



# 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.**
- **You 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 services, care or supplies furnished before the enrollment date 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.**

When you are enrolled in the program, you will receive a letter informing you of your acceptance and the effective date of your enrollment. You will also receive a package containing claim forms and instructions on how to obtain the appropriate Provider Manual which is available online at [www.eMedNY.org](http://www.eMedNY.org). If you do not have internet access, you can obtain the appropriate Provider Manual by calling the eMedNY Call Center at (800) 343-9000. The Provider Manual contains New York State Medicaid policy, a list of information sources, and billing instructions. Click on Provider Manuals and scroll down and choose the appropriate manual. The Medicaid Update may also be accessed at [www.eMedNY.org](http://www.eMedNY.org), click on Information, then DOH Medicaid Updates 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  
Dentist  
EMEDNY-416101 (08/09)

## **MEDICAID PROVIDER ENROLLMENT DENTIST 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
- TYPE OF APPLICATION\*
- NATIONAL PROVIDER IDENTIFIER (NPI)
- SOCIAL SECURITY NUMBER
- CORRESPONDENCE ADDRESS
- PAY TO ADDRESS
- SERVICE ADDRESS
- PLACE OF SERVICE
- ALL YES/NO QUESTIONS MUST BE ANSWERED\*\*
- DENTIST'S 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 DENTISTS MUST SUBMIT A COPY OF THEIR NYS EDUCATION DEPARTMENT LICENSE/REGISTRATION RENEWAL CERTIFICATE
- OUT OF STATE DENTISTS MUST SUBMIT A COPY OF THEIR LICENSE DOCUMENTATION FROM THEIR STATE'S LICENSING AGENCY.

DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM

IF YOU ARE REPORTING A FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):

- SUBMIT A COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN.

IF MOBILE VAN:

- IF YOU ARE PROVIDING MOBILE DENTAL SERVICES, YOU MUST ATTACH A SEPARATE SHEET OF PAPER EXPLAINING YOUR SERVICE AND INCLUDE THE VEHICLE IDENTIFICATION NUMBER (VIN) OF THE VEHICLE AND A COPY OF ITS REGISTRATION.

IF SALARIED/CONTRACT:

- 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.

IF YOU ARE A DENTAL SPECIALIST:

- COMPLETE ENCLOSED SPECIALTY APPLICATION (EMEDNY-4903 APPLICATION FOR ENROLLMENT) AND SUBMIT APPROPRIATE DOCUMENTATION.

#### 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  
DENTIST ENROLLMENT FORM INSTRUCTIONS**

- CATEGORY OF SERVICE:** This field must be completed.
- PROVIDER NUMBER:** Leave blank.
- APPLICATION TYPE:** This field must be completed. (See Required Documentation on page 2 of the Checklist.)
- APPLICANT NAME:** Enter the provider name exactly as it appears on your license/registration; that is **last name, first name**.
- DOING BUSINESS AS:** If applicable.
- NATIONAL PROVIDER IDENTIFIER (NPI)** Enter your NPI.
- FEDERAL EMPLOYER ID NUMBER:** If the Department of Treasury, Internal Revenue Service letter is issued to you, please attach a copy. The Federal Employer Identification Number (FEIN) can only be put on your file if the government issued tax certificate is issued in your name. It cannot be put on the file if the FEIN is issued in company's or group's name.
- SOCIAL SECURITY NUMBER:** This is a **mandatory** field.
- 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 dentist 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 request that your checks be sent to an address other than the correspondence address, complete this section. This may be a P.O. Box. If you want your Medicaid checks to be sent to your correspondence address, write "SAME".

**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 **EMEDNY-490101 Additional Service Addresses**.

**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 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.

**DENTAL SPECIALTY CODE:**

Enter the 3 digit code that represents your specialty. Codes are listed on the back of the Specialty Application. **Attach a copy of the Board Certificate.** If not Board Certified, complete the Specialty Application.

