



# 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 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.

**In addition, for Ambulette providers the following applies:**

- Enrollment into the program does not guarantee payment by the program. All non-emergency transports must be prior authorized by the fiscally responsible local department of social services to allow for payment.
- You must contact the Department of Social Services in the area which you intend to operate to see if that agency has a need for your service and if it has any contractual arrangements that you have to meet. The local department of social services is the prior authorization agent for Medicaid transportation and payment cannot be made without their approval.

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.

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 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](http://www.eMedNY.org). Click Information, then Medicaid Provider Updates.

**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, please contact the eMedNY Call Center at (800) 343-9000.

Sincerely,

Fee for Service Provider Enrollment Bureau  
Office of Health Insurance Programs

Transportation  
EMEDNY-424101 (09/09)

## CERTIFICATION/REGISTRATION REQUIREMENTS FOR ENROLLMENT AS A TRANSPORTATION PROVIDER

**AMBULANCE:** Category of Service 0601

- ❖ Provide your National Provider Identifier (NPI).
- ❖ New York State Department of Health Ambulance Service Certification

**INVALID COACH (AMBULETTE):** Category of Service 0602 **and/or**  
**DAY TREATMENT TRANSPORTATION:** Category of Service 0606

- ❖ New York State Department of Transportation (DOT) Common Carrier Certificate, **or** Contract Carrier Permit **or** a letter of exemption issued by the New York State Department of Transportation.

**Please note:** an exemption letter issued by the Department of Transportation stating that you are using station wagons, sedans or mini vans is **not a valid exemption letter for ambulette service**. These vehicles do not meet the New York State Medicaid Program's definition of an ambulette.

- ❖ New York State Department of Motor Vehicles (DMV) letter of receipt and acceptance of your Article 19-A Affidavit of Compliance with an issuance date on or after the most recent April **or** a letter of exemption issued by the New York State Department of Motor Vehicles.
- ❖ **Category of Service 0602** – You must also submit a letter or letters of support from the county (usually from the Department of Social Services in the county) if your DOT certificate specifically indicates services within the following counties: Suffolk; Nassau; Westchester; Rockland; Orange; Erie

**Please note:** If your DOT certificate and/or permit authorizes you to **provide services in any of the five boroughs in New York City**, you are required to submit a copy of your Taxi and Limousine Commission (TLC) Paratransit Base Operator's License, with an issuance date on or after the most recent May 1st.

**TAXI:** Category of Service 0603 (**Counties outside New York City**)

- ❖ A county approval letter dated on or after January 1st of the current year signed by the Commissioner of the County Department of Social Services.

Category of Service 0603 (**Westchester County only**)

- ❖ Copy of Approval Letter from Westchester County Taxi and Limousine Commission which includes proof of valid Base Station Registration and Vehicle Registration.

**LIVERY:** Category of Service 0605 (**New York City Only**)

- ❖ New York City Taxi and Limousine Commission For Hire Base License. The issuance date must be on or after the most recent May 1st.

### REFERENCE PHONE NUMBERS:

New York State Department of Transportation: (518) 457-6503  
New York State Department of Motor Vehicles: (518) 473-9455  
New York City Taxi and Limousine Commission: (718) 391-5609  
Westchester County Taxi and Limousine Commission: (914) 231-3678

EMEDNY-424201 (01/10)

**MEDICAID PROVIDER ENROLLMENT  
TRANSPORTATION 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**

APPLICATION TYPE *	PAY TO ADDRESS
CATEGORY OF SERVICE (SEE "ADDITIONAL INSTRUCTIONS FOR COS")	SERVICE ADDRESS
APPLICANT NAME	ALL YES/NO QUESTIONS MUST BE ANSWERED **
NATIONAL PROVIDER IDENTIFIER (NPI) (AMBULANCE 0601)	LICENSE INFORMATION
SOCIAL SECURITY NUMBER (SELF-EMPLOYED)	MEDICARE INFORMATION (AMBULANCE 0601)
APPLICATION DATE (AMBULANCE 0601 AND TAXI 0603)	OWNER'S SIGNATURE
CORRESPONDENCE ADDRESS	

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

**REQUIRED DOCUMENTATION TO BE SUBMITTED**

MEDICAID PROVIDER ENROLLMENT: TRANSPORTATION FORM	TRANSPORTATION INFORMATION REQUEST FORM
COPY OF CURRENT CERTIFICATION/REGISTRATION (REFER TO PAGE 1 OF THE "TRANSPORTATION INFORMATION REQUEST" FORM FOR THE APPROPRIATE LICENSING DOCUMENTATION)	COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER CONFIRMING YOUR FEIN
DISCLOSURE OF OWNERSHIP AND CONTROL – BUSINESS ENTITY FORM	COPY OF YOUR MEDICARE AWARD LETTER (AMBULANCE 0601)

## REINSTATEMENTS

AN APPLICATION IS CONSIDERED TO BE A REINSTATEMENT IF THE APPLICATION WAS PREVIOUSLY EXCLUDED/TERMINATED FROM THE MEDICAID PROGRAM AS A RESULT OF COMMITTING AN UNACCEPTABLE PRACTICE, DISCIPLINE ACTION TAKEN AGAINST THEIR LICENSE, INDICTMENT, CONVICTION OR MEDICARE EXCLUSION.

