



# 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 you to be aware of the following factors concerning your potential enrollment as a provider.

- **If your application is approved, the effective date of your enrollment will be specified by the Department.**
- **The physician assistant is a non-reimbursable category of service. Services are paid to your supervising physician who must be enrolled in the New York State Medicaid Program and will be at financial risk if you render service 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 your enrollment date is authorized by the Department.**
- **Your signature on the application acknowledges that you have received, read and will comply with the policies and regulations of the Medicaid Program.**

The provisions outlined in the New York State Education Law and the New York State Public Health Law, **state that a physician may supervise no more than two physician assistants in his/her private practice and no more than six physician assistants employed by a hospital.**

Physicians, physician assistants, nurse practitioners and midwives who provide services to New York State Medicaid beneficiaries are required to read the "Introduction to the New York State Medicaid Program" attached to the application. This material, outlining general procedures and policies governing the Medicaid Program, is to be detached from the application and kept by you as a reference which will assist you in maintaining compliance with Medicaid requirements. **Please do not send this material back with your application.**

When you are enrolled in the program, you will receive a letter informing you of your acceptance and the effective date of your enrollment.

The Medicaid Update may be accessed on line at [www.eMedNY.org](http://www.eMedNY.org), click on Information then DOH Medicaid Update Website.

**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](http://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.

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.

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

Sincerely,

Fee for Service Provider Enrollment Bureau  
Office of Health Insurance Programs

Enclosure  
Physician Assistant  
EMEDNY-412101 (08/09)

# Introduction to the New York State Medicaid Program

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**Definitions: As referenced in this material.**

Practitioner: Physician, Podiatrist, Physician's Assistant, Nurse Practitioner or Midwife.

Provider: Any individual or entity who has enrolled under the Medical Assistance Program to furnish medical care, services or supplies.

## **An Introduction to the Medicaid Program**

Medicaid enrollment is a contractual agreement between a provider and the Department of Health (administrator of the Medicaid Program). The contractual agreement can be withdrawn by either party without cause by a written 30-day notice.

Medicaid is the largest third party insurer in the State of New York. By law it is the payer of last resort. Therefore, no claim for reimbursement shall be submitted to Medicaid unless the provider has investigated all other resources to ascertain the existence of third party insurance and has sought reimbursement from liable third parties.

### **By Enrolling in the Medicaid Program, a Provider Agrees To:**

- ◆ comply with the rules, regulations and directives of the Department;
- ◆ comply with the disclosure requirements of the Department with respect to ownership and controlling interest, significant business transactions and involvement with convicted persons;
- ◆ accept payment under the Medicaid Program as payment in full for the services rendered;
- ◆ prepare and maintain legible contemporaneous medical records in English; and
- ◆ permit audits of all books and records relating to services furnished and payments received.

### **Responsibilities as a Practitioner:**

- ◆ keep your provider information current; this includes notifying the Department of all changes in your service location, type of practice, including group participation, and if you wish to withdraw from participation;
- ◆ you are responsible for all services ordered and billed under your National Provider Identifier (NPI)/MMIS #;
- ◆ know who your employer is. As a physician or podiatrist, you can not be employed by a person or corporation not authorized by the New York State Education Department to practice medicine. As a physician's assistant or nurse practitioner you must comply with the requirements established by the Education Department governing your practice.
- ◆ you can not affiliate yourself with a provider who has been excluded from the Medicaid Program;
- ◆ to maintain complete legible records in English for six years from the date of payment;
- ◆ if you employ a billing service, the billing service must be enrolled in the Medicaid Program as a non-billing provider; and
- ◆ familiarize yourself with all Medicaid procedures and regulations currently in effect, and as they are issued.

## Utilization Monitoring Measures:

The Restricted Recipient Program (RRP) limits certain beneficiaries to specific providers in specific areas. The Department may restrict a beneficiary's access to services if it is found that the beneficiary has received duplicative, excessive, contraindicated or conflicting services, drugs or supplies. In such cases the Department may require that the beneficiary access specific types of medical care and services through a designated provider or providers.