**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

**GROUP/ORGANIZATION:**

If you are applying to be a member of a group currently enrolled in the New York State Medicaid Program, enter the Provider Name, Provider # and National Provider Identifier of the of the group.

**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.

**EMAIL ADDRESS:**

Enter your email address if applicable.

**SIGNATURE OF PROVIDER:**

Providers 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:

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

DENTIST  
CATEGORY OF SERVICE 0200  
 0200 DENTIST (OFFICE)  
 0200 DENTIST (MOBILE VAN)

MEDICAID PROVIDER ENROLLMENT

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

PROVIDER NUMBER  (LEAVE BLANK)

APPLICANT NAME   
NAME EXACTLY AS IT APPEARS ON YOUR LICENSE/REGISTRATION

NATIONAL PROVIDER IDENTIFIER (NPI)

YOUR D/B/A NAME OR ANY OTHER NAME THAT THE COMPANY IS KNOWN BY

FEDERAL EMPLOYER ID NUMBER  SOCIAL SECURITY NUMBER  (REQUIRED)

APPLICATION TYPE  
 New Enrollment/Reactivation  
 Reinstatement (See definition on pg 2 of checklist)

CORRESPONDENCE ADDRESS (Claim forms and mail)

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

STREET - LINE 1   
- 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.

LICENSING INFORMATION - Attach Copy

LICENSE No.

AGENCY CODE  NYS Dentist (03)  
 Out-of-State Dentist (99)

LIMITED LICENSE PROVIDER   
Please submit a copy of your current NYS Education Dept. Affidavit of Agreement Letter (2 pages)

DEA - Attach Copy

PAY TO ADDRESS (Checks and Remittance Statements)

STREET - LINE 1   
- LINE 2

CITY   
Do NOT use abbreviations

STATE  ZIP CODE  COUNTY

MEDICARE INFORMATION  
Are you enrolled in Medicare?  Yes  No

DENTAL SPECIALTY CODE

The Dental Specialty Codes can be found on the back of the Specialty Application. (DOH-529)

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.

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.

PLACE OF SERVICE (Check ONE)

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

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.

GROUP/ORGANIZATION MEDICAID PROVIDER NUMBER AND NATIONAL PROVIDER IDENTIFIER (NPI)

GROUP/ORGANIZATION PROVIDER NAME

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.

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?

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  
EMEDNY-416401 (01/10)

EMAIL ADDRESS

PREPARER NAME & TITLE (PRINT) TELEPHONE #

## DISCLOSURE OF OWNERSHIP AND CONTROL

### INDIVIDUAL

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**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.

**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.

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)\_\_\_\_\_

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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 | Address | Social Security Number | Relationship of Person to you | Federal Employer Identification Number |
|------|---------|------------------------|-------------------------------|--|
|      |         |                        |                               |  |
|      |         |                        |                               |  |

6. Type of entity:  
 Sole Proprietorship       Unincorporated Association       Partnership  
 Corporation                       Non Profit                       Other (Specify) \_\_\_\_\_

7. Has there been a change of ownership or control within the last 12 months to any of the above listed entities?  
 Yes                       No  
 If "Yes", give Date: \_\_\_\_\_

8. Do you anticipate a change of ownership within the next 12 months to any of the above listed entities?  
 Yes                       No  
 If "Yes", When: \_\_\_\_\_

**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 (Please print or type) \_\_\_\_\_ TITLE(eg., MD, RN, DC, DDS, etc.) \_\_\_\_\_

SIGNATURE (STAMPS ARE NOT ACCEPTABLE) \_\_\_\_\_ 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** \_\_\_\_\_ ]

**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** \_\_\_\_\_ ]

**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** \_\_\_\_\_ ]

**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)

**Application for Enrollment as a Specialist**  
**NEW YORK STATE DEPARTMENT OF HEALTH**

- INSTRUCTIONS:** (1) Type or print the information requested in the space provided.  
 (2) Submit a copy of ALL of the following appropriate documents:  
 (a) certification by an appropriate specialty board; or  
 (b) notice of admissibility to final examination from appropriate specialty board; or  
 (c) evidence of satisfactory completion of residency or fellowship training.  
 (3) Submit completed application and required documentation to  
**Computer Sciences Corporation**  
**P.O. Box 4610**  
**Rensselaer, NY 12144-4610.**

