

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 you first treated a NYS Medicaid Enrollee: \_\_\_\_\_

**NOTE --** *It is extremely important that you supply the first service date you need covered under this enrollment on this form.  
Back-dating is a lengthy process which could cause your claim to become too old for timely filing.*

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