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.
- If your application is accepted, the effective date of your enrollment will be specified by the Department.
- **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. Until the group enrollment process is completed you should continue to submit claims under the individual practitioner's Medicaid Provider ID number.**
- 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 and/or denial.
- 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.

Your signature on the application acknowledges that the Owner(s) or Board Member(s) of the group agree(s) that they are fully responsible for the professional services rendered by all members of the group of employees, consultants or independent contractors.

New York State Medicaid Regulations allows the Department 90 calendar days after receipt of a complete application to determine wither 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 your 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

Group Enrollment
EMEDNY-426101 (09/09)

MEDICAID PROVIDER ENROLLMENT
GROUP 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 (COS)

APPLICATION TYPE*

APPLICANT NAME

NATIONAL PROVIDER IDENTIFIER (NPI)

FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)

CORRESPONDENCE ADDRESS

PAY TO ADDRESS

SERVICE ADDRESS

ALL YES/NO QUESTIONS MUST BE ANSWERED **

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: GROUP ENROLLMENT FORM **(REQUIRES OWNER'S SIGNATURE)**

DISCLOSURE OF OWNERSHIP AND CONTROL – BUSINESS ENTITY FORM **(REQUIRES OWNER'S SIGNATURE)**

MEDICAID PROVIDER ENROLLMENT: GROUP MEMBER LIST

REQUEST FOR PARTICIPATION AS A GROUP MEMBER (FOR EACH GROUP MEMBER)

GROUP PROVIDER INFORMATION REQUEST FORM (REQUIRES OWNER'S SIGNATURE)

COPY OF DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN

COPY OF YOUR LEASE

MOBILE VAN: ATTACH SEPARATE SHEET OF PAPER EXPLAINING YOUR SERVICE AND INCLUDE VEHICLE IDENTIFICATION NUMBER (VIN) OF THE VEHICLE AND A COPY OF THE VAN'S CURRENT REGISTRATION

IF SERVICE LOCATION IS NOT WITHIN NEW YORK STATE, A COPY OF YOUR STATE'S MEDICAID (OR EQUIVALENT) APPROVAL LETTER

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 GROUP ENROLLMENT FORM INSTRUCTIONS

PROVIDER NUMBER:	Leave blank.
CATEGORY OF SERVICE:	Check the category that applies. **Please note: A Multi-Service Group is defined as a group whose members consist of more than one provider type. For example: if 2 physicians and 1 nurse-midwife are in the group, the group must enroll as a Multi-Service Group.**
APPLICATION TYPE:	This field must be completed. (See Required Documentation on page 2 of the Checklist.)
APPLICANT NAME:	Enter the name exactly as it appears on your letter from the Department of Treasury, Internal Revenue Service.
DOING BUSINESS AS (DBA) NAME:	If applicable.
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter your NPI.
FEDERAL EMPLOYER ID NUMBER:	Enter the Department of Treasury, Internal Revenue Service Federal Employer Identification Number (FEIN) issued for the group. Attach a copy of the Department of Treasury, Internal Revenue Service letter assigning the FEIN.

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 business 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 addressother than the correspondence address, complete this section. 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 group.
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.
MEDICARE INFORMATION	Indicate whether you are enrolled in Medicare.
TYPE OF PRACTICE:	For each service address, check the box from the list which describes your type of practice at that address. 1. Individual (Sole Proprietor) 2. Group
PLACE OF SERVICE:	For each service address, check the box from the list which describes the site. 1. Private Office 2. Hospital/Nursing Home 3. Free Standing Clinic 4. Health Maintenance Organization 5. Shared Health Facility

YES/NO QUESTIONS:

It is **mandatory** that all four 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.

OWNER'S SIGNATURE:

The owner must **personally sign** and **date** the enrollment form acknowledging the attestation statement. If the group is owned by a medical corporation or hospital, a member of the Board of Directors must sign the application. **Signature stamps, photocopies, etc. are not acceptable.**

EMAIL ADDRESS:

Enter your email address if applicable.

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

GROUP ENROLLMENT

MEDICAID PROVIDER ENROLLMENT

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

PROVIDER NUMBER (LEAVE BLANK)

CATEGORY
- ☐ 0020 - Dental Group (Office)
- ☐ 0020 - Dental Group (Mobile Van)
- ☐ 0046 - Physician Group
- ☐ 0050 - Podiatric Group
- ☐ 0090 - Multi-Service Group
- ☐ 0052 - Nurse Midwife Group
- ☐ 0058 - Clinical Psychologist Group
- ☐ 0062 - Therapy Group

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

APPLICANT NAME

DBA NAME

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

NATIONAL PROVIDER IDENTIFIER (NPI)

FEDERAL EMPLOYER ID NO.

