



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 to make you aware of the following factors concerning your potential enrollment as a provider:

- An enrollment application does **not** guarantee enrollment in the Medicaid Program.
- At this time the Department does not enroll mail order pharmacies. Mail order pharmacies are defined as pharmacies which provide more than 15% mail order pharmacy services.
- 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 services to Medicaid patients before successfully completing the enrollment process. Payment will not be made for any claims submitted for service, care or supplies furnished before the enrollment date authorized by the Department.**
- All of the information reported by you on the application will be verified by the Department before your acceptance into the Medicaid Program.
- Enrollments for New York City, Nassau, Rockland, Suffolk and Westchester Counties, out of state, ownership changes, previous terminations and sanctions are subject to further review.
- Subsequent requests for information concerning your application must receive a response within the time frames specified by the Department or your application is subject to termination.
- Enrollment may be denied for failure to accurately or completely disclose information during the application process and for any other factors the Department determines to be applicable.
- All enrolled pharmacies **MUST** participate in the mandatory Prospective Drug Utilization Program (ProDUR) to receive reimbursement. This important ProDUR information and certification requirements (separate from the enrollment requirement) can be accessed online at www.eMedNY.org. Click on Provider Manuals and select the Pharmacy Manual. The ProDur/ECCA Provider Manual is contained in the Pharmacy Manual.

First you will receive an **inactive** prereview letter advising you to use your National Provider Identifier (NPI)/Medicaid Provider #. Please note this letter does not constitute approval in the Medicaid Program. Until you are approved, your NPI/Medicaid Provider # may be used **SOLELY** to allow testing of your software so that you can comply with the mandatory on-line ProDUR.

New York State Medicaid Regulations allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

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.

If you have any questions, please contact the eMedNY Call Center at 1-800-343-9000.

Sincerely,

Fee for Service Provider Enrollment Bureau
Office of Health Insurance Programs

Pharmacy
EMEDNY-409101 (09/09)

**MEDICAID PROVIDER ENROLLMENT
PHARMACY/SUPERVISING PHARMACIST 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

CATEGORY OF SERVICE (COS)	PAY TO ADDRESS
APPLICATION TYPE	SERVICE ADDRESS
APPLICANT NAME	ALL YES/NO QUESTIONS MUST BE ANSWERED**
NATIONAL PROVIDER IDENTIFIER (NPI)	DEA NUMBER IF DISPENSING CONTROLLED SUBSTANCES
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	OWNER'S SIGNATURE
CORRESPONDENCE ADDRESS	

*IF REINSTATEMENT IS CHECKED PLEASE SEE REQUIRED DOCUMENTATION ON PAGE 2 OF 2 OF THIS CHECKLIST.

**IF YES ANSWERED TO ANY OF THE FOUR QUESTIONS, YOU MUST COMPLETE THE "PRIOR CONDUCT QUESTIONNAIRE" AVAILABLE ON THE WWW.EMEDNY.ORG WEBSITE. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES.

REQUIRED DOCUMENTATION TO BE SUBMITTED

MEDICAID PROVIDER ENROLLMENT: PHARMACY FORM	COPY OF DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN
COPY OF CURRENT LICENSE/REGISTRATION	COPY OF THE LEASE
DISCLOSURE OF OWNERSHIP AND CONTROL – BUSINESS ENTITY FORM	COPY OF YOUR DEA CERTIFICATE IF YOU ARE DISPENSING CONTROLLED SUBSTANCES
PHARMACY INFORMATION REQUEST FORM	COPY OF MEDICARE AWARD LETTER
BALANCE SHEET WITH SPECIFIC LINE ITEM ASSET INFORMATION	PERSONAL IDENTIFICATION NUMBER (PIN) REQUEST FORM
HOSPITAL, NURSING HOME, CLINIC BASED PHARMACY QUESTIONNAIRE	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 .