The Medicaid Eligibility Verification System (MEVS) is a means to confirm that the beneficiary is eligible for benefits, identify the type of benefits for which they are eligible, and generate a service authorization. In addition, MEVS functions as an electronic gatekeeper by matching services ordered by a practitioner with services actually rendered. It has become increasingly necessary for practitioners to use MEVS in their transactions. Although it is not mandatory that you have an MEVS unit in your practice, it is highly recommended.

Utilization Threshold (UT) places limits on the number of services a Medicaid beneficiary may receive in a benefit year. When a beneficiary nears the threshold of annual visits (for example, the number of approved visits for physician services is ten) a letter is sent to the beneficiary to make them aware of the threshold. When given to the practitioner, the letter allows the practitioner, (physicians, physician's assistants or nurse practitioners) to assess services needed and if necessary, to request an extension of services, using a threshold override application.

The Drug Utilization Review Program (ProDur) maintains a full on-line record of each beneficiary's prescription history for a 90-day period. When a new claim is submitted by a pharmacy, the claim information is compared to the history. In the event that a potential problem is detected, the pharmacist receives an on-line warning or rejection notice. This system also aids in identifying duplications of medications prescribed. The pharmacist's can take appropriate action and contact the physician as necessary.

## Payment Restrictions:

- ◆ Medicaid will not cover services rendered in the absence of an authorization from MEVS in accordance with Utilization Threshold requirements. In addition, Medicaid will not cover services that are rendered after the beneficiary has reached the Utilization Threshold established for a specific provider service type, without a threshold override.
- ◆ Medicaid will not cover services for which prior approval was required and not obtained; and

Medicaid will deny payments on behalf of a beneficiary to a fee-for-service provider if the beneficiary is enrolled in a managed care program. **The exception to this is family planning services.** A beneficiary is free to choose to receive family planning/reproductive health services from any enrolled provider, regardless of the beneficiary's managed care status.

## **Ordered Services:**

Ordered services include:

- Pharmacy
- Durable Medical Equipment
- Transportation services
- Laboratory services
- Radiology services
- Hospital services

Ordered services are medically necessary services or items provided upon the written order of a qualified practitioner:

- ◆ the practitioner who writes the order is responsible for all ordered services, even though no direct payment is received by the practitioner; and
- ◆ all ordered services must be medically necessary and relate to the specific complaints and symptoms of the patient.

## **Sanctions:**

Sanctions under the Medicaid Program may include exclusion from the Medicaid Program for a period of several years. This is the most serious sanction and results from committing an unacceptable practice. An unacceptable practice is conduct by a provider or person, which conflicts with any of the policies, standards or procedures of the Medicaid Program. Some examples include:

- ◆ knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;
- ◆ failing to maintain records necessary to fully disclose the extent of the care, services or supplies furnished (improper documentation);
- ◆ submitting bills or accepting payment for care, services or supplies rendered by a person suspended or excluded from participating in the Medicaid Program;
- ◆ providing services which are not medically necessary;
- ◆ accepting any type of bribe or kickback; and
  
- ◆ participating in fraudulent activities.

## **Ramifications of Exclusion From the Medicaid Program:**

- ◆ Your name will be placed on Medicaid's list of excluded providers, and other individuals whose orders and services Medicaid will deny (PVR 292). It is circulated to all fillers of ordered services, stating that the Medicaid Program will not pay for services provided by providers or persons on this list.
- ◆ You may have difficulty in obtaining employment in a hospital or clinic.

## **Ramifications of Exclusion From the Medicaid Program (con't):**

- ◆ You may also be excluded from the Medicare Program.
- ◆ Your name and cause for exclusion will be provided to other states, third party insurers, the Office of Professional Medical Conduct and Medicare, all of which may take further action.

## **Prevention:**

Preventive measures can be taken to protect yourself and your practice against problems with the Medicaid Program. Preventive measures include:

- ◆ physicians, beware of “storefront clinics”, where a physician’s assistant is acting as the primary care provider and you only have to be on-site a few hours a week;
- ◆ practice your own medicine; for example, do not be pressured by either a partner or a beneficiary to prescribe medications or services unless you feel that they are medically necessary;
- ◆ be wary where a provider number is required before employment is offered;
- ◆ be responsible for the services you order; and
- ◆ do not sign blank prescription or order forms.