IF YES ANSWERED TO ANY OF THE FOUR QUESTIONS, YOU MUST COMPLETE THE PRIOR CONDUCT QUESTIONNAIRE AVAILABLE AT [WWW.EMEDNY.ORG](http://WWW.EMEDNY.ORG). YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES. IF YOU ANSWER YES TO THE FIRST OF THE YES/NO QUESTIONS BECAUSE YOU WERE EXCLUDED, TERMINATED, SANCTIONED, OR RESTRICTED BY AN AGREEMENT FROM ANY MEDICAID PROGRAM AND/OR MEDICARE PROGRAM YOU MAY BE REQUESTED TO SUPPLY INFORMATION AND/OR DOCUMENTATION DETAILING ALL CORRECTIVE STEPS YOU HAVE TAKEN TO DEMONSTRATE THE VIOLATIONS THAT LED TO YOUR EXCLUSION/TERMINATION WILL NOT BE REPEATED.

### EXAMPLES:

- RE-EDUCATION COURSES;
- ATTESTATIONS FROM THIRD PARTY PAYERS;
- REPORTS FROM QUALITY ASSURANCE COMMITTEES REGARDING REVIEW OF RECORDS;
- MEDICARE REINSTATEMENT

### PLEASE NOTE:

**IF AN APPLICANT IS DENIED REINSTATEMENT, THE APPLICANT CANNOT RE-APPLY FOR REINSTATEMENT FOR TWO (2) YEARS FROM THE DATE OF THE DENIAL.**

# INSTRUCTIONS FOR COMPLETING AND SUBMITTING THE MEDICAID PROVIDER ENROLLMENT APPLICATION

## GENERAL INSTRUCTIONS

- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- Forms containing white out will be rejected.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not use staples.
- When including attachments less than 8 ½ “ x 11” in size, affix the attachment (using transparent single-sided tape) to an 8 ½” x 11” sheet of paper. When required attachments are greater than 8 ½ “ x 11” in size, make a reduced copy of the attachment using an 8 ½ “ x 11” sheet of paper.
- Double-sided forms will be rejected.

## MEDICAID PROVIDER ENROLLMENT TRANSPORTATION FORM INSTRUCTIONS

<b>PROVIDER NUMBER:</b>	Leave blank.
<b>OWNERSHIP CODE:</b>	Enter the number that is applicable.
<b>CATEGORY OF SERVICE:</b>	Check the categories that apply. <b>(SEE ADDITIONAL INSTRUCTIONS FOR COS).</b>
<b>APPLICATION TYPE:</b>	This field must be completed. (See Required Documentation on page 2 of the Checklist.)
<b>APPLICANT NAME:</b>	Enter the name exactly as it appears on your certification/registration.
<b>DOING BUSINESS AS (DBA):</b>	If applicable.
<b>NATIONAL PROVIDER IDENTIFIER (NPI)</b>	You must provide your NPI if you are applying for COS 0601, Ambulance..
<b>FEDERAL EMPLOYER ID NUMBER:</b>	Enter the Department of Treasury, Internal Revenue Service Federal Employer Identification Number issued for the company. Attach a copy of the IRS assignment letter confirming the FEIN.
<b>SOCIAL SECURITY NUMBER:</b>	This field is <b>mandatory</b> if self-employed.

**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 company name or for an apartment or 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 must indicate where your medical records are located and must match your License/Certification.

**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 the appropriate licensing information for the categories of service for which you are applying. Attach the appropriate licensing documentation for each category of service which you are applying. (Refer to page 1 of the "Transportation Information Request" form for the appropriate licensing documentation.)

**MEDICARE INFORMATION** Indicate if you are enrolled in Medicare. **If you are applying for Ambulance COS 0601, you must be enrolled in Medicare. Submit a copy of your Medicare award letter.**

**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.

**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.**

**PREPARER' NAME:**

Print the name of the person completing this form and include a telephone number where the preparer can be reached.

**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

## **ADDITIONAL INSTRUCTIONS FOR CATEGORY OF SERVICE(S)**

If you are applying for Category of Service 0601 (Ambulance) **and** any additional Category of Service (0602, 0603, 0605, 0606) it is now necessary to complete two (2) enrollment applications.

