



## Provider Services Portal Facilities, Agencies, Organizations and Groups Milestone 5

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### Overview

This document describes how Facilities, Agencies, Organizations (FAOs) and Groups should complete Milestone 5 of an 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 5 of an Application

Milestone 5 of an application is comprised of steps 11-13. Optional steps will be marked as such on the left-hand menu next to the step number. Required fields are marked with a red asterisk (\*). The application will not move forward if required fields are left blank. To identify information missing from an incomplete step, hover over the triangle with an exclamation point (⚠).

#### Step 11 is Complete Enrollment Checklist.

**Click** the arrow next to the Show/Hide button in the purple instructions banner of any screen to display or hide instructions for that step.

**Select** either Yes or No for each of the questions on the Enrollment Checklist. Selecting Yes will open a comment box to provide additional information for that question. All questions must be answered.

**Note:** Depending on your enrollment type the questions may vary. **If a question is not applicable, please select "No."**

**Click** Save at the bottom right of the page.

**Click** Next Step.

**Complete Enrollment Checklist** \* Mandatory Fields

Enrollment checklist required for submission

**Instructions** Hide ^

- Answer all the questions. For questions that are not applicable, select "No". For any answer of "Yes", a comment is required. Uploads of documents may be requested.

**Questions**

Has the applicant/provider, any of the individuals/entities disclosed, (as required by 42 CFR Part 455.104 and 18NYCRR, Section 504.1) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or in any other State, Medicare, or any other governmental or private medical insurance program? If you answered "Yes", please specify the number of occurrences (e.g., once, twice, or multiple times) in the comments field. Additionally, you must complete and upload the "Prior Conduct Questionnaire" in the "Add Supporting Documents" step.

Yes  No

Has the applicant/provider, any of the individuals/entities disclosed, (as required by 42 CFR Part 455.104 and 18NYCRR, Section 504.1), ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State? If you answered "Yes", please specify the number of occurrences (e.g., once, twice, or multiple times) in the comments field. Additionally, you must complete and upload the "Prior Conduct Questionnaire" in the "Add Supporting Documents" step.

Yes  No

Has the applicant/provider, any of the individuals/entities disclosed, (as required by 42 CFR Part 455.104 and 18NYCRR, Section 504.1) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State? If you answered "Yes", please specify the number of occurrences (e.g., once, twice, or multiple times) in the comments field. Additionally, you must complete and upload the "Prior Conduct Questionnaire" in the "Add Supporting Documents" step.

Yes  No

[Save](#) [Next Step](#)

**Step 12 is Add Supporting Documents.**

Follow the instructions for uploading as in previous Milestones.

**Add Supporting Documents** \* Mandatory Fields

Documents and attachments to support the application

**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.
- The list of supporting documents uploaded during previous steps is displayed below. Additional supporting documents can be uploaded if needed on this page.

**Additional Documents**

Upload a copy of additional supporting documents

Document Type \*  Document Name \*

File Name \*  [Choose](#)

File must be under 10 MB in size

[Upload document](#)

**Step 13** is Submit Enrollment Application for Approval.

**IMPORTANT: If you are preparing this application and you are NOT the Owner or a Managing Employee of the provider, or you are NOT disclosed on this application or the provider's enrollment record, STOP HERE.**

The Owner or Managing Employee must have their own NY.Gov Business account and must be the individual to sign and submit the application by logging into the Provider Services Portal with their own credentials. **The application can be accessed by going to Track Application and entering the Application ID, EIN/FEIN, Primary Practice Location Phone Number and the Owner's or Managing Employee's Social Security Number (SSN) and Date of Birth**

The screenshot shows a web form titled "Track Application" with a sub-header "For Additional security, please enter following information". The form is divided into "Application Details" and contains the following fields:

- Application ID \***: A text input field containing "20260211227751".
- EIN/FEIN \***: A text input field containing "00-0000000" with a visibility icon.
- Primary Practice Location Phone Number \***: A text input field containing "(000) 000 - 0000".
- Owner/Managing Employee SSN \* ⓘ**: A text input field containing "000-00-0000" with a visibility icon.
- Owner/Managing Employee DOB \***: A date input field with the placeholder "MM/DD/YYYY" and a calendar icon.

At the bottom right of the form are two buttons: "Cancel" and "Submit". A legend in the top right corner indicates "\* Mandatory Fields".

