFORMATION AND/OR DOCUMENTATION DETAILING ALL CORRECTIVE STEPS YOU HAVE TAKEN TO DEMONSTRATE THE VIOLATIONS THAT LED TO YOUR EXCLUSION/TERMINATION WILL NOT BE REPEATED.

EXAMPLES:

- RE-EDUCATION COURSES;
- ATTESTATIONS FROM THIRD PARTY PAYERS;
- REPORTS FROM QUALITY ASSURANCE COMMITTEES REGARDING REVIEW OF RECORDS;
- MEDICARE REINSTATEMENT

PLEASE NOTE:

IF AN APPLICANT IS DENIED REINSTATEMENT, THE APPLICANT CANNOT RE-APPLY FOR REINSTATEMENT FOR TWO (2) YEARS FROM THE DATE OF THE DENIAL.

**INSTRUCTIONS FOR COMPLETING AND SUBMITTING THE MEDICAID PROVIDER
ENROLLMENT APPLICATION**

GENERAL INSTRUCTIONS

- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- Forms containing white out will be rejected.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not use staples.
- When including attachments less than 8 ½ “ x 11” in size, affix the attachment (using transparent single-sided tape) to an 8 ½” x 11” sheet of paper. When required attachments are greater than 8 ½ “ x 11” in size, make a reduced copy of the attachment using an 8 ½ “ x 11” sheet of paper.
- Double-sided forms will be rejected.

**MEDICAID PROVIDER ENROLLMENT
PODIATRIST FORM INSTRUCTIONS**

- PROVIDER NUMBER:** Leave blank.
- APPLICATION TYPE:** This field must be completed. (See Required Documentation on page 2 of the Checklist.)
- APPLICANT NAME:** Enter the name exactly as it appears on your license/registration; that is **last name, first name**.
- DOING BUSINESS AS:** If applicable.
- NATIONAL PROVIDER IDENTIFIER (NPI)** Enter your NPI.
- FEDERAL EMPLOYER ID NUMBER:** If the Department of Treasury, Internal Revenue Service letter is issued to you, please attach a copy. The Federal Employer Identification Number (FEIN) can only be put on your file if the government issued tax certificate is issued in your name. It cannot be put on the file if the FEIN is issued in a company's or group's name.
- SOCIAL SECURITY NUMBER:** This is a **mandatory** field.
- CORRESPONDENCE ADDRESS:** Enter the address where all correspondence and claim forms will be sent. A street address is required to accommodate shipment of bulk material.
- Attention Line: Use this only if the name or person who will receive the mail is different than the podiatrist's or for an apartment/suite number or building location.
- Street: Cannot be a P.O. Box unless accompanied by an actual street

PAY TO ADDRESS: If you request that your checks be sent to an address other than the correspondence address, complete this section. This may be a P.O. Box. If you want your Medicaid checks to be sent to your correspondence address, write "SAME".

SERVICE ADDRESS: This address must be a street. Write "SAME" if the service address is the same as the correspondence and pay to address. If services are provided at more than one location, complete EMEDNY-490101 **Additional Service Addresses**.

CORPORATE ADDRESS INFORMATION Supply this information if this NPI is associated with a corporate entity which sponsors other Medicaid services enrolled under other NIP(s). **NOTE:** Annual tax documents will be sent to this address. If you previously enrolled an NPI with this FEIN, the address on file for the FEIN will be duplicated here. If this is the first NPI you are reporting for this FEIN and this field is left blank, the address you supplied as the Pay-To address will be duplicated here.

LICENSING INFORMATION: Enter your license number. **Attach a copy of your current license/registration renewal certificate.**

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBER: If you are licensed to prescribe or dispense controlled substances, enter the DEA number. **Attach a copy of the certificate.**

MEDICARE INFORMATION: All Podiatrists who enroll in the Medicaid Program to receive Medicaid payments, as appropriate for Medicare coinsurance and the deductible, **MUST** provide proof of enrollment in Medicare. Proof will consist of a copy of your Medicare award letter. .

TYPE OF PRACTICE: For each service address, check the box from the list which describes your type of practice at that address.

- | | |
|---------------|-------------|
| 1. Individual | 3. Salaried |
| 2. Group | 4. Contract |

PLACE OF SERVICE: For each service address, check the box from the list which describes the site.

- | | |
|--------------------------|------------------------------------|
| 1. Private Office | 4. Health Maintenance Organization |
| 2. Hospital/Nursing Home | 5. Shared Health Facility |
| 3. Free Standing Clinic | |

YES/NO QUESTIONS: It is **mandatory** that all 4 questions be answered.

If yes answered to any of the four questions, you must complete the Prior Conduct Questionnaire available at www.eMedNY.org. You are required to provide documentation and/or details explaining the circumstances.