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

- LINE 2

CITY

Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE ( ) - EXT.

OWNERSHIP CODE

16- SOLE PROPRIETORSHIP

17- PARTNERSHIP

18- PROFESSIONAL CORPORATION

19- OTHER/NOT-FOR-PROFIT

PAY TO ADDRESS (Checks and Remittance Statements)

ATTENTION

STREET - LINE 1

- LINE 2

CITY

Do NOT use abbreviations

STATE ZIP CODE - COUNTY

MEDICARE INFORMATION

Are you enrolled in Medicare? ☐ Yes ☐ No

TYPE OF PRACTICE (Check ONE)

☐ Individual / Sole Proprietorship (1) ☐ Group (2)

PLACE OF SERVICE (Check ONE)
- ☐ Private Office (1)
- ☐ Hospital, Nursing Home (2)
- ☐ Free Standing Clinic (3)
- ☐ Health Maintenance Organization (4)
- ☐ Shared Health Facility (5)

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.

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	
☐	☐	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?

ATTESTATION: The signature of the Owner or Board Member acknowledges that the group agrees that it is fully responsible for the professional services rendered by members of the group as employees, consultants or independent contractors.

OWNER OR BOARD MEMBER NAME (PRINT)

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

OWNER OR BOARD MEMBER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)

DATE SIGNED

EMAIL ADDRESS

PREPARER NAME (PRINT) TELEPHONE #

MAIL TO:

MEDICAID PROVIDER ENROLLMENT
ADDITIONAL SERVICE ADDRESS

COMPUTER SCIENCES CORPORATION
P.O. BOX 4603
RENSSELAER, NY 12144

PROVIDER ID# [______________]

NATIONAL PROVIDER IDENTIFIER [______________]

APPLICATION DATE MM/DD/YY [___/___/___]

CATEGORY OF SERVICE [___________]

APPLICANT NAME [____]

SERVICE ADDRESS INFORMATION

ATTENTION [________________________________]

ADDRESS-1 [________________________________]

ADDRESS-2 [________________________________]
This MUST be a physical location, NOT a P.O. Box

CITY [________________________________]
Do NOT use abbreviations

STATE [____] ZIP CODE [_______-_______] COUNTY _______

TELEPHONE [(____) ____-________ EXT ___________]

TYPE OF PRACTICE (Check ONE)

☐ Individual (1) ☐ Salaried (3)
☐ Group (2) ☐ Contract (4)

PLACE OF SERVICE (Check ONE)

☐ Private Office (1)
☐ Hospital/Nursing Home (2)
☐ Free Standing Clinic (3)
☐ Health Maintenance Org. (4)
☐ Shared Health Facility (5)

SERVICE ADDRESS INFORMATION

ATTENTION [________________________________]

ADDRESS-1 [________________________________]

ADDRESS-2 [________________________________]
This MUST be a physical location, NOT a P.O. Box

CITY [________________________________]
Do NOT use abbreviations

STATE [____] ZIP CODE [_______-_______] COUNTY _______

TELEPHONE [(____) ____-________ EXT ___________]

TYPE OF PRACTICE (Check ONE)

☐ Individual (1) ☐ Salaried (3)
☐ Group (2) ☐ Contract (4

PLACE OF SERVICE (Check ONE)

☐ Private Office (1)
☐ Hospital/Nursing Home (2)
☐ Free Standing Clinic (3)
☐ Health Maintenance Org. (4)
☐ Shared Health Facility (5)

SERVICE ADDRESS INFORMATION

ATTENTION [________________________________]

ADDRESS-1 [________________________________]

ADDRESS-2 [________________________________]
This MUST be a physical location, NOT a P.O. Box

CITY [________________________________]
Do NOT use abbreviations

STATE [____] ZIP CODE [_______-_______] COUNTY _______

TELEPHONE [(____) ____-________ EXT ___________]

TYPE OF PRACTICE (Check ONE)

☐ Individual (1) ☐ Salaried (3)
☐ Group (2) ☐ Contract (4)

PLACE OF SERVICE (Check ONE)

☐ Private Office (1)
☐ Hospital/Nursing Home (2)
☐ Free Standing Clinic (3)
☐ Health Maintenance Org. (4)
☐ Shared Health Facility (5)

MEDICAID PROVIDER ENROLLMENT

GROUP MEMBER LIST

APPLICANT NAME

CATEGORY OF SERVICE

This form MUST be completed with each group member's name, license number, Medicaid Provider Identification Number and National Provider Identifier (NPI). If the member is not yet enrolled but has submitted an enrollment application, write *pending* after the name of the group member.