For billing purposes, it will now be necessary to have one (1) Medicaid provider number for Category of Service 0601 (Ambulance) that **requires** a National Provider Identifier (NPI).

For atypical providers, a second Medicaid provider number is necessary for any additional Category of Service, such as 0602 (Ambulette), 0603 (Taxi outside NYC), 0605 (Livery NYC) or 0606 (Day Treatment) that **does not** require an NPI.

TRANSPORTATION

MEDICAID PROVIDER ENROLLMENT

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

CATEGORY OF SERVICE (Check which apply)
(See Additional Instructions For COS)
PROVIDER NUMBER (LEAVE BLANK)
APPLICATION TYPE
New Enrollment/Reactivation
Reinstatement (see definition on pg 2 of checklist)

APPLICANT NAME

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

NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED FOR COS 0601 AND 0609 ONLY
FEDERAL EMPLOYER ID NUMBER
SOCIAL SECURITY NUMBER (IF SELF-EMPLOYED)

CORRESPONDENCE ADDRESS (CLAIM FORMS AND MAIL)
ATTENTION
STREET - LINE 1
- LINE 2
CITY
STATE ZIP CODE COUNTY
TELEPHONE

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
- LINE 2
CITY
STATE ZIP CODE COUNTY

LICENSING INFORMATION
Provide a copy of the appropriate certification/registration for each requested Category of Service.
(See CERTIFICATION/REGISTRATION REQUIREMENTS FOR ENROLLMENT AS A TRANSPORTATION PROVIDER.)

SERVICE ADDRESS INFORMATION
ATTENTION
STREET - LINE 1
- LINE 2
CITY
STATE ZIP CODE COUNTY
TELEPHONE

MEDICARE INFORMATION
Are you enrolled in Medicare? Yes No
Medicare Award Letter required for COS 0601 and 0609 only.

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).
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
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 was 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?

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) PREPARER NAME (PRINT) TELEPHONE #
EMEDNY-424501 (09/09)

## 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](http://www.health.state.ny.us).**

In addition, pursuant to 42 CFR §455.105, by enrolling in the Medicaid Program, you are entering into an agreement with the NYS Department of Health by which you agree to and may be requested to provide the following information within 35 days upon request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request; and
2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.

**Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or Secretary of Health and Human Services, as appropriate.**

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NAME OF OWNER/BOARD MEMBER (Please print or type)

TITLE

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SIGNATURE (STAMPS ARE NOT ACCEPTABLE)

DATE

## Transportation Information Request

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. Attach additional sheets when necessary. **(SEE ADDITIONAL INSTRUCTIONS FOR COS).**

- Check each of the following services that are offered by your organization, and attach the corresponding certificates, registrations, permit or a copy of licenses (as marked by X) for each service. **(Refer to Form EMEDNY-4242 Certification/Registration Requirements for Enrollment as a Transportation Provider for a description of license requirements)**

	DOH	DOT	DMV	LOCAL DSS	TLC (Service New York City)
0601 <input type="checkbox"/> AMBULANCE	X				
0602 <input type="checkbox"/> AMBULETTE/ INVALID COACH		X	X		X
0606 <input type="checkbox"/> DAY TREATMENT		X	X		X
0605 <input type="checkbox"/> LIVERY					
0603 <input type="checkbox"/> TAXI (COUNTIES OUTSIDE NYC)				X	X (Also required for Westchester County) 0603

- Are you an out of state provider of medical services interested in participation for one occurrence of care delivered to one beneficiary?

Yes  No Date of Service      /      /       
mm dd yy

**If yes,** do not continue completing this form, but you must sign the form on page 5.

- Are you an out of state provider of medical services interested in participation for services to a beneficiary for a period up to a maximum of 60 days?

Yes  No Date of Service From      /      /      To      /      /       
mm dd yy mm dd yy

**If yes,** you do not need to continue completing this form.

- List the name of the owner(s) of your company and their social security number(s) and percentage of ownership. **The names listed must match the names given on question #5 of the Disclosure of Ownership and Control Form.** If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their social security numbers.

<u>Last Name, First Name</u>	<u>Social Security Number</u>	<u>% of Ownership</u>
_____	- -	_____
_____	- -	_____
_____	- -	_____
_____	- -	_____

5. List any professional licenses held by the owners. List even if licensed outside of New York State.

<u>Last Name, First Name</u>	<u>License Number (State)</u>	<u>Profession</u>	<u>NPI or NYS Medicaid Provider #</u>

6. Do any of the owners operate a medical care institution (i.e. Nursing home, assisted living facility, etc.)?

Yes  No

a.

<u>Name of Facility</u>	<u>Type of Facility</u>	<u>Facility Address</u>	<u>NPI or NYS Medicaid Provider #</u>

b. Is the transportation cost included in their annual financial report to the Department of Health?