GROUP/ORGANIZATION:

If you are applying to be a member of a group currently enrolled in the New York State Medicaid program, enter the Provider Name, Provider # and National Provider Identifier of the group.

EMAIL ADDRESS:

Enter your email address if applicable.

SIGNATURE OF PROVIDER:

Providers must **personally sign** and **date** the enrollment form acknowledging the attestation statement. **Signature stamps, photocopies, etc. are not acceptable.**

PERSONAL PRIVACY LAW:

The State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting the information and how we will use it.

The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities.

This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider.

The information will be maintained by:

New York State Department of Health
Office of Health Insurance Programs
Division of Provider Relations and Utilization
Management
Fee for Service Provider Enrollment Bureau
150 Broadway, Suite 6E
Albany, NY 12204

PODIATRIST
CATEGORY OF SERVICE 0500

MEDICAID PROVIDER ENROLLMENT

MAIL TO: Computer Sciences Corporation
P.O. Box 4603
Rensselaer, NY 12144

PROVIDER NUMBER (LEAVE BLANK)

APPLICANT NAME

NATIONAL PROVIDER IDENTIFIER (NPI)

FEDERAL EMPLOYER ID NO.

SOCIAL SECURITY NUMBER (REQUIRED)

APPLICATION TYPE
 New Enrollment/Reactivation
 Reinstatement (See definition on pg 2 of checklist)

CORRESPONDENCE ADDRESS (CLAIM FORMS AND MAIL)

ATTENTION STREET - LINE 1

ATTENTION STREET - LINE 2

CITY

STATE ZIP CODE COUNTY

TELEPHONE () - EXT.

LICENSING INFORMATION - Attach Copy

LICENSE #

AGENCY CODE NYS (03) Out-of-State (99)

DEA Attach Copy

PAY TO ADDRESS (CHECKS AND REMITTANCES STATEMENTS)

STREET - LINE 1

STREET - LINE 2

CITY

STATE ZIP CODE COUNTY

MEDICARE INFORMATION

You must submit a copy of your Medicare Award Letter.

TYPE OF PRACTICE (CHECK ONE)

Individual (1) Salaried (3)
 Group (2) Contract (4)

If employed by a facility or clinic, attach a written statement from the financial director, clarifying if the salary is included in the facility's Medicaid rate.

SERVICE ADDRESS INFORMATION

ATTENTION STREET - LINE 1

ATTENTION STREET - LINE 2

CITY

STATE ZIP CODE COUNTY

TELEPHONE () - EXT.

PLACE OF SERVICE (Check ONE)

Private Office (1) Health Maintenance Organization (4)
 Hospital, Nursing Home (2) Shared Health Facility (5)
 Free Standing Clinic (3)

CORPORATE ADDRESS INFORMATION

Supply this information if this NPI is associated with a corporate entity which sponsors other Medicaid services enrolled under other NPI(s). Note: Annual tax documents will be sent to this address. If you previously enrolled an NPI with this FEIN, the address on file for the FEIN will be duplicated here. If this is the first NPI you are reporting for this FEIN and this field is left blank, the address you supplied as the Pay To address will be duplicated here.

ENTER THE NAME EXACTLY AS IT APPEARS ON THE FEIN DOCUMENTATION

ATTENTION LINE (TITLE OR DEPARTMENT NAME ONLY - EXAMPLE "CFO" OR "ACCOUNTING OFFICE")

STREET ADDRESS - LINE 1

STREET ADDRESS - LINE 2

CITY - DO NOT USE ABBREVIATIONS COUNTY

STATE ZIP CODE TELEPHONE () - EXT.

ATTESTATION: The signature on my application acknowledges that I have read and agree to comply with the practices, issues and concepts discussed in the "Introduction to the New York State Medicaid Program" and the information contained within the application is true and accurate.
 I swear that the information that I have provided is true and accurate to the best of my knowledge.

QUESTIONS

YES NO

Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?

Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?

Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, or any way restricted by probation or agreement by any licensing authority in any State?

Is there currently pending any proceedings that could result in the above stated sanctions?

PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED) DATE SIGNED

GROUP/ORGANIZATION MEDICAID PROVIDER NUMBER AND NATIONAL PROVIDER IDENTIFIER (NPI)

GROUP/ORGANIZATION PROVIDER NAME

EMAIL ADDRESS

PREPARER NAME & TITLE (PRINT) TELEPHONE #

New York State Medicaid Disclosure of Ownership and Control – Individual

Note

- The following questions do NOT only pertain to this provider application but include any and all past activity.
- Respond to these questions on behalf of yourself and any individuals or organizations having a direct or indirect ownership or control interest of 5% or more, and any partners, directors, officers, agents or managing employees of the named provider completing this form.