AFTER THE PROVIDER IS ENROLLED AND RECEIVES A PROVIDER ID, AN ELECTRONIC/PAPER TRANSMITTER IDENTIFICATION NUMBER APPLICATION AND A CERTIFICATION STATEMENT (LOCATED AT WWW.EMEDNY.ORG) MUST BE SUBMITTED FOR ELECTRONIC SUBMISSIONS.

SUPERVISING PHARMACIST

- IF NOT CURRENTLY ENROLLED
- MEDICAID PROVIDER ENROLLMENT: SUPERVISING PHARMACIST FORM (EMEDNY-4098)
- SUPERVISING PHARMACIST AGREEMENT FORM (EMEDNY-4099)
- COPY OF SUPERVISING PHARMACIST'S CURRENT LICENSE/REGISTRATION RENEWAL CERTIFICATE
- DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM
- PASSPORT SIZE PHOTO OF THE SUPERVISING PHARMACIST AFFIXED TO A SEPARATE 8 ½" x 11" SHEET OF PAPER WITH SUPERVISING PHARMACIST NAME, SOCIAL SECURITY NUMBER AND NAME OF PHARMACY
- IF CURRENTLY ENROLLED
- SUPERVISING PHARMACIST AGREEMENT FORM (EMEDNY-4099)

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 PHARMACY FORM INSTRUCTIONS

CATEGORY OF SERVICE:	Check the categories that apply.
PROVIDER NUMBER:	Leave blank.
OWNERSHIP CODE:	Enter the number that is applicable.
APPLICATION TYPE:	This field must be completed. (See Required Documentation on page 2 of the Checklist).
APPLICANT NAME:	Enter the name exactly as it appears on your license/registration.
DOING BUSINESS AS (DBA):	If applicable.
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter your NPI. .
FEDERAL EMPLOYER ID NUMBER:	Enter the Department of Treasury, Internal Revenue Service Federal Employer Identification Number issued for the pharmacy.

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 pharmacy 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 want your checks to be sent to an address other than the correspondence address, complete this section. If you want your Medicaid checks to be sent to your correspondence address, write "SAME".

SERVICE ADDRESS: This address must match the address on your pharmacy license/registration.

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/REGISTRATION INFORMATION: Enter the pharmacy license number.

SUPERVISING PHARMACIST NAME AND LICENSE NUMBER: Enter supervising pharmacist's name and license number.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBER: Enter the pharmacy DEA number, and submit a copy of your DEA certificate if you dispense controlled substances.

MEDICARE INFORMATION: All Pharmacies that enroll in the Medicaid Program to receive Medicaid payments, as appropriate for Medicare coinsurance and the deductible, **MUST** provide proof of enrollment in Medicare. Proof will consist of a copy of your Medicare award letter.

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 on the www.eMedNY.org website. You are required to provide documentation and/or details explaining the circumstances.

OWNER'S NAME:

Print the owner's name.

EMAIL ADDRESS:

Enter your Email address if applicable.

OWNER'S SIGNATURE:

The owner 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:

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

PHARMACY

CATEGORY OF SERVICE – Check Which Apply

- 0441 PHARMACY
- 0442 DURABLE MEDICAL EQUIPMENT

MEDICAID PROVIDER ENROLLMENT

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

(LEAVE BLANK) PROVIDER NUMBER

OWNERSHIP CODE APPLICATION TYPE

69 - Public-Federal 73 - Voluntary
70 - Public-County 74 - Proprietary (Profit)-Corporation
71 - Public-Municipal 75 - Proprietary (Profit)-Partnership
72 - Public-State 76 - Proprietary (Profit)-Individual

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

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION

STREET - LINE 1

Enter the name of the person/department/apartment number where the mail should be sent

- 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)

ATTENTION

STREET - LINE 1

- LINE 2

CITY

Do not use abbreviations

STATE ZIP CODE - COUNTY

SERVICE ADDRESS INFORMATION

ATTENTION

STREET - 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.

OWNER NAME (PRINT)

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

OWNER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)

DATE SIGNED

LICENSING INFORMATION - Attach Copy LICENSE/REGISTRATION NO.

