



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.

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

New York State Medicaid Regulations allows the Department 90 calendar days from 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. 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. Click Information, then DOH [Medicaid Update Website](http://www.eMedNY.org).

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 OPTICAL ESTABLISHMENT 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)	PAY TO ADDRESS
APPLICATION TYPE*	SERVICE ADDRESS INFORMATION
OPTICAL ESTABLISHMENT NAME	OWNER'S SIGNATURE
NATIONAL PROVIDER IDENTIFIER (NPI)	DATE SIGNED
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	ALL YES/NO QUESTIONS MUST BE ANSWERED**
CORRESPONDENCE ADDRESS	

*IF REINSTATEMENT IS CHECKED PLEASE SEE REINSTATEMENTS 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: OPTICAL ESTABLISHMENT FORM	OPTICAL ESTABLISHMENT EMPLOYEE LIST FORM
DISCLOSURE OF OWNERSHIP AND CONTROL – BUSINESS ENTITY FORM (REQUIRES OWNER'S SIGNATURE)	COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN

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 OPTICAL ESTABLISHMENT FORM INSTRUCTIONS

- PROVIDER NUMBER:** Leave blank.
- CATEGORY OF SERVICE:** Check the category that applies.
- 0401** Establishment with Salaried Optometrist/Salaried Optician
MUST HAVE AT LEAST ONE (1) OPTOMETRIST.
- 0402** Establishment with Salaried Optician(s)
NO OPTOMETRIST(S).
- APPLICATION TYPE:** **This field must be completed. (See Required Documentation on page 2 of the Checklist.)**
- OPTICAL ESTABLISHMENT NAME:** Enter the name of your optical establishment.
- 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 issued for the Optical Establishment. Attach a copy of the IRS 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 optical establishment 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 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 be the address where services are being provided.

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.

YES/NO QUESTIONS: It is **mandatory** that all four (4) questions be answered.

If yes answered to any of the four questions, you must complete the Prior Conduct Questionnaire available at www.eMedNY.org. You are required to provide documentation and/or details explaining the circumstances.

MEDICARE INFORMATION: Indicate whether you are enrolled in Medicare.

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

OPTICAL ESTABLISHMENT

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
0401 - Establishment with Salaried Optometrist/ Salaried Optician
0402 - Establishment with Salaried Optician
New Enrollment/Reactivation
Reinstatement (see definition on pg 2 of checklist)

OPTICAL ESTABLISHMENT NAME

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

NATIONAL PROVIDER IDENTIFIER (NPI) FEDERAL EMPLOYER IDENTIFICATION NUMBER

CORRESPONDENCE ADDRESS (Claim forms and mail)
ATTENTION
STREET - LINE 1
- LINE 2
CITY
STATE ZIP CODE COUNTY
TELEPHONE () - EXT.

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
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?

SERVICE ADDRESS INFORMATION
ATTENTION
STREET - LINE 1
- LINE 2 (This MUST be a physical location, NOT a P.O. Box)
CITY
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).
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.

MEDICARE INFORMATION
Are you enrolled in Medicare? Yes No

EMAIL ADDRESS

OWNER NAME (PRINT)
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 #

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

**MEDICAID PROVIDER ENROLLMENT
SALARIED OPTICIAN/SALARIED OPTOMETRIST FORM CHECKLIST**

THE FOLLOWING INFORMATION **MUST** BE PROVIDED TO PROCESS YOUR ENROLLMENT APPLICATION.

NOTE: IF YOU WISH TO JOIN A MULTI-TYPE GROUP YOU MUST COMPLETE THE SELF EMPLOYED OPTICIAN-OPTOMETRIST ENROLLMENT PACKET. IF YOU ARE ENROLLED AS A SALARIED OPTICIAN/SALARIED OPTOMETRIST YOU MUST COMPLETE THE CHANGE OF CATEGORY AND/OR ADDRESS FORM.

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*	SERVICE ADDRESS
APPLICANT NAME	ALL YES/NO QUESTIONS MUST BE ANSWERED**
NATIONAL PROVIDER IDENTIFIER (NPI)	SPECIALTY CODE – IF APPLICABLE
SOCIAL SECURITY NUMBER	APPLICANT’S SIGNATURE

*IF REINSTATEMENT IS CHECKED PLEASE SEE REQUIRED DOCUMENTATION ON PAGE 2 OF 2 OF THIS CHECKLIST.

**IF YES ANSWERED TO ANY OF THE FOUR QUESTIONS, YOU MUST COMPLETE THE PRIOR CONDUCT QUESTIONNAIRE AVAILABLE AT WWW.EMEDNY.ORG. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES.

REQUIRED DOCUMENTATION TO BE SUBMITTED

MEDICAID PROVIDER ENROLLMENT: SALARIED OPTICIAN/SALARIED OPTOMETRIST	COPY OF MEDICARE AWARD LETTER – (IF APPLICABLE)
COPY OF LICENSE/REGISTRATION	COPY OF LOW VISION CERTIFICATE (IF APPLICABLE) (Specialty 714)
DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM	COPY OF CONTACT LENS CERTIFICATE (IF APPLICABLE) (Specialty 715)

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.

MEDICAID PROVIDER ENROLLMENT
SALARIED OPTICIAN/SALARIED OPTOMETRIST FORM INSTRUCTIONS

PROVIDER NUMBER: Leave blank.

