



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 approved, the effective date of your enrollment will be specified by the Department.
- **You will be at financial risk if you render services to Medicaid beneficiaries 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.
- All enrollments, ownership changes, previous terminations and sanctions are subject to further review.
- 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 allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

When you are enrolled in the Medicaid Program, you will receive a letter informing you of your acceptance and the effective date of your enrollment. Approximately two weeks after you receive your acceptance letter, you will receive a package containing claim forms and instructions on how to obtain the appropriate Provider Manual which is available online at www.eMedNY.org. 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 Medicaid Provider Updates.

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

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

Laboratory/Laboratory Director
EMEDNY-429101 (09/09)

**MEDICAID PROVIDER ENROLLMENT
LABORATORY/LABORATORY DIRECTOR 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

TYPE OF APPLICATION*	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
CORRESPONDENCE ADDRESS	

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

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

REQUIRED DOCUMENTATION TO BE SUBMITTED

MEDICAID PROVIDER ENROLLMENT: LABORATORY FORM	COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER ASSIGNING YOUR FEIN
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DISCLOSURE OF OWNERSHIP AND CONTROL – BUSINESS ENTITY FORM	COPY OF MEDICARE AWARD LETTER
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LABORATORY INFORMATION REQUEST
FORM

SUBMIT A COPY OF YOUR **CURRENT** CLINICAL LABORATORY PERMIT

- NEW YORK STATE LABORATORIES MUST SUBMIT THEIR NEW YORK STATE DEPARTMENT OF HEALTH CLINICAL LABORATORY PERMIT
- OUT OF STATE LABORATORIES MUST SUBMIT A COPY OF THEIR STATE LICENSING AGENCY DOCUMENT IN ADDITION TO THEIR NEW YORK STATE DEPARTMENT OF HEALTH CLINICAL LABORATORY PERMIT

LABORATORY DIRECTOR

- MEDICAID PROVIDER ENROLLMENT: LABORATORY DIRECTOR FORM (EMEDNY-429601)
 - DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM
 - LABORATORY DIRECTOR AGREEMENT FORM
 - COPY OF CERTIFICATION OF QUALIFICATION
- PASSPORT SIZE PHOTO AFFIXED TO A SEPARATE 8 ½" X 11" SHEET OF PAPER
WITH LABORATORY DIRECTOR NAME, SOCIAL SECURITY NUMBER AND NAME OF LABORATORY

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 LABORATORY FORM INSTRUCTIONS

PROVIDER NUMBER:	Leave blank.
OWNERSHIP CODE:	Enter the number that is applicable.
APPLICATION TYPE	This field must be completed. (See Required Documentation on page 2 of 2 of the Checklist.)
APPLICANT NAME:	Enter the name exactly as it appears on your clinical laboratory permit.
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) issued for the laboratory. 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 laboratory 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. This may be a P.O. Box. If you want your Medicaid checks to be sent to your correspondence address, write "SAME".

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

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

MEDICARE INFORMATION All Laboratories that enroll in the Medicaid Program to receive Medicaid payments, as appropriate for Medicare coinsurance and the deductible, **MUST** provide proof of enrollment in Medicare. Proof will consist of a copy of your Medicare award letter.

LAB DIRECTOR NAME: Enter Lab Director name.

YES/NO QUESTIONS: It is **mandatory** that all four (4) questions are answered. If yes answered to any of the four question, you must complete the "Prior Conduct Questionnaire" available on the www.eMedNY.org website. 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. **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 the 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

LABORATORY
CATEGORY OF SERVICE 1000

MEDICAID PROVIDER ENROLLMENT

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

PROVIDER NUMBER (LEAVE BLANK)

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

APPLICANT NAME
NAME EXACTLY AS IT APPEARS ON YOUR PERMIT
YOUR D/B/A NAME OR ANY OTHER NAME THAT THE LABORATORY IS KNOWN BY

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

PAY TO ADDRESS (Checks and Remittance Statements)
STREET - LINE 1
- LINE 2
CITY
STATE ZIP CODE COUNTY
TELEPHONE () - EXT.

MEDICARE INFORMATION
Are you enrolled in Medicare?
 Yes No
Lab Director Name

SERVICE ADDRESS INFORMATION
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?

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 COUNTY
STATE ZIP CODE TELEPHONE EXT.

OWNER NAME (PRINT)

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

OWNER SIGNATURE (ORIGINAL SIGNATURE REQUIRED) DATE SIGNED PREPARER NAME (PRINT) TELEPHONE #
EMEDNY-429401 (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

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 LABORATORY DIRECTOR 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 Laboratory Director's name exactly as it appears on the Certificate of Qualification; that is **last name, first name**.
- NATIONAL PROVIDER IDENTIFIER (NPI)** Enter your NPI.
- SOCIAL SECURITY NUMBER:** This is a **mandatory** field.
- CORRESPONDENCE ADDRESS:** Enter the address where all correspondence will be sent.
- Street: Cannot be a P.O. Box unless accompanied by an actual street address.
- SERVICE ADDRESS:** This address must be the address of the laboratory where the Laboratory Director is employed.