**SECTION A - APPLICANT INFORMATION**

1. Name [ \_\_\_\_\_ ] [ \_\_\_\_\_ ] [ \_\_\_\_\_ ] MI  
Last First MI
2. Address \_\_\_\_\_
3. (a) License No. [ \_\_\_\_\_ ] (b) State [ \_\_\_\_\_ ] (c) National Provider Identifier [ \_\_\_\_\_ ]  
 (d) Provider # [ \_\_\_\_\_ ]
4. Soc. Sec. # [ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ]
5. (a) Specialty(ies) Requested \_\_\_\_\_ (b) Code nos. [ \_\_\_\_\_ ] [ \_\_\_\_\_ ] [ \_\_\_\_\_ ]  
 (See Reverse)

**SECTION B - EDUCATION AND TRAINING**

|                | Name and address of institution<br><small>(city and state or country if outside USA)</small> | Dates                          |                              | Degree/Specialty |
|----------------|--|--------------------------------|------------------------------|------------------|
|                |  | From<br><small>Mo. Yr.</small> | To<br><small>Mo. Yr.</small> |                  |
| MEDICAL/DENTAL | _____  | [ __/__/ ]                     | [ __/__/ ]                   | _____            |
| INTERNSHIP     | _____  | [ __/__/ ]                     | [ __/__/ ]                   | _____            |
| RESIDENCY      | _____  | [ __/__/ ]                     | [ __/__/ ]                   | _____            |
| FELLOWSHIP     | _____  | [ __/__/ ]                     | [ __/__/ ]                   | _____            |

**SECTION C - HOSPITAL APPOINTMENT INFORMATION (for last five years only)**

| Name & address | Dates                          |                              | Title & Specialty | Average Hours/Week |
|----------------|--------------------------------|------------------------------|-------------------|--------------------|
|                | From<br><small>Mo. Yr.</small> | To<br><small>Mo. Yr.</small> |                   |                    |
| _____          | [ __/__/ ]                     | [ __/__/ ]                   | _____             | [ _____ ]          |
| _____          | [ __/__/ ]                     | [ __/__/ ]                   | _____             | [ _____ ]          |

**SECTION D - U.S. SPECIALTY BOARD CERTIFICATION(S)**

Name of Board \_\_\_\_\_ Certification Date MO DA YR  
[ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

\_\_\_\_\_ Certification Date [ ][ ][ ] [ ][ ][ ] [ ][ ][ ]

**SECTION E - ORTHODONTISTS ONLY**

If not in exclusive practice, what % of practice is devoted to orthodontics? [ \_\_\_\_\_ ] %  
M D Y M D Y M D Y M D Y

General Practice from [ ][ ][ ] to [ ][ ][ ] Orthodontics from [ ][ ][ ] to [ ][ ][ ]