## **Documentation:**

Documentation will be one of the most important means to protect yourself. All care, services and supplies must be fully documented in the medical record, be legible and in English. Guidelines for documentation include:

- ◆ the full name, address and medical assistance number of each beneficiary examined;
- ◆ the date of the visit;
- ◆ the chief complaint or reason for the visit;
- ◆ the beneficiary’s pertinent medical history as appropriate to the visit, and findings obtained from any physical exam that day;
- ◆ a diagnostic impression;
- ◆ a recording of any progress including the response to treatment;
- ◆ a notation of all medication dispensed, administered or prescribed with the precise dosage and regimen for each medication;
- ◆ a description of any X-rays, laboratory tests, electrocardiograms or other diagnostic tests and a notation of the results;
- ◆ a notation of any referrals, and a statement as to the reason;
- ◆ a statement as to whether or not the beneficiary is expected to return;
- ◆ a chart entry giving the medical necessity for any ancillary diagnostic procedures; and
- ◆ all other books, records or documents necessary to fully disclose the extent of the care, services and supplies provided.

These are the basic tenets of medical chart documentation.

## **MMIS Provider Manual Reference:**

For complete procedures and requirements governing the Medicaid Program, you may reference the Medicaid Management Information System (MMIS) Provider Manual. The manual provides detailed guidance on policies, billing and payment and is available at <http://www.emedny.org/>.

## **Provider Expectations:**

Providers can expect:

- ◆ to be treated with respect by the Department;
- ◆ to have available to them information regarding the Medicaid Program and policy;
- ◆ timely payment for services rendered, in accordance with the rules and regulations of the Medicaid Program;
- ◆ that enrollment in the Medicaid Program does not mandate them to render services to all Medicaid beneficiaries who request care. However, no person shall be denied benefits or be subject to discrimination based on race, color, national origin, age, sex, religion or handicap.
- ◆ to have access to the Telephone Verification System for information on beneficiary eligibility status through MEVS or by calling 1-800-997-1111;
- ◆ that within its capacity the Medicaid Program will make reasonable response to requests for assistance in all aspects of the program;
- ◆ assistance in researching claim denials or billing problems through the fiscal agent;
- ◆ that all patient records submitted under their National Provider Identifier (NPI)/MMIS # will be treated as confidential; and
- ◆ to be afforded the right to a hearing if the Department determines that they have engaged in unacceptable practices.

## Practitioner Telephone Reference Guide for New York State Medicaid

<b>CONTACTS</b>	<b>DESCRIPTION</b>	<b>TELEPHONE NUMBER(S)</b>
<b>Computer Science Corporation – Fiscal Agent for Medicaid</b>		
Provider Relations	All billing problems regarding: UT's, pend/denied claims, claim status, etc.	(800) 343-9000
Threshold Override Applications	Used to increase service limits for a beneficiary	(800) 343-9000
On-Site Visits	To arrange billing seminars with regional staff	(800) 343-9000
<b>Department of Health</b>		
Billing	NYS review for pend/denied claims	(800) 342-3005 or (518) 473-4029
Co-Payments	Beneficiaries financial responsibility towards medical services	(518) 473-2160 (800) 343-9000
Eligibility for Beneficiaries		Beneficiary's County
MEVS (Medicaid Eligibility Verification System)	Phone Verification Help Desk	(800) 997-1111 (800) 343-9000
Enrollment	Issues for providers regarding: address changes, specialties, status of application, locator code changes, etc.	(800) 343-9000
Fraud (to report a case of suspected fraud)	Provider: Beneficiary – Upstate/New York City	(518) 486-9057 (877) 873-7283
Managed Care	PCP's/HMO's	(800) 206-8125
MANS (Medicaid Automated Name Search)	Used to locate a beneficiary's ID # and for provider check amounts	(518) 447-9504
Prior Approval		(800) 342-3005 or (518) 474-8161
QMB (Qualified Medicaid Beneficiary)	Limited Medicaid payments for approved Medicare services	Refer to Local County DSS
Restricted Recipient		(518) 474-6866
Unresolved Issues/General Medical Policy Inquiries		(518) 473-2160

**MEDICAID PROVIDER ENROLLMENT  
PHYSICIAN ASSISTANT 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**

- TYPE OF APPLICATION\*
- NATIONAL PROVIDER IDENTIFIER (NPI)
- SOCIAL SECURITY NUMBER
- CORRESPONDENCE ADDRESS
- SERVICE ADDRESS
- TYPE OF PRACTICE
- PLACE OF SERVICE
- ALL YES/NO QUESTIONS MUST BE ANSWERED\*\*
- PHYSICIAN ASSISTANT ORIGINAL SIGNATURE

\*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 AT [WWW.EMEDNY.ORG](http://WWW.EMEDNY.ORG). YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES.

