



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.
- 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 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.

The Medicaid Update, which details important billing and program information, may 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 1-800-343-9000.

Sincerely,

Fee for Service Provider Enrollment
Office of Health Insurance Programs

Supervising Pharmacist
EMEDNY-430501 (09/09)

**MEDICAID PROVIDER ENROLLMENT
SUPERVISING PHARMACIST 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*	SERVICE ADDRESS
APPLICANT NAME	ALL YES/NO QUESTIONS MUST BE ANSWERED**
NATIONAL PROVIDER IDENTIFIER (NPI)	SIGNATURE OF PROVIDER

*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: SUPERVISING PHARMACIST FORM	DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM
COPY OF CURRENT LICENSE/REGISTRATION	SUPERVISING PHARMACIST AGREEMENT FORM

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
SUPERVISING PHARMACIST FORM (EMEDNY-409701) INSTRUCTIONS**

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
SUPERVISING PHARMACIST FORM INSTRUCTIONS**

- PROVIDER NUMBER:** Leave blank.
- APPLICATION TYPE:** This field must be complete. (See Required Documentation on page 2 of the Checklist.)
- APPLICANT NAME:** Enter the Supervising Pharmacist's name as it appears on the license/registration; 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.

Attention Line: Enter the name of the pharmacy where the Supervising Pharmacist is employed.
- SERVICE ADDRESS:** This address must be the address of the pharmacy where the Supervising Pharmacist 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 on the www.eMedNY.org website. You are required to provide documentation and/or details explaining the circumstances

LICENSE/REGISTRATION INFORMATION:

Enter the Supervising Pharmacist's license number. **Attach a copy of your current license/registration renewal certificate.**

EMAIL ADDRESS:

Enter your email address if applicable.

APPLICANT'S SIGNATURE:

The Supervising Pharmacist must **personally sign** the enrollment form. **Signature stamps, photocopies, etc. are not acceptable.**

SUPERVISING PHARMACIST AGREEMENT FORM

This form is self-explanatory and **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 supervising pharmacist name, social security number and name of pharmacy.**

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:

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

SUPERVISING PHARMACIST
CATEGORY OF SERVICE 0444

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 LICENSE/REGISTRATION

NATIONAL PROVIDER IDENTIFIER (NPI)

SOCIAL SECURITY NUMBER

CORRESPONDENCE ADDRESS (Mail & Information)

ATTENTION
Enter the NAME of the person/department/apartment number where the mail should be sent

STREET - LINE 1
Cannot be a Post Office Box UNLESS accompanied by an actual street address

- LINE 2

CITY
Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE () - EXT.

LICENSE/REGISTRATION INFORMATION - Attach Copy

LICENSE NO.

- AGENCY CODE (Check ONE) NYS Pharmacist (03)
 Out-of-State Pharmacist (99)

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.

License Begin Date MM DD YY

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?

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

EMAIL ADDRESS

PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)
EMEDNY-409801 (09/09)

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 _____