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.

LABORATORY DIRECTOR'S NAME: Print the Director's name.

EMAIL ADDRESS: Enter your email address if applicable.

LABORATORY DIRECTOR'S SIGNATURE: The Laboratory Director must **personally sign and date** the enrollment form. **Signature stamps, photocopies, etc. are not acceptable.**

LABORATORY DIRECTOR AGREEMENT FORM: This form must be completed by you and your employer.

PASSPORT PHOTO: Passport size photo affixed to a separate 8 ½" x 11" sheet of paper **with laboratory director name, social security number and name of laboratory.**

PERSONAL PRIVACY LAW: The State's Personal Privacy Protection Law requires us to inform every person from whom we request the 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

LABORATORY DIRECTOR

CATEGORY OF SERVICE 1001

MEDICAID PROVIDER ENROLLMENT

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

PROVIDER NUMBER (LEAVE BLANK)

APPLICATION TYPE
 New Enrollment/Reactivation
 Reinstatement (see definition on pg 2 of checklist)

APPLICANT NAME
NAME EXACTLY AS IT APPEARS ON YOUR CERTIFICATE OF QUALIFICATION

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.

SERVICE ADDRESS INFORMATION (MUST match address on your certificate)

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.

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?

DIRECTOR NAME (PRINT)

EMAIL ADDRESS

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

LAB DIRECTOR 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)_____

/

/

/

/

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 _____

LABORATORY INFORMATION REQUEST FORM

You must answer all questions. If a question is not applicable, explain why. Use additional sheets of paper where necessary.

- 1a. 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's) or Medicaid Provider numbers or professional licenses held by the owners, if applicable. 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 (NPI's) or Medicaid Provider numbers or professional licenses held.

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

- b. Are any of the above named engaged in other businesses that provide services for Medicaid beneficiaries?

Yes No

If yes,

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

2. List **all** your current business locations, including all collecting stations. Provide the full address and length of time at location. Indicate if the location is a collecting station or a main site, and if it is a fixed or mobile facility. (e.g. van)

<u>Address</u>	<u>Main Site or Collecting Station</u>	<u>Fixed or Mobile</u>	<u>Length of Time At Location</u>

3. Leasehold arrangements (must be provided for all locations utilized by your laboratory):

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

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 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>Address</u>	<u>Social Security Number</u>
		- -
		- -
		- -

d. If the building is owned by a corporation or partnership, list the name of the corporation or partnership and its officers, directors, principal stockholders, partners and their social security numbers.

Name of Corporation or Partnership _____

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

Provide the name and address to whom the rent is paid.

Last Name, First Name

Address

-
-
4. If laboratory has been recently purchased or acquired by the current owners, enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the acquisition.
-
-

5. Personnel:

- a. Identify in-house personnel, specifically laboratory director(s), laboratory supervisor(s). Include names, titles, professional qualifications, professional license numbers and social security numbers for each individual listed and hours and days employed. ***(Use In-house Personnel Attachment 5A to complete this question).***
- b. Provide a list of your licensed employees, a description of their appropriate professional and/or technical licenses, their corresponding license numbers and social security numbers. Provide hours of employment and location. Provide copies of all licenses and/or Laboratory Personnel Qualification appraisal. ***(Use Licensed Employees Attachment 5B to complete this question).***
- c. Provide the staffing pattern of your laboratory facility. Identify support staff, technical/professional personnel and administrative personnel. Identify employees' names, job titles, and social security numbers and hours employed. ***(Use Staffing Pattern Attachment 5C to complete this question).***
- d. List any individuals who are employed or compensated by the laboratory and who provide outside services in areas other than the main laboratory. ***(Use Outside Personnel Attachment 5D to complete this question).***
6. List any services or supplies (e.g. waste disposal, telefax) that your laboratory provides to physicians/clinics or other orderers of tests from your laboratory. Give details on the type of service, supply the names, addresses and National Provider Identifiers or NYS Medicaid provider numbers of the physicians/clinics or other orderers receiving these services/supplies and designate at whose expense these services/supplies are provided.
-
-
-

7a. Does your laboratory **employ** sales agents? Yes No

If **yes**, how are they compensated (e.g. commission, salary, both)? Please provide the name and social security number of each sales agent. **If there is a contract, attach a copy.**

<u>Last Name, First Name</u>	<u>Social Security Number</u>	<u>Salary, Commission or Both</u>	<u>Percent of Commission</u>
	- -		%
	- -		%
	- -		%

b. Does your laboratory use **independent** sales agents? Yes No

If **yes**, how are they compensated? Include percentage of commission paid. Provide the name and social security number of each sales agent. **If there is a contract, attach a copy.**

<u>Last Name, First Name</u>	<u>Social Security Number</u>	<u>Salary, Commission or Both</u>	<u>Percent of Commission</u>
	- -		%
	- -		%
	- -		%

c. If no sales agents are utilized, how does the laboratory market its services?

