

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
DIVISION of PROVIDER RELATIONS AND UTILIZATION MANAGEMENT

REQUEST FOR OUT OF STATE HOSPITAL ENROLLMENT PACKAGE

Please complete all fields and fax this form to the Rate-Based Provider Bureau at
(518) 473-6705.

Hospital Name: _____

FEIN: _____ NPI: _____

Physical Address of Facility: _____
(as it appears on home state license) _____

Address where the package
Is to be sent: _____
(Please include attention line) _____

Contact Name: _____ Title: _____

eMail Address: _____ Phone Number: _____

Date requested based on treatment of a NYS Medicaid Enrollee: _____

NOTE -- *New York State will enroll Out of State Hospital providers only if the date of service listed above is no earlier than 90 days prior to the date this request is received by NYS.*

Type of Service rendered:

___ Inpatient ___ Outpatient ___ Emergency Room ___ Ambulatory Surgery

Were the services rendered emergency in nature? ___ Yes ___ No

Were services Prior Approved? ___ Yes ___ No

Was this facility ever previously enrolled in the NYS Medicaid Program?

___ Yes ___ No If yes, previous Provider ID Number: _____

FOR STATE USE ONLY:

Enrollment Tracking # _____

Review:

FEIN match? _____ Name match? _____

Previous Provider ID #: _____ OOS code 8? _____

Status: _____ Date: _____

Action:

_____ Send New Enrollment Package _____ B _____ O _____ HU

_____ Send Reinstatement Package

_____ eMail "already enrolled" notification _____ Deny request – over 90 days from date of service

NOTE: Outgoing enrollment packages are logged. Completed enrollment forms must be returned to NYS within 90 days of the package being sent out. Enrollments returned after 90 days will be denied.