



# Provider Services Portal Facilities, Agencies, Organizations and Groups Milestone 2

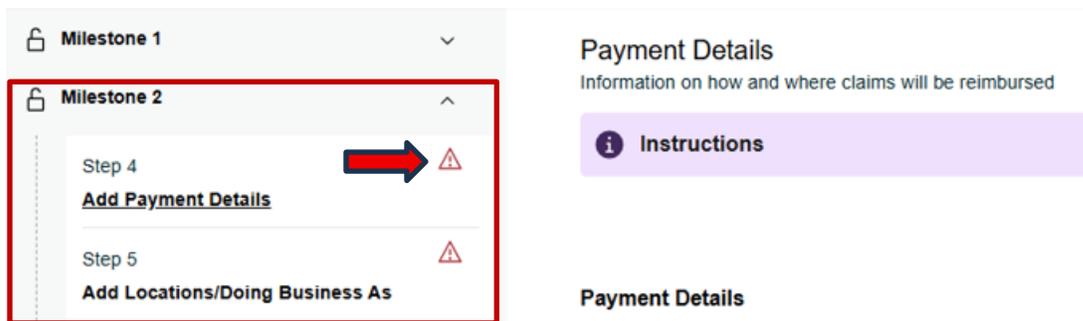
## Overview

This document describes how Facilities, Agencies, Organizations (FAOs) and Groups should complete Milestone 2 of the enrollment application in the Provider Services Portal. This Quick Reference Guide is based on an example of a Group provider enrollment. Enrollment screens and requirements will vary based upon the specific provider type enrolling.

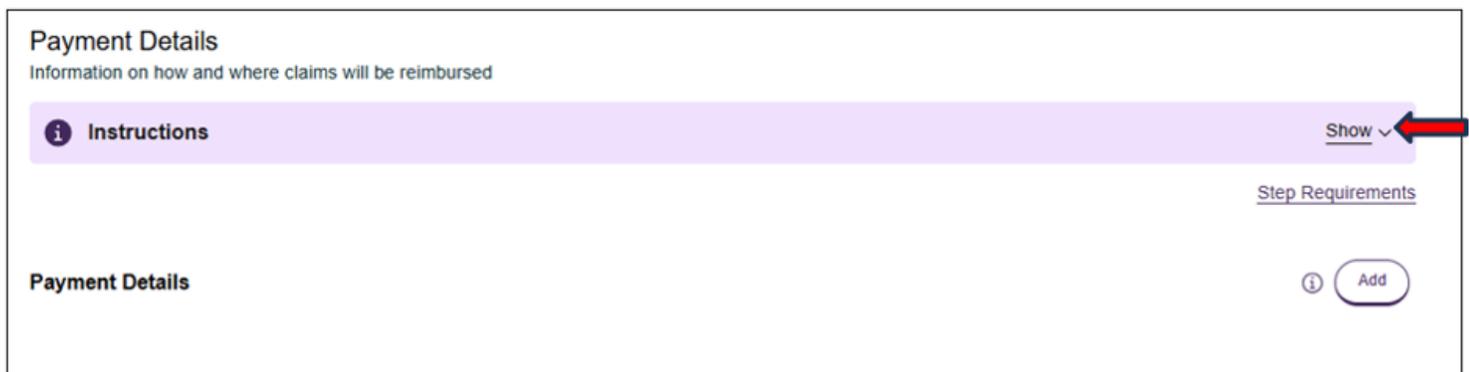
**Note:** At this time, the portal is only available to providers who have never been enrolled in NYS Medicaid and who do not have a paper application pending in the eMedNY system.

## Milestone 2 of an application

Milestone 2 of an application is comprised of steps 4 and 5. Required fields are marked with a red asterisk (\*). The application will not move forward if required fields are left blank. To identify information still missing from a step marked as incomplete, hover over the triangle with an exclamation point ( ⚠ ).



**Clicking** the arrow next to the Show button in the purple instructions banner of any screen will display instructions for that step.



