

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS**
Division of Provider Relations and Utilization Management
Rate Based Provider Bureau

FAX FORM TO: (518) 473-6705

Complete Form & Fax to the Rate Based Provider Bureau
Please Photocopy & Complete a separate form for each NPI you wish to enroll

PROVIDER NAME & FEIN NUMBER		<u>REQUEST TO ENROLL</u> <u>UNREPORTED OR NEW NPI</u>	
Name: FEIN No.:			
PHYSICAL ADDRESS OF FACILITY		NPI:	
Street Address		Primary Taxonomy Code:	
City, State, Zip Code:		Secondary Taxonomy Code:	
ADDRESS TO SEND FORM(S) / CONTACT INFO / AUTHORIZATION		<u>Medicaid Services to be billed using this NPI:</u>	
Name:		<input type="checkbox"/> Hospital Inpatient Acute Care <input type="checkbox"/> Hospital Psychiatric Services <input type="checkbox"/> Hospital Rehabilitation Services <input type="checkbox"/> Hospital Based Outpatient Srvc <input type="checkbox"/> Diagnostic & Treatment Center <input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Hosp or clinic Based Pharmacy <input type="checkbox"/> Hosp or clinic Based Lab	
Street Address:		<input type="checkbox"/> Residential Health Care Facility <input type="checkbox"/> Adult Day Health Care Program <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Long Term Home Health Care <input type="checkbox"/> Assisted Living Program <input type="checkbox"/> Personal Emergency Response <input type="checkbox"/> School Supportive Health <input type="checkbox"/> Early Intervention Program <input type="checkbox"/> Child Care Agency <input type="checkbox"/> Residential Treatment Facility <input type="checkbox"/> Hospice	
City, State, Zip Code:		<input type="checkbox"/> OASAS Sponsored Program Type_____	
Email Address:		<input type="checkbox"/> OMH Sponsored Program Type_____	
Contact Name, Title & Telephone Number:		<input type="checkbox"/> OMRDD Sponsored Program Type_____	
Signature of Authorized Representative:		<input type="checkbox"/> Case Management Services Type_____	
_____ DATE: _____ <small>The person signing this enrollment document on behalf of the Provider warrants that he/she has legal authority to bind Provider</small>			
Currently Enrolled NPIs:		Legacy MMIS ID #s for the services indicated above:	
FOR STATE USE ONLY			
PACKAGE SENT DATE		Package Type	Comments:
MAIL	EMAIL		
ENTITY ID:		STATE TRACKING NUMBER:	

Contact the New York State Medicaid Program:
 Mailing Address: Suite 6E, 150 Broadway, Albany, New York 12204
 Telephone : (518) 474-3575 or 1-800-342-3005
 eMail Address: RBU@health.state.ny.us
 Web Site: www.eMedNY.org