



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.

**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.**

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](http://www.eMedNY.org). If you do not have internet access, you may 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](http://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](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.

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

Sincerely,

Fee for Service Provider Enrollment Bureau  
Office of Health Insurance Programs

Hearing Aid Dealer/Audiologist  
EMEDNY-423101 (09/09)

## **MEDICAID PROVIDER ENROLLMENT HEARING AID DEALER/AUDIOLOGIST 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	CORRESPONDENCE ADDRESS
APPLICATION TYPE*	PAY TO ADDRESS
NATIONAL PROVIDER IDENTIFIER (NPI)	SERVICE ADDRESS
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	ALL YES/NO QUESTIONS MUST BE ANSWERED **
SOCIAL SECURITY NUMBER	PROVIDER/OWNER'S ORIGINAL SIGNATURE

\*IF REINSTATEMENT IS CHECKED PLEASE SEE REQUIRED DOCUMENTATION ON PAGE 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**

- NEW YORK STATE HEARING AID DEALERS MUST SUBMIT A COPY OF THEIR NYS DEPARTMENT OF STATE REGISTRATION.
- OUT OF STATE HEARING AID DEALERS MUST SUBMIT A COPY OF THEIR LICENSE/REGISTRATION FROM THEIR APPROPRIATE STATE AGENCY, IF APPLICABLE.
- NEW YORK STATE AUDIOLOGISTS MUST SUBMIT A COPY OF THEIR NYS EDUCATION DEPARTMENT LICENSE/REGISTRATION.
- OUT OF STATE AUDIOLOGISTS MUST SUBMIT A COPY OF THEIR LICENSE/REGISTRATION FROM THEIR APPROPRIATE STATE AGENCY.
- ALL AUDIOLOGISTS MUST SUBMIT A COPY OF THEIR MEDICARE AWARD LETTER.
- HEARING AID DEALER'S AUDIOLOGIST EMPLOYEE LIST FORM AND SUBMIT A CURRENT COPY OF EACH AUDIOLOGIST'S LICENSE/REGISTRATION.

- IF YOU ARE REPORTING A FEDERAL EMPLOYEE IDENTIFICATION NUMBER (FEIN), SUBMIT A COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN.
- DISCLOSURE OF OWNERSHIP AND CONTROL – BUSINESS ENTITY FORM **(REQUIRES OWNER'S SIGNATURE)**
- IF YOU ARE APPLYING FOR COS 0325 ONLY YOU MUST COMPLETE THE DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM.

### **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  
HEARING AID DEALER/AUDIOLOGIST ENROLLMENT FORM INSTRUCTIONS**

- PROVIDER NUMBER:** Leave blank.
- CATEGORY OF SERVICE:** Check the category that applies to services you render.
- 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.
- 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.
- SOCIAL SECURITY NUMBER:** This is a **mandatory** field for audiologist.
- 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 hearing aid dealer/audiologist 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".

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

**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

HEARING AID DEALER/  
AUDIOLOGIST

**MEDICAID PROVIDER ENROLLMENT**

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

PROVIDER NUMBER	(LEAVE BLANK)	CATEGORY OF SERVICE (Check which apply)	APPLICATION TYPE
<input type="text"/>		<input type="checkbox"/> 0322 HEARING AID DEALER	<input type="checkbox"/> New Enrollment/Reactivation
		<input type="checkbox"/> 0324 HEARING AID DEALER/AUDIOLOGIST	<input type="checkbox"/> Reinstatement (See definition on pg 2 of checklist)
		<input type="checkbox"/> 0325 AUDIOLOGIST	

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

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION

STREET - LINE 1

STREET - LINE 2

CITY

STATE  ZIP CODE  -  COUNTY

TELEPHONE (  ) -  EXT.

OWNERSHIP CODE

69 - Public-Federal 73 - Voluntary

70 - Public-County 74 - Proprietary (Profit)-Corporation

71 - Public-Municipal 75 - Proprietary (Profit)-Partnership

72 - Public-State 76 - Proprietary (Profit)-Individual

HEARING AID DEALER  
Registration Number - Attach Copy

LICENSE NUMBER

AGENCY CODE  NYS Department of State (04)  
 Out-of-State (99)

PAY TO ADDRESS (Checks and Remittance Statements)

ATTENTION

STREET - LINE 1

STREET - LINE 2

CITY

STATE  ZIP CODE  -  COUNTY

TELEPHONE (  ) -  EXT.

AUDIOLOGIST  
License Number (Attach Copy)

AGENCY CODE  NYS Education Department (03)  
 Out-of-State (99)

SERVICE ADDRESS INFORMATION

ATTENTION

STREET - LINE 1

STREET - LINE 2

CITY

STATE  ZIP CODE  -  COUNTY

TELEPHONE (  ) -  EXT.

MEDICARE INFORMATION  
Are you enrolled in Medicare?  Yes  No

**YES NO**

Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?

Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?

Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any State?

Is there currently pending any proceedings that could result in the above stated sanctions?

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.

EMAIL ADDRESS

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

PREPARER NAME (PRINT)  TELEPHONE #

OWNER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)

PRINT OWNER NAME

DATE SIGNED

## 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 \_\_\_\_\_



## 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

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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