**Payment Details**  
Information on how and where claims will be reimbursed

**Instructions** Hide ^

- Familiarize yourself with the 'Step Requirements' link located immediately after the Instructions section. Here you will find any required documentation that will need based on the STEP you are completing. Some requirements will include hyperlinks (URLs) to forms that will need to be downloaded, filled out, uploaded along with your submission.
- Enter the required electronic funds transfer(EFT) information under Payment Details.
- The EFT authorization/agreement must be read fully and accepted.
- Attach one of the following as needed under Supporting Documents.
- For Checking Accounts, attach a blank cancelled check. The word "VOID" must be written across the face of the check.
- For deposit-only checking accounts (without checks) or a savings account, submit a letter from a bank officer. The letter must be on bank letterhead, signed by a bank officer, notarized by a notary public, and include the financial information provided in the Payment Details.
- In addition to the above, if changing the bank information, attach a letter indicating the changes. The letter must be on company letterhead and include and provider number(s) (MMIS and NPI), new account number and routing number, and a brief explanation of the change. The letter must have an original signature and title must be indicated.
- The EFT authorization/agreement must be completed with an original signature and the date signed. For individual practitioner applicants, the agreement must be signed by the practitioner. For groups, businesses, or institutions, it must be signed by an authorized representative.



Click on the Step Requirements link to display Required and Optional documents for the step.

**Payment Details**  
Information on how and where claims will be reimbursed

**Instructions** Show v

[Step Requirements](#)

**Payment Details** Add



**Step Requirements**

Application ID	Enrollment Type Facility/Agency/Organization(FAO) & Group	Applicant Type Fee For Service (Billing)	Application Status In Process	Name	
<b>Document Name</b>					
Step Name ↑	Document Type ↑↓	Document Name ↑↓	File Name ↑↓	Sample Document Link ↑↓	Required/Optional ↑↓
Add Payment Details	Payment	Bank Letter or Cancelled Check			Required
Add Payment Details	Payment	EFT Agreement			Required
Add Payment Details	Payment	EFT Change Letter			Optional

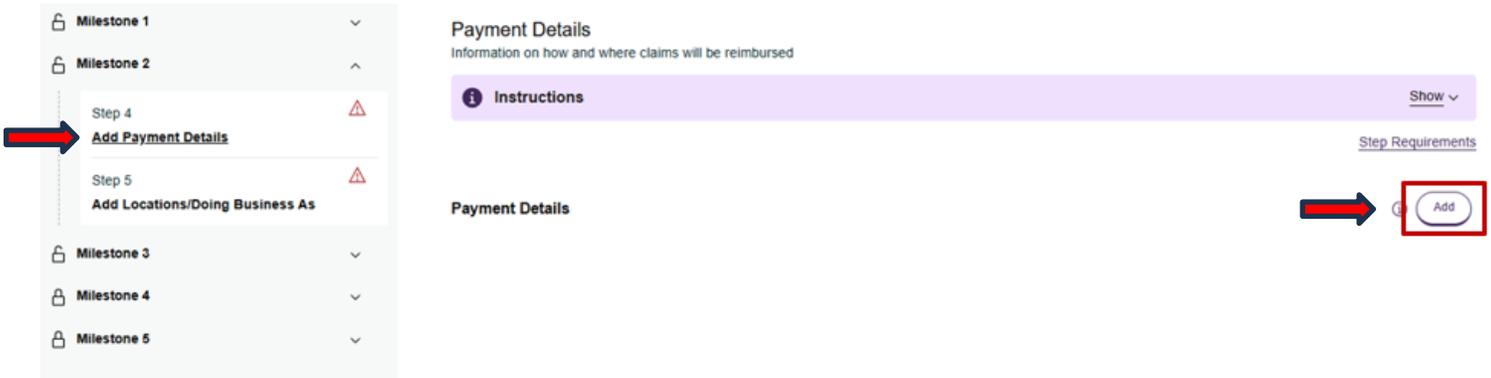
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03/09/2026

03/03/2026

**Step 4** is the Add Payment Details step.

Click on Add to begin this step.



Information such as Social Security Number/EIN/FEIN and Provider Name will pre-populate based on information entered in Milestone 1. Payment Method defaults to Electronic Funds Transfer (EFT) for direct deposit.

Under Financial Institution Information, complete the required Start Date, Financial Institution Name, Routing Number, Account Number and Type of Account fields. NOTE: the required start date would typically be the day you complete this field.

Under Pay-To Contact Details, complete the required Contact Name, Phone Number and Email Address fields.

