



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.**
- 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.

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

MEDICAID PROVIDER ENROLLMENT DURABLE MEDICAL EQUIPMENT 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
APPLICATION TYPE*	PAY TO ADDRESS
APPLICANT NAME	SERVICE ADDRESS
NATIONAL PROVIDER IDENTIFIER (NPI)	ALL YES/NO QUESTIONS MUST BE ANSWERED**
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	OWNER'S SIGNATURE
SOCIAL SECURITY NUMBER (ONLY IF SELF EMPLOYED)	

*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. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES.

REQUIRED DOCUMENTATION TO BE SUBMITTED

MEDICAID PROVIDER ENROLLMENT:
DURABLE MEDICAL EQUIPMENT FORM

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

DISCLOSURE OF OWNERSHIP AND
CONTROL – BUSINESS ENTITY FORM

COPY OF THE LEASE

DURABLE MEDICAL EQUIPMENT
PROVIDER INFORMATION REQUEST FORM

COPY OF MEDICARE APPROVAL LETTER
Failure to maintain your participation with
Medicare could result in termination from the
Medicaid Program.

BALANCE SHEET WITH SPECIFIC LINE
ITEM ASSET INFORMATION

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

ORTHOPEDIC FOOTWEAR DEALERS

- A COPY OF CURRENT CERTIFICATION BY **ONE** OF THE FOLLOWING:
- THE AMERICAN BOARD FOR CERTIFICATION IN ORTHOTICS AND PROSTHETICS
- THE BOARD FOR CERTIFICATION IN PEDORTHICS
- THE BOARD FOR ORTHOTIST CERTIFICATION

OXYGEN OR RELATED EQUIPMENT

- A COPY OF CURRENT LICENSE/REGISTRATION OF THE RESPIRATORY THERAPIST ON STAFF OR IF UNDER CONTRACT COPY OF LICENSE/REGISTRATION AND CONTRACT

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
DURABLE MEDICAL EQUIPMENT FORM INSTRUCTIONS**

PROVIDER NUMBER:	Leave blank.
CATEGORY OF SERVICE:	Check the categories that apply.
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 Services.
DOING BUSINESS AS (DBA):	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). Attach a copy of the Department of Treasury, Internal Revenue Service letter assigning the FEIN.
SOCIAL SECURITY NUMBER:	Enter 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 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 address other 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 business.

CORPORATE ADDRESS INFORMATION

Supply this information if this NPI is associated with a corporate entity which sponsors other Medicaid services enrolled under other NPI(s). **NOTE:** Annual tax documents will be sent to this address. If you previously enrolled an NPI with this FEIN, the address on file for the FEIN will be duplicated here. If this is the first NPI you are reporting for this FEIN and this field is left blank, the address you supplied as the Pay-To address will be duplicated here.

OWNERSHIP CODE:

Enter the number that is applicable.

MEDICARE INFORMATION

You must submit a copy of your Medicare award letter. Failure to maintain your participation with Medicare could result in termination from the Medicaid Program.

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.

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

DURABLE MEDICAL EQUIPMENT

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

0321 DURABLE MEDICAL EQUIPMENT, APPLIANCES OR SUPPLIES New Enrollment/Reactivation

0323 OXYGEN OR RELATED EQUIPMENT Reinstatement (See definition on pg 2 of checklist)

APPLICANT NAME

DBA NAME

NATIONAL PROVIDER IDENTIFIER (NPI) YOUR D/B/A NAME OR ANY OTHER NAME THAT THE COMPANY IS KNOWN BY

FEDERAL EMPLOYER ID NUMBER SOCIAL SECURITY NUMBER (Only If Self Employed)

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION

STREET - LINE 1 Enter the NAME of the person/department/apartment number where the mail should be sent

- LINE 2 Cannot be a Post Office Box UNLESS accompanied by an actual street address

CITY Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE () - EXT.

OWNERSHIP CODE

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

MEDICARE INFORMATION
You must provide a copy of your Medicare Award Letter.

QUESTIONS

YES	NO	QUESTIONS
<input type="checkbox"/>	<input type="checkbox"/>	Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?
<input type="checkbox"/>	<input type="checkbox"/>	Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any State?
<input type="checkbox"/>	<input type="checkbox"/>	Is there currently pending any proceedings that could result in the above stated sanctions?

PAY TO ADDRESS (Checks and Remittance Statements)

ATTENTION

STREET - LINE 1

- LINE 2

CITY Do NOT use abbreviations

STATE ZIP CODE - COUNTY

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.

OWNER NAME (PRINT) EMAIL ADDRESS

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

OWNER SIGNATURE (ORIGINAL SIGNATURE REQUIRED) DATE SIGNED PREPARER NAME (PRINT) TELEPHONE #

EMEDNY-427401 (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.

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

Durable Medical Equipment Provider Information Request

If you are only seeking enrollment for Medicare crossover (co-pay and deductibles) claims only, check the yes box below and sign this form.

Yes

If yes, you do not need to complete this form.

Are you an out of state provider of durable medical equipment services interested in participating in the NYS Medicaid Program? Yes No

Is this application for one NYS Medicaid Program beneficiary? Yes No

If yes, please provide the first and last date of service for this beneficiary.