Enter the number from your license registration certificate. If the number is less than eight digits, use preceding zeros. Example: License No. is 012345 - Enter 00012345, License No. is B12345 - Enter 00B12345

AGENCY CODE NYS Pharmacies (03)
(Check one) Out-of-State (99)

License Begin Date

MM DD YY

SUPERVISING PHARMACIST NAME

SUPERVISING PHARMACIST LICENSE NUMBER

DEA Certificate (Required if dispensing controlled substances)

DEA Number

DEA Issue Date

MM DD YY

MEDICARE INFORMATION

Are you enrolled in Medicare? Yes No

QUESTIONS

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% license 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

PREPARER NAME (PRINT)

TELEPHONE #

New York State Medicaid Disclosure of Ownership and Control – Business Entity

Name of Business Entity _____

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. List names, addresses and social security numbers for individuals (Owners, Trustees, Board of Directors) and the FEIN (Federal Employer Identification Number) for organizations having direct or indirect ownership or a controlling interest of 5% or more in the above named agency, institution or organization. If controlling interest is 5% or less, attach a list of the board of directors and social security numbers. 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

Residence Address _____

Social Security # _____ Employer Identification # _____

Name _____
Last First MI

Residence Address _____

Social Security # _____ Employer Identification # _____

Name _____
Last First MI

Residence Address _____

Social Security # _____ Employer Identification # _____

6. Type of entity

- Sole Proprietorship Unincorporated Association
 Corporation Governmental
 Partnership Other (Specify) _____

7. Are any of the above owner(s) listed in Number 5 also a Medicaid/Medicare provider or have been owners of other Medicare/Medicaid facilities or other entities? If "yes", list names and Medicaid provider number or National Provider Identifiers. Attach additional sheets if necessary.

- Yes No

Name _____
Last First MI

Facility Name/Entity Name _____

Medicaid # or NPI _____

Name _____
Last First MI

Facility Name/Entity Name _____

Medicaid # or NPI _____

Name _____
Last First MI

Facility Name/Entity Name _____

Medicaid # or NPI _____

8. Has there been a change of ownership or control within the last 12 months?

- Yes No

If "Yes," provide both: _____ / _____ / _____
MM / DD / YYYY

Medicaid # or National Provider Identifier (NPI) _____

9. Do you anticipate a change of ownership within the next 12 months?

Yes No

If "Yes," give date _____
MM / DD / YYYY

10. Is this facility operated by a management company, or leased in whole or in part by another organization?

Yes No

If "Yes," give date _____
MM / DD / YYYY

11. Has there been a change in your laboratory director/supervising pharmacist within the last 12 months?

Yes No Not Applicable

12. Do you currently have any unpaid balances owed to the Medicaid Program?

Yes No

If "Yes," indicate amount \$ _____

o Has payment been arranged?

Yes No

If "Yes," please attach verification of this.

13. If this application is for a change of ownership or an impending change of ownership, are you assuming all current or future liabilities owed by the seller to the Medicaid program for the entity that you have purchased or are purchasing?

Yes No

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.

Owner/Board Member Name (printed)

Signature (No stamps)

Date

HOSPITAL, NURSING HOME, CLINIC BASED PHARMACY QUESTIONNAIRE

1. a. Is your intent to be an outpatient community pharmacy open to the public?

Yes_____ No_____

b. Is this a closed pharmacy, i.e. servicing your own patients? Yes_____ No_____

2. Is your pharmacy on the premises of a hospital, clinic or nursing home or at an off-site satellite location?

Yes_____ No_____

If yes, provide the name of the facility and indicate your affiliation with this facility.

3. Is this pharmacy licensed under a different name other than the name of the facility?

Yes_____ No_____

If yes, provide the name: _____

4. Is the pharmacy licensed as a "for-profit" outpatient retail pharmacy?

Yes_____ No_____

5. Please indicate if you will be dispensing to:

o General Public: Yes_____ No_____

o Hospital Yes_____ No_____

o Nursing Home Yes_____ No_____

o Clinic Yes_____ No_____

o Assisted Living Environment Yes_____ No_____

Signature

d. Provide the name and address to whom the rent is paid. Attach a copy (front and back) of the most recent canceled rent check.

e. If rent is paid to a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their social security numbers and any NYS Medicaid Program provider numbers, National Provider Identifiers or professional licenses held.