NAME OF GROUP MEMBER	LICENSE NUMBER	MEDICAID PROVIDER IDENTIFICATION NUMBER	NATIONAL PROVIDER IDENTIFIER (NPI)

REQUEST FOR MEDICAID PARTICIPATION AS A GROUP MEMBER

NOTE:
Each member MUST complete and sign this form. This form may be photocopied.

1. Group Member's Name: ______________________________
2. Member's National Provider Identifier (NPI): ______________ Medicaid # ______________
   (You must enroll to participate.)
3. Name of Group: ______________________________
4. List the Service Address(es) where you work as a group member. Do not list private practice service addresses.

(a) ______________________________
____
____

(c) ______________________________
____
____

(b) ______________________________
____
____

(d) ______________________________
____
____

I agree to participate in the Medicaid Program as a member of the above named group. I realize that I continue to remain personally responsible for all claims billed to NYS Medicaid using both the Group National Provider Identifier (NPI)/Medicaid # and my Individual National Provider Identifier (NPI)/Medicaid #. I may have my name withdrawn from the above named group upon written request to the Office of Health Insurance Programs.

Print full name.

NAME ______________________________
FIRST **MIDDLE** **LAST**

SIGNATURE ______________________________ **DATE** ______________

EMEDNY-426601 (09/09)

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

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

Group Provider Information Request Form

1. List the name of the owner(s) of the business and their social security number(s) and percentage of ownership. List any National Provider Identifiers (NPI) or New York State (NYS) Medicaid provider numbers or professional licenses held by the owners. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their social security numbers and any National Provider Identifiers or NYS Medicaid provider numbers or professional licenses held. If you are a not-for-profit organization, in lieu of social security numbers provide verification of not-for-profit status.

Last Name, First Name	Social Security Number	Percentage of Ownership	NPI or Medicaid # or Professional License
	- -		
	- -		
	- -		
	- -		
	- -		

2. Leasehold arrangements (for each location):

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

   b. If you do not have a lease explain your arrangement and why you do not have a lease.

   ____
   ____
   ____

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

   ____
   ____
   ____

   d. Provide the name and address of the owner(s) 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 and their social security numbers.

Last Name, First Name	Social Security Number
	- -
	- -

3. If you are a hospital based group, provide a letter from the Chief Financial Officer indicating if patient care is included in the hospital's Medicaid rate for the services provided by the members of the group.

4. a. Are the members of the group employees? Yes ☐ No ☐

   b. Are the members of the group independent contractors or consultants?
   Yes ☐ No ☐

5. a. If the members of the group are employees, attach **W2(s)**, contracts and/or employment verification between the group and the individual members.

   b. If the members of the group are independent contractors and/or consultants, attach copies of each member's 1099 and current contract.

6. a. Have any members of the group been excluded or denied enrollment and/or re-enrollment from Medicaid?

   Yes ☐ No ☐

   b. If yes, list these members.

Name	**License Number**	**NPI or NYS Medicaid #**

7. Identify other medically related business interests in which any group members or their immediate families may have an interest, including, but not limited to, entrepreneurial relationships in durable medical equipment suppliers, long term medical care, pharmacies, transportation, laboratories, and/or real property interests leased to the other medically related businesses:

Name	**Business Interest**	**Location**

8. List all physician assistants and/or nurse practitioners employed by the group that were not included as members of the group.

Name	**License Number**

9. Identify all service locations where you bill and the percentage of practice at each location. Also list any hospital out-patient or diagnostic and treatment center locations and the percentage of your practice at each location.

Address	**Hours Per Week Open**	**Percentage of Your Total Practice at Each Location**

10. a. Does your group utilize a billing service (service bureau)?

Yes ☐ No ☐

b. If yes, provide their name and address. If enrolled in the NYS Medicaid Program provide the provider number and a copy of your contract or statement of agreement.

Name	**Address**	**NPI or NYS Medicaid #**

c. If you do not utilize a billing service attach a statement identifying the person who will be authorized to sign the NYS Medicaid claim form and provide original examples of the signatures. **Signature stamps, photocopies, etc., are not acceptable.**

11. Estimate percentage of total business to be billed to the NYS Medicaid Program.______________

Owner's Name (Print):____

Owner's Signature: ____ Date Signed: _______________
(Signature Stamps Are Not Permitted)

Application Prepared by (Print):____

Telephone Number: _____________________________________