INSTRUCTIONS FOR COMPLETING THE NY MEDICAID ENROLLMENT FORM FOR SERVICE BUREAU

1. General Instructions:

- Complete ALL items on the form unless otherwise instructed below. Failure to complete all required fields will result in your enrollment form being returned to you which may have an impact on the enrollment effective date.
- Required document (see #3 below) MUST cover the application date and be continuous through the current date.
- Completion of signature field is required and must be original. Initials or rubber stamped signatures will not be accepted.
- Type or legibly print in black or blue ink. Do not use red ink, nor white-out. All attachments will be scanned so they must be legible and on standard 8 ½ x 11 paper in good condition.
- Keep a copy of all documents submitted.

2. Additional Instructions and Definitions for Form Completion:

Choose only ONE of the following options & check the corresponding box on the top of the Enrollment Form

- ✓ *Check Billing Provider- If the applicant/provider intends on Billing NYS Medicaid*
- ✓ *Check Managed Care Only (Non Billing)- If the applicant/provider is contracted with a Managed Care and is required to enroll with NYS Medicaid per the 21st Century Cures Act.*

Category(s) of Service: Enter the following 4-digit code on the Enrollment Form: **0080**

Choose ONE and check the corresponding box on the Enrollment Form:

- ✓ *Check New Enrollment if the Applicant is not currently enrolled in NYS Medicaid*
- ✓ *Check Revalidation if the Provider is currently enrolled and you were notified that Revalidation is required per 42 CFR, Part 455.414. The Provider ID can be found on the Revalidation Letter you received*
- ✓ *Check Reinstatement/Reactivation if the provider was previously enrolled but is not currently active. Please note: You will be at financial risk if you render services to Medicaid beneficiaries before successfully completing the enrollment process.*

NPI: Leave Blank

License # Fields: Leave Blank

DBA Name: If appropriate

DEA Number & Dates: Leave Blank

Association Types: Enter the letter (B, F, H, M, P or U) which best corresponds to the individual's role:

B: Board of Directors Member	F: Facility Administrator	H: Compliance Officer
M: Managing Employee	P: Supervising Pharmacist	U: Laboratory Director

3. ADDITIONAL REQUIREMENTS

S**ee 18NYCRR,Section 504.9 Service bureaus, billing services and electronic media billers (attached)**

OMIG Provider Compliance Certification – Confirmation notice for the OMIG Provider Compliance Program may be required. Visit www.omig.ny.gov to determine if the Applicant / Provider must comply. If yes, a copy of the confirmation notice (printed from the website) must be included with this application.

42 CFR, Part 455.460 requires the collection of an application fee for a new enrollment, revalidation, change of ownership and reinstatement/reactivation. Click here for more information.

REQUIRED DOCUMENTS TO BE SUBMITTED WITH THIS FORM:

- IRS Assignment Letter indicating the FEIN and Applicant Name on the Enrollment Form (W-9 NOT ACCEPTABLE). IRS Assignment Letter (Form: SS-4) can be obtained by going to IRS.Gov or call IRS at 1-800-829-4933.
- Application Fee
- ETIN Certification Statement for New Enrollments Form (EMEDNY-490602) (not required for revalidation or reinstatement/reactivation, or if you are enrolling as a Managed Care Only non-billing provider)

504.9 Service bureaus, billing services and electronic media billers.

(a)(1) Persons submitting claims, verifying client eligibility or obtaining service authorizations for or on behalf of providers, except those individuals employed by providers enrolled in the medical assistance program, must enroll in the medical assistance program in accordance with this Part and must meet the appropriate additional requirements set forth in this section. However, payment may be made only to the provider of the medical care, services or supplies; or in accordance with a reassignment from a provider to a government agency or reassignment by court order; or to an employer of a practitioner, if the practitioner is required as a condition of his/her employment to turn over his/her fees to the employer; or to a facility or a foundation, plan or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the facility or organization submits the claims; or to a business agent, including a service bureau, billing service, or accounting firm, if the payment is made in the name of the provider and the agent's compensation for the services is related to the cost of processing the claim, is not related on a percentage or other basis to the amount billed or collected, and is not dependent upon collection of the payment.

(2) Providers submitting their claims by means of electronic/magnetic media (computer tape, disks, etc.) must also meet the requirements of this section in order to be eligible to submit their claims by such media.

(b) Service bureaus must maintain a system approved by the department for notifying providers of the claims to be submitted on their behalf. Prior to submission to the department, claim submissions must be reviewed by the provider of the care, services or supplies in order that the provider may correct any inaccurate claims, delete improper claims or otherwise revise the intended submission to ensure that only claims for services actually provided, due and owing are submitted.

(c) Service bureaus must submit systems documentation to the department for the systems configuration which they will be using to process claims prior to acceptance of their enrollment application. Such documentation must be revised as necessary to assure its accuracy. The department will not disclose any proprietary software, firmware or other systems component of a proprietary nature to any person other than another governmental agency as may be required for the efficient administration of the program.

(d) Service bureaus must meet the processing standards established by the department and its fiscal intermediary and satisfactorily perform claims submissions based upon a test claim provided by the department or its fiscal intermediary prior to acceptance of their enrollment applications.

(e) Service bureaus must enter into an electronic/magnetic billing agreement with the department or its fiscal intermediary, establishing the rights and obligations of the service bureau, the provider and the department, prior to acceptance of any claims from the service bureau. Such agreements will include provisions for liability in case of errors, submission criteria, record retention requirements, data integrity, confidentiality of client data, and audit requirements.

(f) Client identifying data may not be used by any service bureau, provider, or any person verifying eligibility or obtaining service authorizations on behalf of a provider for any purpose other than claiming for medical care, services or supplies actually furnished to the client, or verifying client eligibility or obtaining service authorizations or another valid purpose directly related to the administration of the medical assistance program, and may not be released or disclosed to any person or entity other than the department, the State Medicaid Fraud Control Unit or the Federal Department of Health and Human Services without express written authorization of the department.

(g) Any provider desiring to submit claims, verify client eligibility, or obtain service authorizations for or on behalf of any other provider must enroll as a service bureau in addition to enrolling as a provider of medical care, services or supplies.

(h)(1) A Qualified Health Information Technology Entity, as defined in paragraph (2) of this subdivision, seeking access to medical assistance information must enroll in the medical assistance program in accordance with this Part and must meet the appropriate additional requirements set forth in this section.

(2) Qualified Health Information Technology Entities, which may include but are not limited to regional health information organizations (RHIOs), are entities to whom recipient-specific medical assistance information is released, with the consent of the medical assistance recipient, for the purpose of sharing such information with one or more of its members that are providing medical care, services, or supplies to such recipient. The release of such information is intended to improve the quality of care delivered to medical assistance recipients, reduce the occurrence of medically adverse events, and reduce costs through better coordination of care.

(3) As a condition of enrollment and of receipt of medical assistance information pursuant to this subdivision, Qualified Health Information Technology Entities must develop and maintain policies and procedures:

(a) to ensure that informed consent is obtained from medical assistance recipients for the release of confidential information;

(b) to handle and safeguard confidential information in compliance with all applicable federal and state laws and regulations; and

(c) to ensure that their members comply with all applicable federal and state laws and regulations regarding confidential information.