**Payment Details**  
Information on how and where claims will be reimbursed

**Instructions** Show

[Step Requirements](#)

**Mode of Payment**

SSN/EIN/FEIN  Provider Name\*

Payment Method  Electronic Funds Transfer (Direct Deposit)

Start Date\*  End Date

**Financial Institution Information**

Financial Institution Name\*  Routing Number\*

Account Number\*  Type of Account\*

**Pay-To Contact Details**

Contact Name\*  Phone Number\*  Email Address\*  Fax Number

The EFT Agreement must be read in full and acknowledged. The signature (First and Last Name) box's will remain greyed out until the entire EFT Agreement has been read (scroll down to read in its entirety). Enter the First Name, Last Name and Date.

Click on the box that acknowledges the EFT Agreement has been read and agreed to.

Click on Save Details.

**EFT Agreement**

The Electronic Fund Transfer form will be pre-filled with the information provided on this page. But it must still be signed to signify the agreement with the terms on page 2 of the EFT form. Both pages must then be sent in along with any additionally required documentation. This information will appear on the form that gets created. However, the signature field will be empty in the form and must therefore be signed before sending in the EFT Agreement.

 **Agreement**

Providers who receive payment of claims under the Title XIX (Medicaid) program in New York State Department of Health must agree to the following terms and conditions:

1. Legal Compliance: Provider shall abide by all federal and state laws governing the Medicaid program.
2. EFT information: Provider will submit the EFT information that includes the Payee, name of the bank, address of bank, transit number, account number, and a bank letter or voided check on the account to which funds will be transferred.
3. Acceptance of Funds: Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the New York State Medicaid program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. The provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.
4. Notice of Change: Provider will notify the Department of any changes in Payee, Payee's name or address, or bank account details. This notification must be supported in writing on company letterhead and include the provider's number(s) (MMIS ID or NPI), new account number, routing number, and a brief explanation for the change. The letter must also be signed by the provider and their title must be indicated.
5. Alternate Payment Methods: For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the Department may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by the Department. Payment by check will be made to the pay-to address on record with the Department.
6. Incorporated Document: This EFT Agreement is incorporated into the Statement of Participation and shall not modify or eliminate any provision of the Statement of Participation (including applicable Policies and Procedures manuals of the Department) except as specifically provided herein.
7. Expiration or Termination of EFT: In the event the eMedNY Fiscal Agent receives notification that the account provided in this agreement has been closed, frozen, or if there have been changes to the account details (such as account number or routing number), EFT will be automatically terminated.
8. The eMedNY Fiscal Agent contractor for the New York State Department of Health will have the right to recover any amount that has been credited to your account incorrectly

First Name \*

Last Name \*

Date \*

  I hereby acknowledge that I have read and agreed to the terms and conditions stated in the EFT Agreement. (Authorization Agreement - By Selecting the Check Box) \*

 [Save Details](#)

Click on Add under Address Details to enter the Pay-To Address. This is where paper checks (if necessary) and paper remittances will be sent until electronic or PDF remits are set up.

**Address Details**



<input type="checkbox"/> Address Type ↑↓	Address ↑↓	Actions
No records found!		

0-0 of 0 item of 1 page

**Supporting Documents**

<input type="checkbox"/> Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date
No records found!					

Select Pay-To Address from the Type of Address drop-down, then enter Address Line 1 and the Zip Code.

Click on Validate Address, then the City/Town and State/Province fields will populate. If an error message is received, correct the error.

Once all information is validated, click on Save.

**Address Details**

Type of Address \*

**Address**

Address Line 1 \*

Enter Street Address or PO Box Only

Address Line 2  Address Line 3

City/Town \*  State/Province \*

County  Country \*

Zip Code \*





Once the Pay-To Address has been saved, you will be redirected back to the previous screen. Scroll down to the Address Details section to see the saved Pay-to Address.

Click on Add under Address Details, to enter the Financial Institution address.

**Address Details**



The screenshot shows a header bar with two buttons: 'Add' (dark purple) and 'Delete' (light purple). A red arrow points to the 'Add' button. Below this is a table with columns: 'Address Type ↑↓', 'Address ↑↓', and 'Actions'. The first row is 'Pay-To Address' with a checkbox on the left and edit/delete icons on the right.