**REQUIRED DOCUMENTATION TO BE SUBMITTED**

SUBMIT A COPY OF YOUR CURRENT LICENSE/REGISTRATION CERTIFICATE

- NEW YORK STATE PHYSICIAN ASSISTANTS MUST SUBMIT A COPY OF THEIR NYS EDUCATION DEPARTMENT LICENSE/REGISTRATION RENEWAL CERTIFICATE
- OUT OF STATE PHYSICIAN ASSISTANTS MUST SUBMIT A COPY FROM THEIR STATE LICENSING AGENCY.

DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM

PHYSICIAN ASSISTANTS ENROLLMENT QUESTIONNAIRE

SUPERVISING PHYSICIAN CERTIFICATION

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](http://WWW.OMIG.STATE.NY.US).

PASSPORT SIZE PHOTO AFFIXED TO A SEPARATE 8 ½" x 11" SHEET OF PAPER **WITH PHYSICIAN ASSISTANT NAME AND SOCIAL SECURITY NUMBER**

IF YOUR PRACTICE LOCATION IS OFFICE BASED SURGERY ACCREDITED:

- SUBMIT A COPY OF YOUR CERTIFICATE OF ACCREDITATION ISSUED BY ONE OF THE THREE ORGANIZATIONS DESIGNATED BY THE COMMISSIONER OF HEALTH AS OUTLINED AT [WWW.NY.HEALTH.GOV](http://WWW.NY.HEALTH.GOV)

## 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](http://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 PHYSICIAN ASSISTANT FORM INSTRUCTIONS**

<b>PROVIDER NUMBER:</b>	Leave blank.
<b>APPLICATION TYPE:</b>	This field must be completed. (See required Documentation on page 2 of the Checklist.)
<b>APPLICANT NAME:</b>	Enter the your name exactly as it appears on your license/registration; that is <b>last name, first name</b> .
<b>NATIONAL PROVIDER IDENTIFIER (NPI)</b>	Enter your NPI..
<b>SOCIAL SECURITY NUMBER:</b>	This is a <b>mandatory</b> field.
<b>CORRESPONDENCE ADDRESS:</b>	Enter the address where all correspondence 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 physician assistant or for an apartment/suite number or building location.  Street: Cannot be a P.O. Box unless accompanied by an actual street address.

**SERVICE ADDRESS:** This address is where you render services. If the service address is the same as the correspondence address write "SAME". If services are provided at more than one location, complete the **Additional Service Addresses form EMEDNY-490101**. If the service address is an accredited Office Based Surgery site please check the box marked Office Based Surgery.

**TYPE OF PRACTICE:** For each service address, check the box from the list which describes your type of practice at that address.

- |               |             |
|---------------|-------------|
| 1. Individual | 3. Salaried |
| 2. Group      | 4. Contract |

**PLACE OF SERVICE:** For each service address, check the box from the list which describes the site.

1. Private Office
2. Hospital/Nursing Home
3. Free Standing Clinic
4. Health Maintenance Organization
5. Shared Health Facility

**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 at [www.eMedNY.org](http://www.eMedNY.org). You are required to provide documentation and/or details explaining the circumstances.

**LICENSING INFORMATION:** Enter your license number. **Attach a copy of your current license/registration renewal certificate.**

**DEA NUMBER:** If you are licensed to prescribe or dispense controlled substances, enter the DEA number. **Attach a copy of the certificate.**

**MEDICARE INFORMATION:** Indicate if you are enrolled in Medicare.

**GROUP/ORGANIZATION:** If your supervising physician is a member of a group currently enrolled in the New York State Medicaid Program, enter the Provider Name, the group Provider # and National Provider Identifier of the group.