≡ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PROVIDER SPECIALTY CODES**  
**PHYSICIAN SPECIALTY CODES**

| <u>CODE</u> | <u>SPECIALTY</u>                 | <u>CODE</u> | <u>SPECIALTY</u>  |
|-------------|----------------------------------|-------------|---|
| 010         | <b>ALLERGY AND IMMUNOLOGY</b>    |             | <b>PEDIATRICS</b>   |
|             |                                  | 150         | Pediatrics  |
| 020         | <b>ANESTHESIOLOGY</b>            | 151         | Pediatric Cardiology  |
|             |                                  | 152         | Pediatric Hematology-Oncology                                     |
| 102         | <b>ASTHMA EDUCATOR</b>           | <b>154</b>  | Pediatric nephrology  |
|             |                                  | 155         | Neonatal-Perinatal Medicine                                       |
|             | <b>DERMATOLOGY</b>               | 156         | Pediatric Endocrinology   |
| 040         | Dermatology                      | 157         | Pediatric Pulmonology   |
| 041         | Dermatopathology                 | 161         | Pediatric Critical Care   |
|             |                                  | 163         | Pediatric Gastroentology  |
| 103         | <b>DIABETES EDUCATOR</b>         |             |   |
|             |                                  | 160         | <b>PHYSICAL MEDICINE &amp; REHABILITATION</b>                     |
| 250         | <b>EMERGENCY MEDICINE</b>        |             |   |
| 050         | <b>FAMILY PRACTICE</b>           | 162         | <b>OSTEOPATHIC MANIPULATIVE MEDICINE</b>                          |
|             |                                  |             |   |
|             | <b>INTERNAL MEDICINE</b>         |             | <b>PREVENTIVE MEDICINE</b>  |
| 060         | Internal Medicine                |             | General Preventive Medicine                                       |
| 062         | Cardiovascular Disease           | 182         | Occupational Health   |
| 063         | Endocrinology & Metabolism       | 183         | Public Health   |
| 064         | Gastroenterology                 | 184         | Aerospace Medicine  |
| 065         | Hematology                       | 185         |   |
| 066         | Infectious Disease               |             | <b>PSYCHIATRY AND NEUROLOGY</b>                                   |
| 067         | Nephrology                       |             | Child Psychiatry  |
| 068         | Pulmonary Disease                | 191         | Psychiatry  |
| 069         | Rheumatology                     | 192         | Child Neurology y   |
| 241         | Medical Oncology                 | 193         | Neurology   |
|             |                                  | 194         | Psychiatry and Neurology  |
| 080         | <b>NUCLEAR MEDICINE</b>          | 195         |   |
|             | <b>OBSTETRICS AND GYNECOLOGY</b> |             | <b>RADIOLOGY</b>  |
| 089         | Obstetrics and Gynecology        |             | Radiology   |
| 092         | Maternal & Fetal Medicine        | 200         | Diagnostic Radiology  |
| 093         | Reproductive Endocrinology       | 201         | Diagnostic Radiology with Special Competence in Nuclear Radiology |
| 242         | Gynecologic Oncology             | 202         | Therapeutic Radiology   |
| 100         | <b>OPHTHALMOLOGY</b>             | 205         |   |
| 120         | <b>OTOLARYNGOLOGY</b>            | 187         | <b>MEDICAL GENETICS</b>   |
|             |                                  |             |   |
|             | <b>PATHOLOGY</b>                 |             | <b>SURGERY</b>  |
| 131         | Blood Banking                    | 030         | Colon and Rectal Surgery  |
| 135         | Clinical Pathology               | 070         | Neurological Surgery  |
| 136         | Forensic Pathology               | 110         | Orthopedic Surgery  |
| 137         | Hematology                       | 153         | Pediatric Surgery   |
| 138         | Chemical Pathology               | 170         | Plastic Surgery   |
| 139         | Medical Microbiology             | 210         | General Surgery   |
| 141         | Neuropathology                   | 220         | Thoracic Surgery  |
| 142         | Anatomic Pathology               |             |   |
| 143         | Dermatopathology                 | 230         | <b>UROLOGY</b>  |
| 146         | Anatomic & Clinical Pathology    |             |   |
| 148         | Radioisotopic Pathology          |             |   |

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**DENTAL SPECIALTY CODES**

| <u>CODE</u> | <u>SPECIALTY</u> | <u>CODE</u> | <u>SPECIALTY</u>              |
|-------------|------------------|-------------|-------------------------------|
| 801         | Orthodontics     | 806         | Periodontics                  |
| 802         | Endodontics      | 807         | Public Health                 |
| 803         | Oral Pathology   | 808         | Oral Surgery                  |
| 804         | Pedodontics      | 809         | Dental Anesthesiology         |
| 805         | Prosthodontics   | 810         | Parenteral Conscious Sedation |