<u>Last Name, First Name</u>	<u>Social Security Number</u>	<u>Medicaid Number/NPI/ Professional License</u>
	- -	
	- -	
	- -	

3. If the business location was previously a place at which NYS Medicaid pharmacy services were rendered, list the NYS Medicaid Provider Number/National Provider Identifier(s) of the prior owner(s).

4. Enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the sale.

5. Estimate the dollar value of the pharmaceutical stock and medical supplies currently on hand. Please attach a detailed list of your current inventory. (If there has recently been an ownership change, submit all supplier invoices or inventories from previous owners that verify stock on hand.)

6. Estimate the percentage of business that will be billed to the NYS Medicaid Program. _____%

7. a. Identify the name, address and account number(s) of the bank(s) to be used by the business.

<u>Name of Bank</u>	<u>Address</u>	<u>Account Number</u>

b. Provide the names and social security numbers of all personnel authorized to sign corporate checks against those accounts.

<u>Person(s) Authorized to Sign Checks</u>	<u>Social Security Number</u>
	- -
	- -
	- -
	- -

8. Attach a statement identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signatures. **Signature stamps, photocopies, etc., are not acceptable.**

9. List the name and license number of each pharmacist. State the days and hours of the week the pharmacist will be working.

<u>Name</u>	<u>License Number</u>	<u>Days of the Week Worked</u>	<u>Hours of the Week Worked</u>

10. Indicate the days and corresponding hours the pharmacy will be open.

Monday	_____ to _____	Friday	_____ to _____
Tuesday	_____ to _____	Saturday	_____ to _____
Wednesday	_____ to _____	Sunday	_____ to _____
Thursday	_____ to _____		

11. Indicate which services your pharmacy provides and how they are provided.

- | | | |
|--|----|-------|
| a. Free delivery. Please specify any limitations. | a. | _____ |
| b. Emergency service: | b. | _____ |
| After hours phone number | | _____ |
| After hours beeper number | | _____ |
| c. Health counseling (e.g. blood pressure checks, diabetic care, etc.) Please be specific. | c. | _____ |
| | | _____ |
| | | _____ |
| d. Multilingual counseling. Please identify the language(s) spoken and indicate which pharmacist or supervising pharmacist speaks the language(s) listed. | d. | _____ |
| | | _____ |
| | | _____ |
| e. Multilingual labeling. Please specify the language(s). | e. | _____ |
| | | _____ |
| f. Compound prescriptions. | f. | _____ |
| g. Private consultation area. Please describe. | g. | _____ |
| h. Patient information leaflets. (Please attach a copy). | h. | _____ |
| i. Drug and allergy monitoring. Please explain. | i. | _____ |
| | | _____ |
| j. How does your establishment provide access to the handicapped (ramps, passage, parking, etc.)? | j. | _____ |
| | | _____ |

Identify any additional circumstances or services which you offer that significantly improve health services to your clients other than those listed above.

12. Explain how your customers are made aware of the services your pharmacy provides.
- _____
- _____
- _____
13. Of your total pharmacy revenue, what percentage is provided by mail order or delivery (i.e. Fed Ex, UPS, US Mail, etc.)?
- _____
- a. Identify the types of medication or supplies that you provide by mail order or delivery.
- _____
- _____
- b. How do you provide these services to your customers?
- _____
- _____
- c. Where do the customers that receive these services reside?
- _____
14. Provide the name and telephone number of the accountant for the business.
- _____
- _____
- _____
15. Provide the name, address and telephone number of the attorney for the business.
- _____
- _____
- _____
16. a. Are you an out of state provider of pharmacy services interested in participating in the NYS Medicaid Program? Yes No
- b. Is this application for a single occasion for one NYS Medicaid Program recipient? Yes No
- c. If yes, please provide the first date of service for this recipient. / / / / /
M M D D Y Y