**SIGNATURE OF PROVIDER:** Providers must **personally sign** and **date** the enrollment form acknowledging the attestation statement. **Signature stamps, photocopies, etc. are not acceptable.**

**EMAIL ADDRESS:** Enter your email address if applicable.

**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:

New York State Department of Health  
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

PHYSICIAN ASSISTANT  
CATEGORY OF SERVICE 0462

MEDICAID PROVIDER ENROLLMENT

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

(LEAVE BLANK)

PROVIDER NUMBER

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 (REQUIRED)

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION   
STREET - LINE 1   
- LINE 2   
CITY   
STATE  ZIP CODE  -  COUNTY   
TELEPHONE (  ) -  EXT.

LICENSING INFORMATION - Attach Copy  
LICENSE/PERMIT NO.   
AGENCY CODE  NYS (03)  
 Out-of-State (99)  
LIMITED PERMIT PROVIDER   
Please submit a copy of your current NYS Education Dept. Letter stipulating your supervising physician.  
DEA Attach Copy

SERVICE ADDRESS INFORMATION

STREET - LINE 1   
- LINE 2   
CITY   
STATE  ZIP CODE  -  COUNTY   
TELEPHONE (  ) -  EXT.

MEDICARE INFORMATION  
Are you enrolled in Medicare?  
 Yes  No

GROUP/ORGANIZATION MEDICAID PROVIDER NUMBER

NATIONAL PROVIDER IDENTIFIER (NPI)

GROUP/ORGANIZATION PROVIDER NAME

TYPE OF PRACTICE (Check ONE)

Individual (1)  
 Group (2)  
 Salaried (3)  
 Contract (4)

If employed by a facility or clinic, attach a written statement from the financial director, clarifying if the salary is included in the facility's Medicaid rate.

PLACE OF SERVICE (Check ONE)

Private Office (1)  
 Hospital, Nursing Home (2)  
 Free Standing Clinic (3)  
 Health Maintenance Organization (4)  
 Shared Health Facility (5)

**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% 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?

**ATTESTATION**

The signature on my application acknowledges that I have read and agree to comply with the practices, issues and concepts discussed in the "Introduction to the New York State Medicaid Program" and the information contained within the application is true and accurate.

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

PROVIDER SIGNATURE (Original Signature REQUIRED) DATE SIGNED

EMAIL ADDRESS

PREPARER NAME & TITLE (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](http://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

**MAIL TO:**

**MEDICAID PROVIDER ENROLLMENT  
ADDITIONAL SERVICE ADDRESS**

COMPUTER SCIENCES CORPORATION  
P.O. BOX 4603  
RENSSELAER, NY 12144

**PROVIDER ID#** [ \_\_\_\_\_ ]

**NATIONAL**

**PROVIDER**

**IDENTIFIER** [ \_\_\_\_\_ ]

**APPLICATION**

**MM/DD/YY**

**DATE**

[ \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ]

**CATEGORY OF SERVICE**

[ \_\_\_\_\_ ]

**APPLICANT**

**NAME** [ \_\_\_\_\_ ]

**SERVICE ADDRESS INFORMATION**

ATTENTION [ \_\_\_\_\_ ]

ADDRESS-1 [ \_\_\_\_\_ ]

ADDRESS-2 [ \_\_\_\_\_ ]

This MUST be a physical location, NOT a P.O. Box

CITY [ \_\_\_\_\_ ]

Do NOT use abbreviations

**ZIP**

STATE [ \_\_\_\_ ] CODE [ \_\_\_\_ - \_\_\_\_ ] COUNTY \_\_\_\_\_

TELEPHONE [ ( \_\_\_\_ ) - \_\_\_\_\_ EXT \_\_\_\_\_ ]

**OFFICE BASED SURGERY**

**TYPE OF PRACTICE (Check ONE)**

Individual (1)

Salaried (3)

Group (2)

Contract (4)

**PLACE OF SERVICE (Check ONE)**

Private Office (1)

Hospital/Nursing Home (2)

Free Standing Clinic (3)

Health Maintenance Org. (4)

Shared Health Facility (5)

**SERVICE ADDRESS INFORMATION**

ATTENTION [ \_\_\_\_\_ ]

ADDRESS-1 [ \_\_\_\_\_ ]