Select Financial Institution Address from the Type of Address drop-down, then enter Address Line 1 and the Zip Code.

Click on Validate Address, then the City/Town and State/Province fields will populate. If an error message is received, correct the error.

Click on Save.

**Address Details**

Type of Address \*  
Financial Institution Address

**Address**

Address Line 1 \*  
Enter Street Address or PO Box Only

Address Line 2      Address Line 3

City/Town \*      State/Province \*  
Select      Select

County      Country \*  
Select      UNITED STATES

Zip Code \*



The screenshot shows three buttons: 'Validate Address' (light purple), 'Back' (light purple), and 'Save' (dark purple). A red arrow points to the 'Validate Address' button, and another red arrow points to the 'Save' button.

Once the Financial Institution Address has been saved, you will be redirected back to the previous screen. Scroll down to the Address Details section to see both the saved Pay-To and Financial Institution Addresses listed.

**Address Details**

<input type="button" value="Add"/> <input type="button" value="Delete"/>		
<input type="checkbox"/> Address Type ↑↓	Address ↑↓	Actions
<input type="checkbox"/> Pay-To Address		
<input type="checkbox"/> Financial Institution Address		
1-2 of 2 items		1 of 1 page

**Scroll** up to the EFT Agreement and **Click** on Download in the upper right corner.

**Note:** The Download button will not be available until both the Pay-To and Financial Institution addresses have been entered.

**Agreement** [Download](#)

Providers who receive payment of claims under the Title XIX (Medicaid) program in New York State Department of Health must agree to the following terms and conditions:

1. Legal Compliance: Provider shall abide by all federal and state laws governing the Medicaid program.
2. EFT Information: Provider will submit the EFT information that includes the Payee, name of the bank, address of bank, transit number, account number, and a bank letter or voided check on the account to which funds will be transferred.
3. Acceptance of Funds: Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the New York State Medicaid program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. The provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.
4. Notice of Change: Provider will notify the Department of any changes in Payee, Payee's name or address, or bank account details. This notification must be supported in writing on company letterhead and include the provider's number(s) (MMIS ID or NPI), new account number, routing number, and a brief explanation for the change. The letter must also be signed by the provider and their title must be indicated.

Once the EFT Agreement has been downloaded, it must be **printed, physically signed by the provider, saved to computer and uploaded** under the Supporting Documents section of this step.

**NOTE:** DO NOT use the EFT Authorization Form (eMedNY- 701101) from the eMedNY.org website.

### Sample EFT Agreement

DEPARTMENT OF COMMUNITY HEALTH ELECTRONIC FUNDS TRANSFER AGREEMENT		
<b>PROVIDER INFORMATION</b>		
Provider Name <b>SAMPLE DME</b>		
Provider Address Street <b>STREET1 STREET2 STREET3</b>		
City <b>CITY</b>	State/Province <b>STATE</b>	Zip Code/Postal Code <b>ZipCode</b>
<b>PROVIDER IDENTIFIERS INFORMATION</b>		
Social Security Number (SSN) or Federal Employer Identification Number (FEIN) or Employer Identification Number (EIN) <b>012345678</b>		
National Provider Identifier (NPI) <b>1234567890</b>		
<b>PROVIDER CONTACT INFORMATION</b>		
Contact Name <b>John</b>		
Phone Number <b>555555555</b>	Email Address <b>example@email.com</b>	Fax Number
<b>FINANCIAL INSTITUTION INFORMATION</b>		
Routing Number <b>012345678</b>	Type of Account <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings	
Account Number <b>123456789</b>		
Financial Institution Name <b>ABC Bank</b>		
Financial Institution Address Street <b>111 Main St</b>		
City <b>Schenectady</b>	State/Province <b>NEW YORK</b>	Zip Code/Postal Code <b>12345</b>
<b>MODE OF PAYMENT</b>		
Payment Method <input checked="" type="checkbox"/> Electronic Funds Transfer(EFT)		
<b>AUTHORIZED SIGNATURE</b>		
Original Signature of Practitioner/Authorized Representative		
Printed Name of Practitioner/Authorized Representative <b>John Doe</b>		
Printed Title of Practitioner/Authorized Representative		
Submission Date <b>19-FEB-26</b>	Effective Start Date/Cycle#	

Click on Add under Supporting Documents.