Owner's Name (Print): _____

Owner's Signature: _____ Date Signed: _____
(Signature Stamps Are Not Permitted)

Application Prepared by (Print): _____

Telephone Number: _____

PERSONAL IDENTIFICATION NUMBER (PIN) REQUEST

For Pharmacy Only:

The Electronic Claim Capture and Adjudication (ECCA) feature is optional. Pharmacies that choose to use the ECCA option must select a Personal Identification Number (PIN) and forward that number to the NYSDOH for processing. Please use this form for your request.

National Provider Identifier (NPI): _____

Medicaid Provider ID: _____

NYS Medicaid Provider Name: _____

Address: _____

PIN Number: _____
(Any four (4) digits)

Please specify and keep a record of your number.

Name of Person Completing Form: _____
Print or Type

Signature of Person Completing Form: _____

Date Signed: _____

Telephone Number: (____) _____

Return with your Enrollment Package.

**MEDICAID PROVIDER ENROLLMENT
SUPERVISING PHARMACIST FORM INSTRUCTIONS**

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
SUPERVISING PHARMACIST FORM INSTRUCTIONS**

- PROVIDER NUMBER:** Leave blank.
- APPLICATION TYPE:** This field must be complete. (See Required Documentation on page 2 of the Checklist.)
- APPLICANT NAME:** Enter the Supervising Pharmacist's name as it appears on the license/registration; that is **last name, first name**.
- NATIONAL PROVIDER IDENTIFIER (NPI)** Enter your NPI
- SOCIAL SECURITY NUMBER:** This is a **mandatory** field.
- CORRESPONDENCE ADDRESS:** Enter the address where all correspondence will be sent.

Attention Line: Enter the name of the pharmacy where the Supervising Pharmacist is employed.
- SERVICE ADDRESS:** This address must be the address of the pharmacy where the Supervising Pharmacist is employed.
- 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 on the www.eMedNY.org website. You are required to provide documentation and/or details explaining the circumstances

**LICENSE/REGISTRATION
INFORMATION:**

Enter the Supervising Pharmacist's license number. **Attach a copy of your current license/registration renewal certificate.**

EMAIL ADDRESS:

Enter your Email address if applicable.

APPLICANT'S SIGNATURE:

The Supervising Pharmacist must **personally sign** the enrollment form. **Signature stamps, photocopies, etc. are not acceptable.**

**SUPERVISING PHARMACIST
AGREEMENT FORM**

This form is self-explanatory and **MUST** be completed by you and your employer.

PASSPORT PHOTO:

Passport size photo affixed to a separate 8 ½" x 11" sheet of paper **with supervising pharmacist name, social security number and name of pharmacy.**

SUPERVISING PHARMACIST
CATEGORY OF SERVICE 0444

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

NATIONAL PROVIDER IDENTIFIER (NPI)

SOCIAL SECURITY NUMBER

CORRESPONDENCE ADDRESS (Mail & Information)

ATTENTION
Enter the NAME of the person/department/apartment number where the mail should be sent

STREET - LINE 1
Cannot be a Post Office Box UNLESS accompanied by an actual street address

- LINE 2

CITY
Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE () - EXT.

LICENSE/REGISTRATION INFORMATION - Attach Copy

LICENSE NO.

- AGENCY CODE (Check ONE) NYS Pharmacist (03)
 Out-of-State Pharmacist (99)

SERVICE ADDRESS INFORMATION

ATTENTION

STREET - LINE 1
(This MUST be a physical location, NOT a P.O. Box)

- LINE 2

CITY
Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE () - EXT.

License Begin Date MM DD YY

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?

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

EMAIL ADDRESS

PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)
EMEDNY-409801 (09/09)

DATE SIGNED

PREPARER NAME (PRINT)

TELEPHONE #

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 \$ _____

o 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

