PRIOR CONDUCT QUESTIONNAIRE

Confidential Information

ADDITIONAL QUESTIONS REGARDING PRIOR CONDUCT

All responses must be thorough and complete. If there is not sufficient space available for a response, you may attach additional sheets to this form. Failure to fully respond or to provide accurate and detailed information can result in a delay in the processing of your application or can result in the denial of your request for enrollment or reinstatement request.

Please Note: For those entering information through Adobe Reader, character restrictions exist for lines requiring details, when a limit is met please Tab to the next line and continue your explanation.

Applicant Name:_____

New York State Provider ID #:_____ NPI #:_____

I. A. Prior Medicare History (Federal Program, Title XIX)

1. Have you ever been excluded, terminated and/or suspended by Medicare?

   Yes☐ No☐

   If yes:

   (a) Date of exclusion, termination or suspension. ____/____/____
   MM / DD / YY

   (b) Cause of exclusion, termination or suspension (you must be specific and provide full details).
   _____

   _____

   (c) Were you reinstated? Yes☐ No☐

   If yes, provide a copy of your reinstatement letter.

2. Have you ever been restricted by agreement or sanctioned by Medicare which did not result in a exclusion, termination or suspension?

   Yes☐ No☐

   (a) Identify date and type of action. _____

   _____

   (b) Identify reason for restriction or sanction. _____

   _____

   (c) Are you currently participating in Medicare without any restrictions or sanctions?

   Yes☐ No☐

   (d) Date the restriction or sanction ended? ____/____/____
   MM / DD / YY

B. Prior Medicaid History (State Program, Title XVIII)

1. Have you ever been excluded, terminated and/or suspended by Medicaid in any state?

   Yes☐ No☐

   If yes:

   (a) Date of exclusion, termination or suspension. ____/____/____
   MM / DD / YY

   (b) Cause of exclusion, termination or suspension (you must be specific and provide full details).
   _____

   _____

   (c) Were you reinstated? Yes☐ No☐

   If yes, provide a copy of your reinstatement letter.

2. Have you ever been denied enrollment by Medicaid in any state?

   Yes☐ No☐

   If yes:

   (a) Identify state(s), date of denial and reason. _____

   _____

   (b) Submit a copy of your denial letter.

3. Have you ever been restricted by agreement or sanctioned by Medicaid which did not result in an exclusion, termination or suspension?

   Yes☐ No☐

   (a) Identify date and type of action. _____

   _____

   (b) Identify reason for restriction or sanction. _____

   _____

   (c) Are you currently participating in Medicare without any restrictions or sanctions?

   Yes☐ No☐

   (d) Date the restriction or sanction ended? ____/____/____
   MM / DD / YY

II. A. 1. Have you ever been convicted of stealing from any federally or state funded Medicaid/Medicare Program? (Medicaid/Medicare Fraud)

Yes☐ No☐

If yes:

(a) What was the date and location of the conviction? _____

(b) What were the causes that resulted in the conviction? _____

_____

(c) Provide a copy of your conviction papers.

(d) Are you currently on probation?

Yes☐ No☐

If yes, provide a copy of your probation papers and a current status report.

B. 1. Have you ever been convicted of public assistance or welfare fraud?

Yes☐ No☐

If yes:

(a) Identify the state and date of the conviction. _____

(b) What penalty was imposed as a result of the conviction? _____

_____

C. 1. Have you ever been convicted of any crime relating to the furnishing of or billing for medical care, services or supplies or which is considered an offense involving fraud, theft, against public administration, or against public health and morals, other than previously listed on this form?

Yes☐ No☐

If yes:

(a) Identify the state(s) and date of conviction. _____

(b) What penalty was imposed as a result of the conviction? _____

_____

III. A. 1. Has your medical license or registration ever been revoked and/or suspended in any state?

Yes☐ No☐

If yes:

(a) Identify the state(s) and the date of revocation and/or suspension. _____

_____

(b) Identify the causes for the revocation and/or suspension. _____

_____

(c) Has your license been restored? Yes☐ No☐

(d) Date your license was restored. ____/____/____
MM / DD / YY

(e) Are you currently on probation? Yes☐ No☐

(f) Date you expect probation to end. ____/____/____
MM / DD / YY

B. 1. Has your medical license or registration ever been surrendered in any state?

Yes☐ No☐

If yes:

(a) Identify state(s) and date your license was surrendered. _____

(b) Identify the reason you surrendered your license. _____

_____

(c) Date your license was re-issued. ____/____/____
MM / DD / YY

C. 1. Has your license and/or registration ever been placed on probation or have you entered into any type of agreement by any licensing authority in any state?

Yes☐ No☐

If yes:

(a) Identify state(s) and date(s) of action. _____

(b) Identify reason for the action. _____

_____

(c) List any restrictions placed on your license. _____

_____

(d) If currently on probation, attach a letter which indicates you are currently in compliance with all terms of your probation.

IV. A. 1. Are there any pending proceedings that could result in any sanction in any state? listed below: Yes☐ No☐

If yes:

(a) Identify all sanctions that may result from the pending action:

Medicare:

_____ termination from Medicare
_____ denial of enrollment by Medicare
_____ suspension from Medicare
_____ restriction by agreement from Medicare
_____ conviction of Medicare fraud

Medicaid:

_____ termination from Medicaid
_____ denial of enrollment by Medicaid
_____ suspension from Medicaid
_____ restriction by agreement from Medicaid
_____ conviction of Medicaid fraud

Other:

_____ conviction for stealing
_____ conviction for welfare fraud or public assistance fraud
_____ license or registration revoked
_____ license or registration suspended
_____ license or registration surrendered
_____ license or registration restricted by probation
_____ license or registration restricted by agreement

B. 1. Expected date in which a decision should be rendered.

_____/_____/_____
MM / DD / YY

I certify that the answers provided are correct.

Full name (please print):_____
First Middle Last

_____
Provider Signature Date MM / DD / YY