

REQUEST FOR MEDICAID VERIFICATION AND RATES
NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs
Suite 6E
150 Broadway
Albany, New York 12204-2736
(Attention Rate Based Provider Bureau)
FAX # (518) 473-6705

Dear Provider of Service to a New York State Medicaid client:

Enrollment in the New York State Medicaid program requires verification of your enrollment in your home state's Medicaid program and verification of the rate methodology and reimbursement rates.

Please complete the three fields in the box below and forward this form to your state's Medicaid program for completion. Your enrollment forms will be held and your facility will not be enrolled until we receive this completed form back from them.

THIS PORTION TO BE COMPLETED BY THE PROVIDER OF SERVICE:

Provider Name: _____ **NPI:** _____

Date you wish this enrollment to be effective: _____

THIS PORTION TO BE COMPLETED BY THE STATE MEDICAID PROGRAM:

(Please mail or fax completed form to the address/fax number info above)

1. Is this provider currently enrolled in your state's Medicaid program? Yes ___ No ___
2. Home State's Medicaid ID #: _____
3. Effective date of Enrollment: _____
4. Payment methodology (inpatient billing): *(please circle methodology and provide information that covers the requested enrollment date and any subsequent updates)*
 - a. Per Diem --- effective date _____ amount _____
effective date _____ amount _____
 - b. % OF CHARGES --- effective date _____ % _____
effective date _____ % _____
 - c. DRG --- effective date _____ Cost per Discharge _____
effective date _____ Cost per Discharge _____

Name of State Medicaid staff completing form

Title

Telephone number

Name of State Rate Setting Agency

Date