

New York State Medicaid Disclosure Form

Thank you for updating your provider records with the Medicaid Program. As a Medicaid provider, you have agreed to comply with the rules, regulations and official directives of the NYS Department of Health including, but not limited to, Part 504 of 18 NYCRR (i.e., Title 18). Title 18 can be found by choosing the Laws and Regulations link of the Department of Health's website, www.health.ny.gov.

This form must be completed when your organization has a change in managing employee(s) or a change in those with a control interest. If your organization has experienced an ownership change, please use Form EMEDNY-426401.

New York State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting 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 the New York State Department of Health, Office of Health Insurance Programs, Division of OHIP Operations, Bureau of Provider Enrollment, Albany New York.

NOTE: Refer back to this page when identifying managing employees and those with a control interest:

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

**NY MEDICAID DISCLOSURE FORM
for
PHYSICIAN & PRACTITIONER GROUPS**

Mail to:

eMedNY
PO Box 4610
Rensselaer, NY 12144

Effective Date of Change:	FEIN:	NPI :
Provider Name	NY Medicaid ID (if known):	

Completion is required by 18NYCRR, Section 502.5(b) **Failure to provide the information requested may impact your enrollment. Visit www.health.ny.gov to review definitions and policy found at 18NYCRR, Section 504.1 before completing this form.**

Managing Employees & Those with a Control Interest – Including, but not necessarily limited to, the following: All Members of the Board of Directors, Compliance Officer, all Managing Employees (includes general, business and office managers; all persons who exercise operational or managerial control of a provider; all persons who directly or indirectly conduct the day-to-day operations of a provider).

Name (Last, First, Middle)		Association Type (see page 1)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	
Name (Last, First, Middle)		Association Type (see page 1)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	
Name (Last, First, Middle)		Association Type (see page 1)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	
Name (Last, First, Middle)		Association Type (see page 1)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	

{This page may be copied for additional listings}

Respond to these questions on behalf of the Provider, the Owners, and Managing Employees and those with a Control Interest:

- Have any of these individuals/entities been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or in any other State, Medicare, or any other governmental or private medical insurance program?
 Yes No
- Have any of these individuals/entities ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?
 Yes No

