



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.

PLEASE NOTE: If you are already enrolled as a Salaried Optician or Salaried Optometrist and are seeking to change your category of service to Self-Employed, you also must complete the CHANGE OF CATEGORY AND/OR ADDRESS FORM (eMedNY-428901).

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.
- **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.**
- If your application is approved, the effective date of your enrollment will be specified 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.
- 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.

The New York State Department of Health and the Department of Correctional Services (DOCS) have jointly implemented a program to provide eyeglass materials to Medicaid recipients whose county of fiscal responsibility is a county other than New York City. Under this program, if you become enrolled in the Medicaid Program as an eyeglass dispenser (i.e., optometrist, optician, or retail optical establishment) you would forward eyeglass prescriptions for Medicaid recipients to the DOCS/DOH Project so that the materials can be produced by DOCS at their Walkkill facility in Ulster County. The completed eyeglasses will be returned directly to you. Dispensing providers will continue to bill the Medicaid Program for their other professional services, i.e., examinations and dispensing fees. If you service recipients from counties other than New York City, you should contact DOCS at (800) 836-2636 to receive an information package, sample frame kit and order forms.

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. 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, 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.

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

Self-Employed Optician/Optomtrist/Eye Prosthesis
EMEDNY-422101 (09/09)

**MEDICAID PROVIDER ENROLLMENT
SELF-EMPLOYED OPTICIAN/SELF-EMPLOYED OPTOMETRIST
AND EYE PROSTHESIS 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)	CORRESPONDENCE ADDRESS
TYPE OF APPLICATION*	PAY TO ADDRESS
APPLICANT NAME	SERVICE ADDRESS
NATIONAL PROVIDER IDENTIFIER (NPI)	ALL YES/NO QUESTIONS MUST BE ANSWERED**
SOCIAL SECURITY NUMBER	SPECIALTY CODE – IF APPLICABLE
	APPLICANT'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: SELF-EMPLOYED OPTICIAN/SELF-EMPLOYED OPTOMETRIST AND EYE PROSTHESIS FORM	COPY OF MEDICARE AWARD LETTER – (IF APPLICABLE)
COPY OF LICENSE/REGISTRATION	COPY OF LOW VISION CERTIFICATE (IF APPLICABLE) (Specialty 714)
DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM	COPY OF CONTACT LENS CERTIFICATE (IF APPLICABLE) (Specialty 715)
	COPY OF OCCULARIST/PROSTHESIS CERTIFICATE (COS 0405)

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
SELF-EMPLOYED OPTICIAN/SELF-EMPLOYED OPTOMETRIST AND EYE PROSTHESIS
FORM INSTRUCTIONS**

CATEGORY OF SERVICE:	Check the category that applies.
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 .
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 optician/optometrist 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 Medicaid 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 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".

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 with 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.**

SPECIALTY CODE: Check the specialty code that applies.

MEDICARE INFORMATION Indicate whether you are enrolled in Medicare.

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, the Group MMIS # and the National Provider Identifier of the Group. **YOU MAY ONLY JOIN A MULTI SERVICE GROUP (COS 090).**

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.

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

APPLICANT'S SIGNATURE: Applicant's 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

SELF-EMPLOYED OPTICIAN/ SELF-EMPLOYED OPTOMETRIST
 CATEGORY OF SERVICE:
 0404 SELF-EMPLOYED OPTICIAN
 0405 EYE PROSTHESIS SERVICE
 0422 SELF-EMPLOYED OPTOMETRIST

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

NATIONAL PROVIDER IDENTIFIER (NPI) FEDERAL EMPLOYER ID NUMBER SOCIAL SECURITY NUMBER (REQUIRED)

CORRESPONDENCE ADDRESS (Claim forms and mail)

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

STREET - LINE 2

CITY

STATE ZIP CODE - COUNTY
Do NOT use abbreviations

TELEPHONE () - EXT.

LICENSING INFORMATION - Attach Copy

LICENSE No.

AGENCY CODE NYS Self-Employed Optician/ Self-Employed Optometrist (03)
 Out-of-State Self-Employed Optometrist/Self-Employed Optician (99)

LICENSE BEGIN DATE

PAY TO ADDRESS (Checks and Remittance Statements)

ATTENTION

STREET - LINE 1

STREET - LINE 2

CITY

STATE ZIP CODE - COUNTY
Do NOT use abbreviations

SPECIALTY CODE (Check which apply)

714 - Low Vision Specialist
 715 - Contact Lens Privilege
 716 - Optometrist/Diagnostic Pharmaceuticals

MEDICARE INFORMATION
 Are you enrolled in Medicare? Yes No

GROUP/ORGANIZATIONAL MEDICAID PROVIDER NUMBER AND NATIONAL PROVIDER IDENTIFIER (NPI).

SERVICE ADDRESS INFORMATION

ATTENTION

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

STREET - LINE 2

CITY

STATE ZIP CODE - COUNTY
Do NOT use abbreviations

TELEPHONE () - EXT.

GROUP/ORGANIZATION PROVIDER NAME

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

COUNTY
CITY - DO NOT USE ABBREVIATIONS

- () -
STATE ZIP CODE TELEPHONE EXT.

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 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?

EMAIL ADDRESS

DATE SIGNED

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

PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)

PREPARER NAME (PRINT) TELEPHONE #

DISCLOSURE OF OWNERSHIP AND CONTROL

INDIVIDUAL

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.

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)_____

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 _____

**CHANGE OF CATEGORY AND/OR ADDRESS FORM
FOR CURRENTLY ENROLLED OPTICIAN/OPTOMETRIST**

Use this form only if you are currently enrolled in the NYS Medical Program and have an active status to change your current category of service and/or your current service address.

NOTE:
Each Optician/Optomtrist **MUST** complete and sign this form.
You may photocopy this form to obtain the number of forms needed.

1. Optician/Optomtrist Name: _____

2. National Provider Identifier (NPI): _____

NYS Medicaid Identification Number: _____

3. Requesting to change current category of service.

Requesting to have an additional category of service.

4. Check the appropriate box to indicate the change or additional category of service.

0403 Salaried Optician

0404 Self-Employed Optician

0421 Salaried Optometrist

0422 Self-Employed Optometrist

5. If the box above is checked requesting a change or additional category of service that is salaried, list the name and address of the optical establishment.

Optical Establishment Name: _____

Address: _____

National Provider Identifier (NPI) for Optical Establishment:

NYS Medicaid Identification Number for Optical Establishment:

6. If self-employed, complete the required address criteria:

a) Pay to address: _____

b) List any additional service address(es) to be added to the file.

(1.) _____ (3.) _____

(2.) _____ (4.) _____

7. If you are enrolled in the NYS Medicaid Program, do you have a low vision certificate?

Yes No

a) If yes, submit a copy of your current license/registration.

b) List the address where the service is provided.

I swear that the information listed above is accurate.

Print full name.

NAME _____
FIRST MIDDLE LAST

SIGNATURE _____ DATE _____

Mail to: **COMPUTER SCIENCES CORPORATION
P.O. BOX 4603
RENSSELAER, NY 12144**