ADDRESS-2 [ \_\_\_\_\_ ]

This MUST be a physical location, NOT a P.O. Box

CITY [ \_\_\_\_\_ ]

Do NOT use abbreviations

**ZIP**

STATE [ \_\_\_\_ ] CODE [ \_\_\_\_ - \_\_\_\_ ] COUNTY \_\_\_\_\_

TELEPHONE [ ( \_\_\_\_ ) - \_\_\_\_\_ EXT \_\_\_\_\_ ]

**OFFICE BASED SURGERY**

**TYPE OF PRACTICE (Check ONE)**

Individual (1)

Salaried (3)

Group (2)

Contract (4)

**PLACE OF SERVICE (Check ONE)**

Private Office (1)

Hospital/Nursing Home (2)

Free Standing Clinic (3)

Health Maintenance Org. (4)

Shared Health Facility (5)

**SERVICE ADDRESS INFORMATION**

ATTENTION [ \_\_\_\_\_ ]

ADDRESS-1 [ \_\_\_\_\_ ]

ADDRESS-2 [ \_\_\_\_\_ ]

This MUST be a physical location, NOT a P.O. Box

CITY [ \_\_\_\_\_ ]

Do NOT use abbreviations

**ZIP**

STATE [ \_\_\_\_ ] CODE [ \_\_\_\_ - \_\_\_\_ ] COUNTY \_\_\_\_\_

TELEPHONE [ ( \_\_\_\_ ) - \_\_\_\_\_ EXT \_\_\_\_\_ ]

**OFFICE BASED SURGERY**

**TYPE OF PRACTICE (Check ONE)**

Individual (1)

Salaried (3)

Group (2)

Contract (4)

**PLACE OF SERVICE (Check ONE)**

Private Office (1)

Hospital/Nursing Home (2)

Free Standing Clinic (3)

Health Maintenance Org. (4)

Shared Health Facility (5)

**PHYSICIAN ASSISTANT ENROLLMENT QUESTIONNAIRE**

**Applicant Name** \_\_\_\_\_  
(Last, First, MI)

**Physician National Provider Identifier (NPI) (Required)** \_\_\_\_\_

**Physician Medicaid Provider # (Required)** \_\_\_\_\_

- 1. Are you working for more than one physician?  Yes  No
- 2. Are you working for one or more physician's group?  Yes  No
- 3. Are you working at more than one location?  Yes  No

If "Yes" answered for any of the above questions, complete the following:

	<u>Location</u>	Provider#	NPI#	No. of Hours/Week	Supervising Physician
a.	_____				
b.	_____				
c.	_____				
d.	_____				
e.	_____				
f.	_____				

4. Provide employment history for previous (2) two years. (Most recent position first. Attach additional sheets if necessary.)

Date From/To	<u>Location</u>	<u>Supervising Physician</u>
_____		
_____		
_____		
_____		
_____		
_____		

**SUPERVISING PHYSICIAN CERTIFICATION**

**This Form Must Be Completed and Signed by Each Supervising Physician.**

- 1. Physician Name: \_\_\_\_\_
- 2. Physician License Number: \_\_\_\_\_
- 3. Physician National Provider Identifier (NPI): \_\_\_\_\_  
Physician Medicaid Provider # \_\_\_\_\_
- 4. Physician Telephone Number: \_\_\_\_\_
- 5. Physician Current Service Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Detail the salary arrangements you have with your Physician Assistant. If the Physician Assistant is salaried by a Physician/Physician Group, attach a copy of the signed contract. If the Physician Assistant is salaried by a Hospital/Facility, attach a letter from the Chief Financial Officer of the Hospital/Facility explaining how the Physician & Physician Assistant salaries are related to the Hospitals/Facilities Medicaid Cost Report. Salary documentation is required in order to add a Supervising Physician(s) to the Registered Physician Assistant's provider file.

7. Will the Physician Assistant practice at the same service location(s) at which you practice?

- Yes
- No

If no is checked, list locations where the Physician Assistant will practice.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Detail how supervision is carried out.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATION STATEMENT**

In accordance with the requirements of the Law and Regulations of the State Department of Education, I have agreed to supervise Physician Assistant \_\_\_\_\_ in the manner detailed in my response to question 8.

Physician Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_