#### Address Details

<input type="checkbox"/> Address Type ↓	Address ↓	Actions
No records found!		

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#### Supporting Documents



<input type="checkbox"/> Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date
No records found!					

A new screen will pop-up allowing the upload of supporting documents for this step.

- Supported file formats include - .gif, .jpg, .jpeg, .html, .htm, .pdf, .xls, .tif, .doc, .docx, .xlsx, and .txt.
- Files must be under 10 MB in size.

For each Required Document to be uploaded (Bank Letter or Cancelled Check and EFT Agreement):

- **Select** the Document Type and Document Name from the drop-down lists
- **Click** on Choose to browse your computer for the documents to be uploaded
- **Click** on Upload Document

Supporting Documents ×

Application ID	Enrollment Type Facility/Agency/Organization(FAO) & Group	Applicant Type Fee For Service (Billing)	Name	Application Status In Process
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**Required Documents**

- Bank Letter or Cancelled Check
- EFT Agreement

Document Type\* ▼

Select

Document Name\* ▼

Select

File Name\*

File must be under 10 MB in size

**Added Documents**

<input type="checkbox"/>	Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date
No records found!						

Click on Close after the documents have successfully uploaded.

**Supporting Documents**

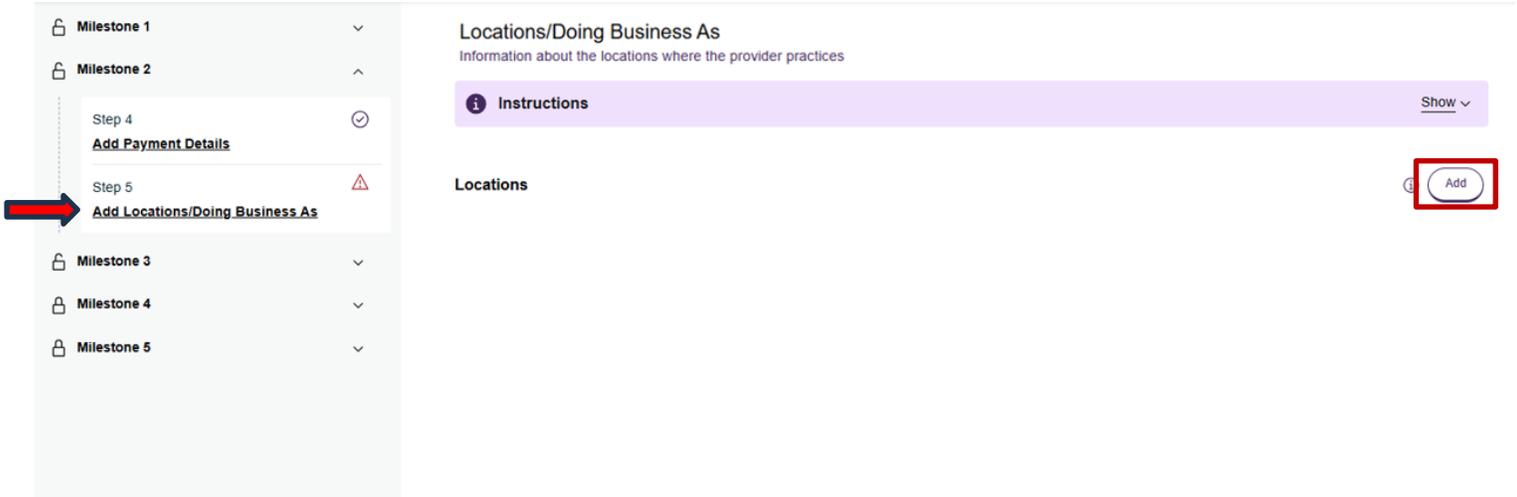
<input type="checkbox"/>	Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date	Actions
<input type="checkbox"/>	Payment	EFT Agreement	<a href="#">78837.jpg</a>			09/04/2025	<input type="button" value="🗑️"/>

Click on Save at the bottom right, once all required documents have been uploaded.

Click on Next Step at the bottom right of the page.

**Step 5** is the Add Locations/Doing Business As step.

Click on Add at the bottom right.



Enter required (fields with red asterisks) and optional Location Details, Contact Details, Office Information, Facility Details, Servicing Area, Languages Spoken, Office Hours and Address.