**Read** the Terms and Conditions in its entirety (scroll down to proceed to the end of the Agreement).

The Owner's or Managing Employee's name will prepopulate at the bottom of the screen when logged in with their own credentials. If someone other than an Owner or Managing Employee is logged in, e.g., credentialing staff, a warning will appear. This is a cue for the user to **STOP** and email the submitting Owner or Managing Employee with the portal URL and the application ID to complete the submission process.

Once the user is an Owner or Managing Employee, they must **Click** the box to accept and agree to the Terms and Conditions and proceed with the remaining steps.

**Click** Next.

Submit Enrollment Application for Approval

\* Mandatory Fields

Agreement to terms and conditions, signature, and final application submission

Instructions

Show

Medical Assistance Provider Enrollment

Terms and Conditions

1. New York State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting information and how we will use it. The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities. This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider. The information will be maintained by the New York State Department of Health, Office of Health Insurance Programs, Division of Health Plan Contracting and Oversight, Bureau of Provider Enrollment, Albany, New York.

2. As a Medicaid provider, you agree to comply with the rules, regulations and official directives of the Department including, but not limited to, Part 504 of 18 NYCRR (i.e., Title 18). Title 18 can be found by choosing the Laws and Regulations link of the Department of Health's website. www.health.ny.gov. You will be at financial risk if you render services to Medicaid beneficiaries before successfully

Form fields for First Name, Last Name, and Date.

By checking this, I certify that I have read and that I agree and accept the enrollment terms and conditions in the NY State Medicaid Provider Enrollment.

The authorized signer of the Terms and Conditions should match the First Name and Last Name of an individual disclosed on this application (or the provider record, if already enrolled) as an Owner, Board of Director, or Managing employee (if institutional provider).

Next

Once Next has been selected, the screen below will display the Credentialed Access Attestation. This is where the Owner or Managing Employee can grant access to selected users for the purpose of maintaining the provider's enrollment record after initial enrollment. The list of Available Users displays the Last Name, First Name and Username of any users who have previously accessed the application.

To provide ongoing access to users/credentialing staff:

- 1. In the Available Users box on the left, click on the name of the user who you want to have access to your file.
2. Click the right-pointing arrow to move the selected name into the Associated Users box.

Once all users have been selected, check the box to authorize the users and click Submit. After Application Approval, the users listed are assigned the Provider Domain with the profiles of Domain Administrator, Provider Enrollment Access, and View Provider Enrollment.

TIP: Owners, Managing Employees, or other disclosed individuals who are authorized to submit the application will typically grant access to users who have assisted in completing the application.

Once all users have been selected, **check the box to authorize** the users and click **Submit**.

### Submit Enrollment Application for Approval

\* Mandatory Fields

Agreement to terms and conditions, signature, and final application submission

**Instructions**

Show 

#### Medical Assistance Provider Enrollment

##### Credentialer Access Attestation

I authorize users selected below to access my Provider Record.

Available Users

[Add All](#) >>

Associated Users

<< [Remove All](#)



First Name \*

Last Name \*

Date \*



As the provider signing this application, I authorize the above staff from the credentialing organization that assisted in the submission of this application to maintain ongoing access to my enrollment record for the purpose of initiating and supporting any future maintenance requests. Such access shall remain in effect until I, or any staff from the credentialing organization that assisted in the submission of this application, initiates revocation of the credentialer's access within the portal and the request is processed. \*

The authorized signer of the Terms and Conditions should match the First Name and Last Name of an individual disclosed on this application (or the provider record, if already enrolled) as an Owner, Board of Director, or Managing employee (if Institutional provider).



submit

Once user authorizations have been submitted, the application is complete and the following screen will display. Notice of a successful application submission will display at the top in pink and the Application Status will say **Submitted**. An email will also be sent to the primary email address entered on the application to notify that the submission was successful.

**Warning**  
Your Application Number 20260212824477 has been successfully submitted for State review. Return with this application number to track the status of your application.

Application ID 20260212824477	Enrollment Type Facility/Agency/Organization (FAO)	Name Mosaic Health 1 Murray Hill Dental Clinic FQHC	Application Status Submitted	Start Date 03/03/2026	End Date 04/17/2026	Options
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**Enroll Provider - Facility/Agency/Organization (FAO)**

Enrollment Requirements

26 Days remaining Completed(100%)

Milestones	Status	Step Remark
Milestone 1	✔ Complete	
Milestone 2	✔ Complete	
Milestone 3	✔ Complete	
Milestone 4	✔ Complete	
Milestone 5	✔ Complete	