M	M	D	D	Y	Y	

M	M	D	D	Y	Y	

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.**

Are you presently open? Yes No

If yes, when did you open

M	M	D	D	Y	Y	

If no, when do you anticipate opening?

M	M	D	D	Y	Y	

1. List the name of the owner(s) of the business 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.** List any National Provider Identifiers (NPI) or New York State Medicaid Program 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 New York State Medicaid Program provider numbers or professional licenses held.

<u>Last Name, First Name</u>	<u>Social Security Number</u>	<u>% of Ownership</u>	<u>NPI or NYS Medicaid # or Professional License</u>

2. Leasehold arrangements:
 - a. Indicate whether rent is paid in equal monthly or yearly installments. **You must attach a signed copy of the current lease.**

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

- c. 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.

<u>Last Name, First Name</u>	<u>Social Security Number</u>
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- d. Provide the name and address to whom the rent is paid. Attach a copy (front and back) of the most recent cancelled rent check.

- e. If rent is paid to a corporation or partnership, list the names of the officers, directors, Principal stockholders, partners and their social security numbers and any National Provider Identifier (NPI) or NYS Medicaid Program provider numbers or professional licenses held.

Last Name, First Name	Social Security Number	NPI or NYS Medicaid # or Professional License
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3. How does your establishment provide access to the handicapped (ramps, parking, adequate passage)?

4. List the name of any other medical providers in the building. If none, state none.

5. If the business location was previously a place at which NYS Medicaid services were rendered, list the National Provider Identifier (NPI) or NYS Medicaid Number of the prior owner(s).

6. Enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the sale.

7. a. List the top 10 items you supply.
- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

b. Will different DME items be provided to Medicaid beneficiaries.

Yes No

If yes, list what items you plan to provide to Medicaid beneficiaries.

c. Estimate the dollar value of the stock and medical supplies currently on hand.

d. List the name and address of all suppliers of your stock.

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

8. a. Attach a statement explaining in detail how your Durable Medical Equipment supplies are marketed. For example, are physicians, nurses, or therapists used.

b. If your marketing plan includes the use of sales representatives, provide the following:

Are your sales representatives employees? Yes No

If yes, please submit copies of their most recent W-2 forms.

Are your sales representatives independent Sales contractors? Yes No

If yes, submit a copy of the contract.

9. If you are a provider of orthopedic footwear, provide a copy of your certification as listed on the Durable Medical Equipment Form Checklist. (EMEDNY-4272, Page 3)

10. If you are not certified, do you employ others who are certified? Yes No

11. List all orthotists and prosthetists in your service and attach a copy of their certification as listed on the Durable Medical Equipment Form Checklist (EMEDNY-4272, Page 3)

<u>Last Name, First Name</u>	<u>Title</u>	<u>Social Security Number</u>	<u>Hours/Week</u>
_____	_____	_____	_____
_____	_____	_____	_____

12. a. List all managerial and technical employees.

<u>Last Name, First Name</u>	<u>Title</u>	<u>Social Security Number</u>	<u>Hours/Week</u>
_____	_____	_____	_____
_____	_____	_____	_____

- b. List all DME training programs completed by the above individuals and attach a copy of their certification.

<u>Last Name, First Name</u>	<u>Training Course</u>
_____	_____
_____	_____

13. a. 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>
_____	_____
_____	_____

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

15. Indicate whether bills to Medicaid will be submitted directly by you or through a billing service. If a billing service, provide the name, address and NYS Medicaid provider number of the billing service.

16. List the top six referring practitioner's names and license numbers who currently order Durable Medical Equipment through your business.

	<u>Last Name, First Name</u>	<u>License Number</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

17. Estimate the percentage of total business that will be billed to the NYS Medicaid Program.

18. Estimate the percentage of services that are ordered by out of state providers. _____
19. Do you maintain a profile or patient history that would identify ordered services that would be considered duplicative or medically unnecessary? Yes No
20. How do you ascertain the medical necessity for the items ordered?

21. Do you have a contract with a nursing home? Yes No

If yes, provide the following:

<u>Name of Nursing Home</u>	<u>Address</u>	<u>Telephone Number</u>
_____	_____	_____
_____	_____	_____

22. Indicate the days and corresponding hours your durable medical equipment store will be open.

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

Owner's Name (Print): _____

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

Application Prepared By (Print): _____

Telephone Number: _____

Prescription Footwear Form

EFFECTIVE APRIL 1, 2009, THE NEW YORK STATE MEDICAID PROGRAM WILL REIMBURSE PROVIDERS FOR PRESCRIPTION FOOTWEAR ONLY IF THEY HOLD A CURRENT CERTIFICATION BY ONE OF THE CERTIFICATION BOARDS LISTED BELOW.

Provider Name: _____

Medicaid Provider Identification Number: _____

National Provider Identifier (NPI): _____

I have attached a copy of my current certification by one of the following:

____ American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.

____ Board for Certification/Accreditation, International

Print Owner's Name: _____ Date: _____

Owner's Signature: _____

The owner must sign and date this form. Signature stamps, photocopies, etc. are not acceptable.

Submit this completed form and required documentation to:

Computer Sciences Corporation
PO Box 4610
Rensselaer, New York 12144

PLEASE NOTE: When your certification expires, please submit a copy of your current certification to the address above.

If you have any questions, please contact the eMedNY Call Center at 1-800-343-9000.