Click on Validate Address, then the City/Town and State/Province fields will populate. If an error message is received, correct the error.

Click on Save.

**Location Details**

Location Type \*  Place Of Service  Doing Business As \*

**Contact Details**

Phone Number \*  Extension  Public Phone Number \*  Extension

Fax Number

Email Address \*  Public Email Address

Web Page  Communication Preference \*

**Office's Information**

Offers Office Based Surgery

Yes  No

Accept New Patients

Yes  No

Is this Location TDD/TDY equipped? ⓘ

Yes  No

Handicap Accessible

Yes  No

Is this Location ASL capable? ⓘ

Yes  No

Accepting New Clients

Yes  No

Pediatric Services

Yes  No

Age Restrictions

Yes  No

In Person/Telehealth \*

Select ▼

Disability Accommodations

Select ▼

Maximum Clients

Offers OB-Gyn Services

Select ▼

**Facility Details**

State Facility ID

Fiscal Year End \* ⓘ

mm/dd

**Servicing Area**

Do you want to provide Service Area?

Yes  No

**Languages Spoken**

Selected Languages \*

Select ▼

**Office Hours**

24/7

Sunday

Monday

Tuesday

Wednesday

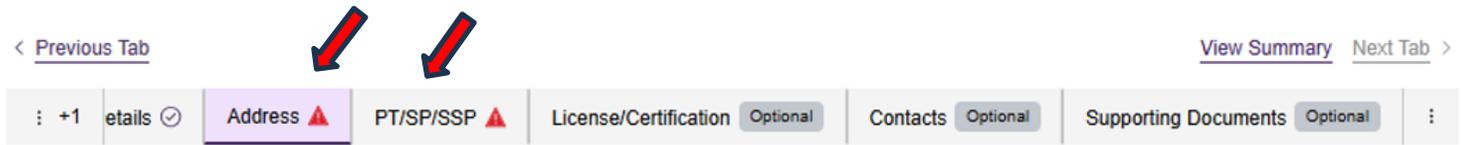
Thursday

Friday

Saturday



**NOTE:** The Address Tab refers you to the area where you will enter the provider’s correspondence address. The PT/SP/SSP refers you to the area where you will enter the provider specialties that are associated to this location. This will be based on information provided in Milestone 1, Step 3. The remaining tabs to the right are optional or situational.



Click on the Address tab first.

Select Correspondence as Type of Address. The Correspondence Address is where any paper communications will be mailed.

TIP: If the Correspondence Address is the same as the Location Address, click the circle next to “Use the same as Location Address.”

Once address details are entered, click on Validate Address then click on Save.

**Click on PT/SP/SSP**

**Select** the specialty(ies) from the box on the left and **click** the arrow pointing to the right to move the specialty over to the box on the right. *This will be based on information you provided in Milestone 1, Sept 3.*

**Click** on Save when all subspecialties have been moved over to the box on the right.

< Previous Tab View Summary Next Tab >

+1 Address **PT/SP/SSP** License/Certification Optional Contacts Optional Supporting Documents Optional

**Provider Type/Specialty/ Subspecialty**

Location: 01-ABC Physician Group Start Date\*: MM/DD/YYYY End Date: MM/DD/YYYY

**Associate Provider Type/Specialty/ Subspecialty**

Available Subspecialty:  Physicians Group/No Specialty/No Subspecialty - 193200000X

Associated Subspecialty\*:  Physicians Group/No Specialty/No Subspecialty - 193200000X

Buttons: Add All, Remove All, Back, **Save**

**Click** on Next Step at the bottom right. A screen will pop up to indicate that Milestone 2 is complete.

**Provider Type/Specialty/Subspecialty List**

Buttons: Delete, Show Filter, Actions

Provider Type-Specialty-Subspecialty-Taxonomy	Start Date	End Date	Actions
<input type="checkbox"/> Physicians Group-No Specialty-No Subspecialty-193200000X	02/18/2026	12/31/2999	

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**Next Step**

Milestone Completed

**Congratulations on Completing Milestone 2**

You've taken a significant step forward in the application process, and we are thrilled to see your progress.

Click on 'Okay' to proceed to 'Milestones list'

**Okay**

**Click** on Okay to acknowledge and move on to Milestone 3.