



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. All Nurse Registries must have a Department of Health license prior to enrolling with Medicaid.

The effective date of your enrollment cannot be earlier than the date a complete application is received by the Department. If additional information must be requested to complete the enrollment package, the date of enrollment will be the date the package is complete.

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.

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

When you are enrolled in the Medicaid Program, you will receive a letter informing you of your acceptance and the effective date of your enrollment. Approximately two weeks after you receive your acceptance letter, you will receive a package containing claim forms and instructions on how to obtain the appropriate Provider Manual which is available online at 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. The Medicaid Update may also be accessed online at www.eMedNY.org. Click 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.

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 (800) 343-9000.

Sincerely,

Fee for Service Provider Enrollment Bureau
Office of Health Insurance Programs

MEDICAID PROVIDER ENROLLMENT NURSE REGISTRY ENROLLMENT 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	SOCIAL SECURITY NUMBER (ONLY IF SELF-EMPLOYED)
APPLICATION TYPE*	CORRESPONDENCE ADDRESS
APPLICANT NAME	SERVICE ADDRESS
NATIONAL PROVIDER IDENTIFIER (NPI)	ALL YES/NO QUESTIONS MUST BE ANSWERED **
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	OWNER'S 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. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES.

REQUIRED DOCUMENTATION TO BE SUBMITTED

MEDICAID PROVIDER ENROLLMENT : NURSE REGISTRY FORM (REQUIRES OWNER'S SIGNATURE)	DISCLOSURE OF OWNERSHIP AND CONTROL – BUSINESS ENTITY FORM (REQUIRES OWNER'S SIGNATURE)
MEDICAID PROVIDER ENROLLMENT: NURSE REGISTRY EMPLOYEE LIST	COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN
COPY OF LICENSE – CHAPTER 959 LICENSED AGENCY IN ACCORDANCE WITH 10 NYCRR SUBPART 765-2	

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 NURSE REGISTRY ENROLLMENT FORM INSTRUCTIONS

CATEGORY OF SERVICE:	Check the category that applies to services you render.
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 Home Care Agency License.
DOING BUSINESS AS:	If applicable.
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter your NPI.
FEDERAL EMPLOYER ID NUMBER:	Enter the Federal Employer Identification Number issued to the Registry and attach a copy of the Department of the Treasury Internal Revenue Service letter confirming your FEIN.
SOCIAL SECURITY NUMBER:	If applicable.
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 nurse registry, 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 must be the physical location of your business.

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.

OWNERSHIP CODE: Enter the number that is applicable.

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

MEDICARE INFORMATION: Indicate whether you are enrolled in Medicare.

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. 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:

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

NURSE REGISTRY

CATEGORY OF SERVICE (Check which apply)

0523 LPN AGENCY/REGISTRY

0524 RN AGENCY/REGISTRY

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

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

NATIONAL PROVIDER IDENTIFIER (NPI)

FEDERAL EMPLOYER ID NUMBER

SOCIAL SECURITY NUMBER (IF SELF EMPLOYED)

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.

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

PAY TO ADDRESS (Checks and Remittance Statements)
ATTENTION
STREET - LINE 1 Enter the NAME of the person/department/apartment number where the mail should be sent
- LINE 2
CITY Do NOT use abbreviations
STATE ZIP CODE - COUNTY

LICENSING INFORMATION - MUST Attach Copy of your Home Care Agency License
LICENSE No.
AGENCY CODE NYS (03) Out-of-State (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.

MEDICARE INFORMATION
Are you enrolled in Medicare? Yes No

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.

QUESTIONS

YES	NO	QUESTIONS
<input type="checkbox"/>	<input type="checkbox"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	Is there currently pending any proceedings that could result in the above stated sanctions?

OWNER NAME (PRINT)

EMAIL ADDRESS

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

PREPARER NAME (PRINT)

DISCLOSURE OF OWNERSHIP AND CONTROL

BUSINESS ENTITY

NAME OF 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 above named agency, institution or organization.

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	Residence Address	Social Security Number	Federal Employer Identification Number

6. Type of entity:
 - Sole Proprietorship
 - Unincorporated Association
 - Partnership
 - Corporation
 - Governmental
 - 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

Owner's Name	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", give Date: _____

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

Yes No

If "Yes", When: _____

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 of change of operations: _____

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

Yes No

Not Applicable

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 OF OWNER/BOARD MEMBER (Please print or type)

TITLE

SIGNATURE (STAMPS ARE NOT ACCEPTABLE)

DATE