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.**

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 allows 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
Clinical Psychologist
EMEDNY-417101 (08/09)

MEDICAID PROVIDER ENROLLMENT
CLINICAL PSYCHOLOGIST 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
- ALL YES/NO QUESTIONS MUST BE ANSWERED**
- MEDICARE INFORMATION
- CLINICAL PSYCHOLOGIST'S ORIGINAL SIGNATURE

*IF REINSTATEMENT IS CHECKED PLEASE SEE REQUIRED DOCUMENTATION ON PAGE 2 0F 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 CLINICAL PSYCHOLOGISTS MUST SUBMIT A COPY OF THEIR NYS EDUCATION DEPARTMENT LICENSE/REGISTRATION.RENEWAL CERTIFICATE

OUT OF STATE CLINICAL PSYCHOLOGISTS MUST SUBMIT A COPY OF THEIR LICENSE DOCUMENTATION FROM THEIR STATE'S LICENSING AGENCY.

DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM

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.

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.

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
CLINICAL PSYCHOLOGIST ENROLLMENT 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 provider 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 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 clinical psychologist or for an apartment/suite number or building location.

Street: Cannot be a P.O. Box unless accompanied by an actual street address.

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 is where you render services. If the service address is the same as the correspondence address write “SAME”. 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 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.

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

MEDICARE INFORMATION: Indicate whether you are enrolled in Medicare.

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

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

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

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

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.

YES/NO QUESTIONS: It is **mandatory** that all four (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.

EMAIL ADDRESS: Enter your Email address if applicable.

SIGNATURE OF PROVIDER: Providers must **personally sign** and **date** the enrollment form. **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

CLINICAL PSYCHOLOGIST
CATEGORY OF SERVICE 0580

MEDICAID PROVIDER ENROLLMENT

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

PROVIDER NUMBER (LEAVE BLANK)

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

APPLICANT NAME
NAME EXACTLY AS IT APPEARS ON YOUR LICENSE/REGISTRATION

YOUR D/B/A NAME OR ANY OTHER NAME THAT THE COMPANY IS KNOWN BY

NATIONAL PROVIDER IDENTIFIER (NPI)
FEDERAL EMPLOYER ID NUMBER
SSN (REQUIRED)

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION
Enter the NAME of the person/department/apartment number where the mail should be sent
ADDRESS - LINE 1
- LINE 2
Cannot be a Post Office Box UNLESS accompanied by an actual street address
CITY
Do NOT use abbreviations
STATE ZIP CODE - COUNTY
TELEPHONE ( ) - EXT.

PAY TO ADDRESS (Checks and Remittance Statements)

ADDRESS - LINE 1
- LINE 2
CITY
Do NOT use abbreviations
STATE ZIP CODE - COUNTY

SERVICE ADDRESS INFORMATION

ATTENTION
ADDRESS - LINE 1
- LINE 2
(This MUST be a physical location, NOT a P.O. Box)
CITY
Do NOT use abbreviations
STATE ZIP CODE - COUNTY
TELEPHONE ( ) - EXT.

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.

LICENSING INFORMATION - Attach Copy

LICENSE No.

AGENCY CODE
☐ NYS Clinical Psychologist (03)
☐ Out-of-State Clinical Psychologist (99)

MEDICARE INFORMATION

Are you enrolled in Medicare? ☐ Yes ☐ No

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.

PLACE OF SERVICE (Check ***ONE***)

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

GROUP/ORGANIZATION MEDICAID PROVIDER NUMBER

NATIONAL PROVIDER IDENTIFIER (NPI)

GROUP/ORGANIZATION PROVIDER NAME

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, surrendered, 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?

EMAIL ADDRESS

I swear that the information that I have provided is true and accurate to the best of my knowledge.

PROVIDER SIGNATURE **(ORIGINAL SIGNATURE REQUIRED)** DATE SIGNED PREPARER NAME & TITLE (PRINT) TELEPHONE #

Mail To: Computer Sciences Corporation
P.O. Box 4603
Rensselaer, NY 12144 – 4603

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 $__________________________

- 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 DATE MM/DD/YY [__/__/__]

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

STATE [____] ZIP 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

STATE [____] ZIP 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

STATE [____] ZIP CODE [_______-_______] COUNTY _______

TELEPHONE [( ) - EXT]

OFFICE BASED SURGERY ☐

TYPE OF PRACTICE (Check ONE)
☐ Individual (1) ☐ Salaried (3)
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PLACE OF SERVICE (Check ONE)
☐ Private Office (1)
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☐ Free Standing Clinic (3)
☐ Health Maintenance Org. (4)
☐ Shared Health Facility (5)