APPLICATION TYPE: This field must be completed (See Required Documentation on Page 2 of the Checklist)

APPLICANT NAME: Enter the provider name exactly as it appears on your license/registration; that is **last name, first name**.

CATEGORY OF SERVICE: Check the category that applies.

NATIONAL PROVIDER IDENTIFIER (NPI) Enter your NPI.

SOCIAL SECURITY NUMBER: This is a **mandatory** field.

CORRESPONDENCE ADDRESS: Enter the address where all correspondence and claim forms will be sent. A street address is required to accommodate shipment of bulk material.

Attention Line: Use this only if the name or person who will receive the mail is different than the optician/optometrist for an apartment/suite number or building location.

Street: Cannot be a P.O. Box unless accompanied by an actual street address.

SERVICE ADDRESS: This address is where you render services. If the service address is the same as the correspondence address write "SAME".

YES/NO QUESTIONS: It is **mandatory** that all four (4) questions be answered.

If yes answered to any of the four questions, you must complete the Prior Conduct Questionnaire available at www.eMedNY.org. You are required to provide documentation and/or details explaining the circumstances.

LICENSING INFORMATION: Enter your license number. **Attach a copy of your current license/registration renewal certificate.**

SPECIALTY CODE: Check the specialty code that applies.

MEDICARE INFORMATION Indicate whether you are enrolled in Medicare. If you are enrolled submit a copy of your Medicare Award Letter

OPTICAL ESTABLISHMENT: Enter the Provider Name, the Medicaid ID # and National Provider Identifier of the Optical Establishment.

EMAIL ADDRESS:

Enter your email address if applicable.

APPLICANT'S SIGNATURE:

Applicant's must **personally sign** and **date** the enrollment form. **Signature stamps, photocopies, etc. are not acceptable.**

PERSONAL PRIVACY LAW:

The State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting the information and how we will use it.

The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities.

This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider.

The information will be maintained by:

New York State Department of Health
Office of Health Insurance Programs
Division of Provider Relations and Utilization
Management
Fee for Service Provider Enrollment Bureau
150 Broadway, Suite 6E
Albany, NY 12204

SALARIED OPTICIAN/SALARIED OPTOMETRIST

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

MEDICAID PROVIDER ENROLLMENT

CATEGORY OF SERVICE:

0403 SALARIED OPTICIAN

0421 SALARIED OPTOMETRIST

(LEAVE BLANK)

PROVIDER NUMBER

APPLICATION TYPE

New Enrollment/Reactivation

Reinstatement (See definition on pg 2 of checklist)

APPLICANT NAME

NAME EXACTLY AS IT APPEARS ON YOUR LICENSE/REGISTRATION

NATIONAL PROVIDER IDENTIFIER (NPI)

SOCIAL SECURITY NUMBER (REQUIRED)

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION STREET - LINE 1
Enter the NAME of the person or department 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.

LICENSING INFORMATION - Attach Copy

LICENSE No.

AGENCY CODE NYS Salaried Optician/Salaried Optometrist (03)

Out-of-State Salaried Optician/Salaried Optometrist (99)

LICENSE BEGIN DATE

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.

SPECIALTY CODE - (Check which apply)

714 - Low Vision Specialist

715 - Contact Lens Privilege

716 - Optometrist/Diagnostic Pharmaceuticals

MEDICARE INFORMATION

Are you enrolled in Medicare?

Yes

No

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?

OPTICAL ESTABLISHMENT:

Name

Provider Number

National Provider Identifier (NPI)

EMAIL ADDRESS

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

PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)

DATE SIGNED

PREPARER NAME (PRINT)

TELEPHONE #

DISCLOSURE OF OWNERSHIP AND CONTROL

INDIVIDUAL

As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, www.health.state.ny.us.

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

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

NOTE: The following questions do NOT only pertain to this provider application but include any and all past activity.

Respond to these questions on behalf of yourself and any individuals or organizations having a direct or indirect ownership or control interest of 5% or more, and any partners, directors, officers, agents or managing employees of the named provider completing this form.

1. Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?
 Yes No
2. Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?
 Yes No
3. Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any state?
 Yes No
4. Is there currently pending any proceedings that could result in the above stated sanctions?
 Yes No
5. Do you or your spouse, parent, child, or sibling have any direct or indirect ownership or a controlling interest of 5% or more in any organizations, agencies, institutions, or other entities?
 Yes No

If **Yes**, complete the rest of this form and submit with your application;

If **No**, sign and date this form and submit with your application.

Organization/Agency/Institution/Entity Legal Name and all d/b/as Address, and FEIN Medicaid # or NPI
Owned/Controlled by whom (state relationship to you)_____

/

/

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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 _____

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

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

NOTE:

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

1. Optician/Optomtrist Name: _____

2. National Provider Identifier (NPI): _____

NYS Medicaid Identification Number: _____

3. Requesting to change current category of service.

Requesting to have an additional category of service.

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

0403 Salaried Optician

0404 Self-Employed Optician

0421 Salaried Optometrist

0422 Self-Employed Optometrist

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

Optical Establishment Name: _____

Address: _____

National Provider Identifier (NPI) for Optical Establishment:

NYS Medicaid Identification Number for Optical Establishment:

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

a) Pay to address: _____

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

(1.) _____ (3.) _____

(2.) _____ (4.) _____

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

Yes No

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

b) List the address where the service is provided.

I swear that the information listed above is accurate.

Print full name.

NAME _____
FIRST MIDDLE LAST

SIGNATURE _____ DATE _____

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