Questions

1. Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?
 Yes No
2. Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?
 Yes No
3. Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any state?
 Yes No
4. Is there currently pending any proceedings that could result in the above stated sanctions?
 Yes No
5. Do you or your spouse, parent, child, or sibling have any direct or indirect ownership or a controlling interest of 5% or more in any organizations, agencies, institutions, or other entities?
 Yes No
 - If “Yes”, complete the rest of this form and submit with your application;
 - If “No”, sign and date this form and submit with your application.

Organization/Agency/Institution/Entity Legal Name and all d/b/as Address, and FEIN, Medicaid # or NPI Owned/Controlled by whom (state relationship to you)

Entity’s Legal Name _____

Address _____

City _____ State _____ Zip _____

Employer Identification # _____ Medicaid or NPI # _____

Controlled by _____ Relationship _____
Last First

Entity's Legal Name _____
Address _____
City _____ State _____ Zip _____
Employer Identification # _____ Medicaid or NPI # _____
Controlled by _____ Relationship _____
Last First

Entity's Legal Name _____
Address _____
City _____ State _____ Zip _____
Employer Identification # _____ Medicaid or NPI # _____
Controlled by _____ Relationship _____
Last First

List names, addresses social security numbers for individuals (Owners, Trustees, Board of Directors) and the FEIN (Federal Employer Identification Number) for each organization in which you, your spouse, parent, child, or sibling has a direct or indirect ownership or a controlling interest of 5% or more in each above named agency, institution or organization. If nonprofit or government related, attach a list of the board of directors, commissioners or other persons in authority. If more than one individual is reported and any of these persons are related to another as spouse, parent, child, or sibling, attach a separate sheet listing these individuals and their relationship to each other.

Name _____
Last First MI
Address _____
Social Security # _____ Employer Identification # _____
Relationship _____

Name _____
Last First MI
Address _____
Social Security # _____ Employer Identification # _____
Relationship _____

Name _____
Last First MI
Address _____
Social Security # _____ Employer Identification # _____
Relationship _____

6. Type of entity
- Sole Proprietorship Unincorporated Association
- Corporation Governmental
- Partnership Other (Specify) _____

7. Has there been a change of ownership or control within the last 12 months to any of the above entities?

Yes No

If "Yes," provide both: _____ / _____ / _____

MM / DD / YYYY

Medicaid # or National Provider Identifier (NPI) _____

8. Do you anticipate a change of ownership within the next 12 months to any of the above entities?

Yes No

If "Yes," give date _____ / _____ / _____

MM / DD / YYYY

9. Do you currently have any unpaid balances owed to the Medicaid Program?

Yes No

If "Yes," indicate amount \$ _____

o Has payment been arranged?

Yes No

If "Yes," please attach verification of this.

As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, www.health.state.ny.us.

In addition, pursuant to 42 CFR §455.105, by enrolling in the Medicaid Program, you are entering into an agreement with the NYS Department of Health by which you agree to and may be requested to provide the following information within 35 days upon request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request; and
2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or Secretary of Health and Human Services, as appropriate.

Name & Title (printed)

Signature (No stamps)

Date

MAIL TO:

**MEDICAID PROVIDER ENROLLMENT
ADDITIONAL SERVICE ADDRESS**

COMPUTER SCIENCES CORPORATION
P.O. BOX 4603
RENSSELAER, NY 12144

PROVIDER ID# [_____]

NATIONAL

PROVIDER

IDENTIFIER [_____]

APPLICATION

MM/DD/YY

DATE

[____ / ____ / ____]

CATEGORY OF SERVICE

[_____]

APPLICANT

NAME [_____]

SERVICE ADDRESS INFORMATION

ATTENTION [_____]

ADDRESS-1 [_____]

ADDRESS-2 [_____]

This MUST be a physical location, NOT a P.O. Box

CITY [_____]

Do NOT use abbreviations

ZIP

STATE [____] **CODE** [____ - ____] **COUNTY** _____

TELEPHONE [(____) - _____ **EXT** _____]

OFFICE BASED SURGERY

TYPE OF PRACTICE (Check ONE)

Individual (1)

Salaried (3)

Group (2)

Contract (4)

PLACE OF SERVICE (Check ONE)

Private Office (1)

Hospital/Nursing Home (2)

Free Standing Clinic (3)

Health Maintenance Org. (4)

Shared Health Facility (5)

SERVICE ADDRESS INFORMATION

ATTENTION [_____]

ADDRESS-1 [_____]

ADDRESS-2 [_____]

This MUST be a physical location, NOT a P.O. Box

CITY [_____]

Do NOT use abbreviations

ZIP

STATE [____] **CODE** [____ - ____] **COUNTY** _____

TELEPHONE [(____) - _____ **EXT** _____]

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STATE [____] **CODE** [____ - ____] **COUNTY** _____

TELEPHONE [(____) - _____ **EXT** _____]

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