Yes  No

c. List category of transportation that is included. \_\_\_\_\_

7. Indicate the estimated percentage of services you provide in the following categories:

\_\_\_\_\_ % Confined to wheelchair      \_\_\_\_\_ % Ambulating with assistance

\_\_\_\_\_ % Fully ambulatory

8. Which geographic area(s) are you certified to serve by the Department of Transportation?

\_\_\_\_\_

9. Indicate the days and corresponding hours you provide transportation services.

Livery/Taxi	Sunday	_____ to _____	Thursday	_____ to _____
	Monday	_____ to _____	Friday	_____ to _____
	Tuesday	_____ to _____	Saturday	_____ to _____
	Wednesday	_____ to _____		

Ambulette	Sunday	_____ to _____	Thursday	_____ to _____
	Monday	_____ to _____	Friday	_____ to _____
	Tuesday	_____ to _____	Saturday	_____ to _____
	Wednesday	_____ to _____		

Day Treatment	Sunday	_____ to _____	Thursday	_____ to _____
	Monday	_____ to _____	Friday	_____ to _____
	Tuesday	_____ to _____	Saturday	_____ to _____
	Wednesday	_____ to _____		

10. Estimate the percentage of business that will be billed to the NYS Medicaid Program. \_\_\_\_\_%.

11a. Identify the name, address and account number(s) of the bank(s) to be used by the business.

<u>Name of Bank</u>	<u>Address</u>	<u>Account Number</u>
_____	_____	_____
_____	_____	_____

b. Provide the names and social security numbers of all personnel authorized to sign corporate checks against those accounts.

<u>Person(s) Authorized to Sign Checks</u>	<u>Social Security Number</u>
_____	- -
_____	- -
_____	- -

12. Attach a statement identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signature. **Signature stamps, photocopies, etc., are not acceptable.**

13. **Personnel**

a. List all office personnel.

<u>Last Name, First Name</u>	<u>Position</u>	<u>Social Security Number</u>
_____	_____	- -
_____	_____	- -
_____	_____	- -

b. List all drivers.

<u>Last Name, First Name</u>	<u>Hrs. Worked Per Week</u>	<u>Social Security Number</u>
_____	_____	- -
_____	_____	- -
_____	_____	- -

14. Provide a history of past employment (5 years) for **all owners, operation managers and office managers.** (Use separate sheets of paper for each individual using the format below)

**Name:**

**Position:** (i.e. Owners, office managers or operation managers. If owner serves as the office or operations manager, list accordingly.)

**Name of Past Employer:** (Name of company or individual)

**Address:** (Full address including phone number)

**Employment Dates:** (Start date to end date)

**Nature of Duties:** (Must be specific)

15. Required information regarding leasehold arrangements.

**a. Business Location:**

Indicate whether rent is paid in equal monthly or yearly installments. You must attach a signed copy of the current lease.

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Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

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Provide the name and address of the owner of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners, their social security numbers and any National Provider Identifiers or NYS Medicaid Program provider numbers or professional licenses held.

<u>Last Name, First Name</u>	<u>NPI or NYS Medicaid Provider # or Professional License</u>	<u>Social Security Number</u>
		- -
		- -
		- -

Provide the name and address to whom the rent is paid. Attach a copy (front and back) of the most recent canceled rent check.

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**b. Garage location: (if different)**

Indicate whether rent is paid in equal monthly or yearly installments. You must attach a signed copy of the current lease.

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Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

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Provide the name and address of the owner of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners, their social security numbers and any National Provider Identifiers or NYS Medicaid Program Provider Numbers or professional licenses held.

<u>Last Name, First Name</u>	<u>NPI or NYS Medicaid Provider # or Professional License</u>	<u>Social Security Number</u>
		- -
		- -
		- -

16. List the following information along with the vehicle identification number (VIN #) for each vehicle operated by (owned or leased) your company in the last year.

	Vehicle Type	Seating Capacity	Model	Year	Owned/ Lease	VIN #	Company Leased To	Equipped w/ Wheelchair Lift/Tie Down
1.								
2.								
3.								
4.								

17. Does your company use subcontractors?  Yes  No

**If yes**, provide the following:

Name of Subcontractor	Vehicle Type	Seating Capacity	Model	Year	VIN#

18. Have any of the owners ever been a subcontractor for a medical transportation provider?

Yes  No

**If yes**, please provide the following:

**Provider Name**

**NPI or NYS Medicaid Provider #**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Owner's Name: \_\_\_\_\_  
(Print)

Owner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature Stamps Are Not Permitted)

Application Prepared by: \_\_\_\_\_  
(Print)

Telephone Number: \_\_\_\_\_