ATTENTION

MEDICAID PREFERRED PHYSICIANS AND CHILDREN PROGRAM (PPAC)

NURSE PRACTITIONER APPLICANTS TO PPAC

MUST COMPLETE THIS APPLICATION TO ENROLL IN THE PPAC PROGRAM.

Instructions:

1. Type or print the information in the space provided.
2. Submit a copy of your current RN license registration and Nurse Practitioner Certification.
3. Attach required documentation.
4. Sign and date ASSURANCES.
5. Submit completed application and required documentation to:
   eMedNY
   P.O. Box 4610
   Rensselaer, NY 12144

SECTION A - IDENTIFYING INFORMATION

1. LAST NAME:_____
   FIRST NAME:_____ MIDDLE INITIAL _____
2. LICENSE NUMBER:_____ STATE:_____
3. PLEASE COMPLETE THIS QUESTION IF YOU ARE AN ENROLLED MEDICAID PROVIDER.
   NATIONAL PROVIDER IDENTIFIER (NPI):_____ MMIS _____

SECTION B - PRACTICE INFORMATION

4. List below the name and NPI number of the PPAC physician(s) with whom you have a collaborative agreement(s):

NAME	NPI/MMIS#
_____	_____/_____
_____	_____/_____
_____	_____/_____

5. List below the addresses of all the places where you have provided services to Medicaid Recipients:

_____
_____
_____

ATTACH ADDITIONAL SHEETS IF NECESSARY

SECTION C - ASSURANCES

6. I recognize that I continue to be bound by the rights, obligations, duties or interests accrued, incurred or conferred as a result of my enrollment in the New York State Medicaid program.

7. As a preferred primary care nurse practitioner I assure the provision of comprehensive medical care services to Medicaid patients below the age of twenty-one years, in accordance with generally accepted standards of medical practice and, for well visits, in accordance with the requirements of the Child/Teen Health Plan.

8. As a preferred primary care nurse practitioner I agree to provide medical care coordination as part of my care, such medical care coordination to include at a minimum: the scheduling of elective hospital admissions; where possible, assistance with emergency admissions; management of and/or participation in hospital care and discharge planning; scheduling of referral appointments with written referral as necessary and with request for follow-up report; scheduling for necessary ancillary services; telephone notification of the Medicaid patient's local department of social services when transportation services are necessary to insure access to health care; and the maintenance of a complete medical record to include but not be limited to notation of referrals and hospitalizations, and copies of test results and reports.

9. I assure that patients with Medicaid will be free to choose their primary care physician or nurse practitioner and will be free to choose, from among qualified providers, the specialist to whom they will be referred.

10. As a primary care nurse practitioner I assure that I will maintain twenty-four hour telephone coverage, which will include timely access to a practitioner qualified to respond to the Medicaid patient's health concerns. I recognize that this requirement cannot be met by a recording referring patients to the emergency room.

11. I assure that I will request as necessary from the NYS Department of Health, and display conspicuously on my premises, designated informational materials that serve to inform the public regarding Medicaid eligibility and services for persons under twenty-one years of age and for pregnant women.

12. I assure that I will notify the NYS Department of Health within thirty (30) days of circumstances resulting in my **ineligibility** to continue this agreement and/or my **inability** to perform the activities and services required under this agreement.

13. I recognize that the State may determine new visit types and rates during the term of this agreement and that the new visit types and rates may supersede those available at the time of this agreement.

14. I assure that I will abide by all reasonable policies, procedures, and instructions provided by the State to implement and execute the Preferred Physicians and Children Program, and will bill Medicaid in accordance with the reimbursement methodology established by the State.

15. I recognize that the New York State Department of Health may cancel my participation in the Preferred Physicians and Children Program at any time, giving me not less than thirty (30) days written notice that on or after the date therein specified, my participation will end. I accept that cause for cancellation of my participation in the Preferred Physicians and Children Program will include but not be limited to my failure to comply with these assurances, including but not limited to failure to accurately bill Medicaid under the reimbursement methodology established.

16. I recognize that I may request cancellation of my participation in the Preferred Physician and Children Program when there are extenuating circumstances, giving to the NYS Department of Health not less than thirty (30) days written notice. I assure that such cancellation will include a description of the basis for the request. I agree to continue to provide and/or arrange services for currently served patients up to the date of termination. I assure that I will assist patients to maintain continuity of care; provide them with information to assist them to transfer their care; and make timely transfer of their records upon request.

17. I accept that upon my designation by the New York State Department of Health to participate in the Preferred Physician and Children Program, these Assurances will be effective and may continue in effect thereafter with the consent of both parties and so long as Federal financial participation is available. I accept that services rendered prior to my enrollment will not be eligible for reimbursement through the Preferred Physician and Children Program.

18. PRINT NAME:_____

19. SIGNATURE:_____

20. DATE:_____

SECTION D - COLLABORATING PPAC PHYSICIAN CERTIFICATION

This information must be completed by at least one PPAC physician with whom you have a collaborative agreement.

21. PHYSICIAN'S SIGNATURE:_____

22. NATIONAL PROVIDER IDENTIFIER: _____MMIS # _____

23. DATE:_____