8. Operations:

What was your total revenue from all sources for the previous calendar year? \$ _____

9. List all other third party health insurers you are contracted or enrolled with.

<u>Name of Company</u>	<u>Date of Contract or Enrollment</u>

10. Estimate the percentage of business that will be billed to the NYS Medicaid Program. _____%
11. Are you seeking Medicaid enrollment for a specialized area of testing in which you are permitted to perform?

Yes No

If yes, which area?

12. Do you employ a third party to manage your laboratory? Provide the name(s), address(es) and method by which each is compensated (e.g. commission, salary or both).

<u>Last Name, First Name</u>	<u>Address</u>	<u>Salary, Commission or Both</u>	<u>Percent of Commission</u>
			%
			%
			%

13. List the percentage of blood or other test specimens directly collected from beneficiaries at the primary laboratory sites. _____ %

Also, list the percentage of blood or other test specimens taken at:

- a. Collecting stations: _____ % c. Dialysis clinics: _____ %
- b. Physicians' offices: _____ % d. Other: _____ %

Identify other: _____

14. Attach blank copies of all test order forms currently used.
15. What arrangements have been made to transport these specimens to your laboratory? Describe schedule pick-up(s) and delivery(ies), specifically, at approximately what time does the courier(s) arrive at the first stop (list time for each courier), how often and at what interval does the courier(s) transport specimens back to the laboratory and what hour is the final site pick-up (list time for each courier). What is the method of transport(s), ownership of transport(s), and specimen storage protocol during transport? Where are the specimens spun?

16. Test Result Reporting:

- a. Attach blank copies of the current test result reporting forms sent to ordering providers.
- b. How are the test result reports generated? If a computer is involved, provide the hardware (computer) and software (program) vendor name(s) and address(es), and manufacturer (if different than vendor) and acquisition agreement (contract, invoice, etc.)

c. Is this a shared system (information, billing, etc.)? Yes No

If yes, who is the system shared with?

17. 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>
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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>
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	- -
	- -

18. Identify the persons who will be authorized to sign NYS Medicaid Program claim forms and provide original examples of their signatures. Signature stamps, photocopies, etc., are not acceptable.

<u>Last Name, First Name</u>	<u>Signature</u>
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19. If Medicaid claims will be submitted through a billing service, identify by name(s) and address(es) and National Provider Identifier or NYS Medicaid Provider Number, if known. Also, include a copy of your current contract(s) with the billing service(s).

<u>Name of Billing Service</u>	<u>Address</u>	<u>NPI or NYS Medicaid Number (if known)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

20. Does your laboratory receive referral work from other laboratories? Yes No

If yes,

<u>Name of Laboratory</u>	<u>Address</u>	<u>NPI or NYS Medicaid Number (if known)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

21. Does your laboratory refer work to other laboratories? Yes No

If yes,

<u>Name of Laboratory</u>	<u>Address</u>	<u>NPI or NYS Medicaid Number (if known)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

22. Do you anticipate a change(s) in your policy regarding referral work if enrolled in the New York State Medicaid Program?

Yes No

If yes, what change(s) do you anticipate?

23. Have any of the laboratory's officers, principals, laboratory director or laboratory supervisor been affiliated with any other laboratories (whether or not they were a Medicaid provider), or any other businesses that provide or provided services related to Medicaid beneficiaries in the last five years?

Yes No

If yes, provide an explanation below, including the affiliation, the name of the individual(s), the name of the laboratory(s) or other business(es) and location(s), National Provider Identifier(s), MEDICAID provider identification number (if any) and length of affiliation.

Owner ' s Name (Print): _____

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

Application Prepared by (Print): _____

Telephone Number: _____

In-House Personnel

Attachment 5A

Last Name, First Name	Job Title	License #	Social Security Number
			- -
			- -
			- -
			- -
			- -
			- -

Licensed Employees

Attachment 5B

Last Name, First Name	Job Title	License #	Social Security Number	Employment Location	Hours Worked
			- -		
			- -		
			- -		
			- -		
			- -		
			- -		

Staffing Pattern

Attachment 5C

Last Name, First Name	Job Title	Social Security Number	Hours Employed
		- -	
		- -	
		- -	
		- -	
		- -	
		- -	

Outside Personnel

Attachment 5D

Last Name, First Name	Function Name	Location Site	Social Security Number
			- -
			- -
			- -
			- -
			- -
			- -