



Provider Services Portal - Modifications

Overview

This document describes how to perform a modification to your provider enrollment file after you have been enrolled in the Medicaid program via the Provider Services Portal (PSP). A modification is a change that is made to a provider enrollment file and can include transactions such as address changes, group affiliations/disaffiliations, EFT update and more. Please note this is an example of a modification being made on a fee-for-service provider file.

Note: At this time, not all modifications are functional in the PSP. Modifications that are available will appear as an editable field. Modifications that are not available will have the fields grayed out, and you will be unable to edit the fields. It is anticipated that additional fields will be available for editing in the future. Please contact the eMedNY Call Center at 800-343-9000 with any questions.

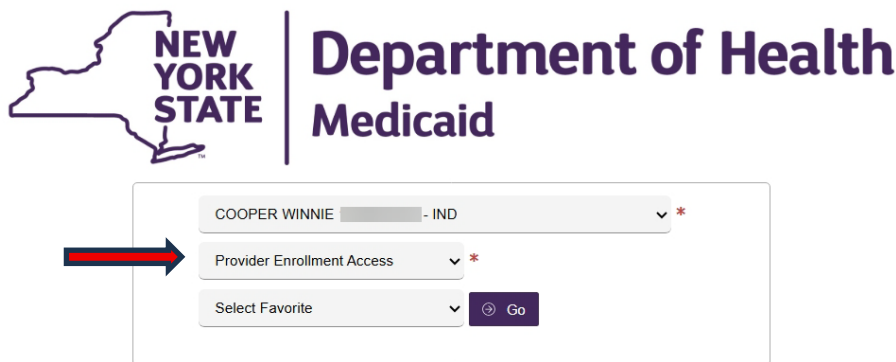
Submitting a Modification

TIPS FOR COMPLETING A MODIFICATION:

- When available, select the “Show” button prior to entering any information. This will expand and provide guidance for completing a particular step.



After an application has been approved, a provider may need to make updates to their enrollment file. When a user logs into the PSP after approval, the screen below will appear with the provider’s name as the domain.

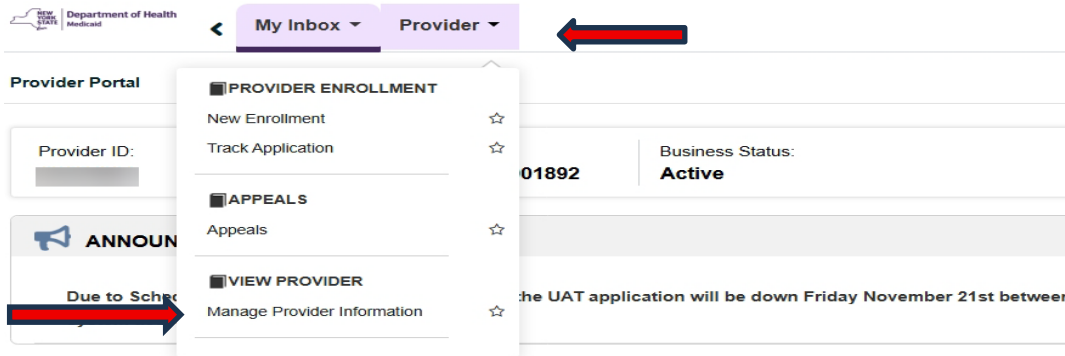


From the domain dropdown, **select** the specific provider’s name for the enrollment file you wish to modify. **Note:** Credentialing staff may have access to several different provider domains if access has been granted. Provider’s accessing their own file should only see their name.

Select Provider Enrollment Access from the second dropdown. **Select** the Provider tab from the top once logged as seen

below.

Select *Manage Provider Information* from the third dropdown.



The following screen is the application dashboard where all the milestones and steps will be displayed:

View/Update Provider Data - Individual

Enrollment Requirements

Milestones	Modification Date	Review Date	Status	Modification Status	Step Remark
Milestone 1					
Step 1 Basic Information	06/24/2025	06/24/2025	Complete		
Step 2 Federal Tax Details	06/24/2025	06/24/2025	Complete		
Step 3 Specialties/Licenses/Certifications	07/22/2025	08/14/2025	Complete	Approved	
Milestone 2					
Step 4 Education/Training/Work History Optional	06/24/2025	06/24/2025	Complete		
Step 5 Payment Details	07/22/2025	07/23/2025	Complete	Approved	
Step 6 Locations/Doing Business As	07/22/2025	07/22/2025	Complete	In Review	
Milestone 3					
Step 7 Associate Billing Provider/Other Associations Optional	06/24/2025	06/24/2025	Complete		
Step 8 Provider Controlling Interest/Ownership Details	06/24/2025	06/24/2025	Complete		
Milestone 4					
Step 9 Complete Modification Checklist	07/22/2025	06/24/2025	Complete	In Review	
Step 10 Add Supporting Documents Optional	06/24/2025	06/24/2025	Complete		
Step 11 Submit Modification Request for Review	07/22/2025	06/24/2025	Complete		

To make a modification, select the Step you wish to modify. For example, if you wish to add a new service address, select *Step 6*.

For some steps, like *Step 5, Payment Details*, you must select the pen underneath *Actions* on the most recent information that was approved. This will allow you to modify the details on the step and will end date the oldest banking details on the file.

When desired modifications are made, the following screen will show every Step that has been updated. To undo a modification, **select** the arrow next to the word *Updated*.

Step 1	Basic Information	12/10/2025	12/09/2025	<input checked="" type="checkbox"/> Complete	Updated
Step 2	Federal Tax Details	12/10/2025	12/09/2025	<input checked="" type="checkbox"/> Complete	Updated
Step 3	Specialties/Licenses/Certifications	12/10/2025	12/09/2025	<input checked="" type="checkbox"/> Complete	Updated
Milestone 2					
Step 4	Education/Training/Work History	Optional	12/09/2025	12/09/2025	<input checked="" type="checkbox"/> Complete
Step 5	Payment Details		12/10/2025	12/09/2025	<input checked="" type="checkbox"/> Complete Updated
Step 6	Locations/Doing Business As		12/10/2025	12/09/2025	<input checked="" type="checkbox"/> Complete Updated
Milestone 3					
Step 7	Associate Billing Provider/Other Associations	Optional	12/09/2025	12/09/2025	<input checked="" type="checkbox"/> Complete
Step 8	Provider Controlling Interest/Ownership Details		12/09/2025	12/09/2025	<input checked="" type="checkbox"/> Complete
Milestone 4					
Step 9	Complete Modification Checklist		12/31/2025	12/09/2025	<input type="checkbox"/> Incomplete Please Answer all the Questions.
Step 10	Add Supporting Documents	Optional	12/09/2025	12/09/2025	<input checked="" type="checkbox"/> Complete
Step 11	Submit Modification Request for Review		12/10/2025	12/09/2025	<input type="checkbox"/> Incomplete Modification Request has not been Submitted.

Select Step 9_ Complete Modification Checklist.

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

- Milestone 1
- Milestone 2
- Milestone 3
- Milestone 4
- Step 9 **Complete Modification Checklist**
- Step 10 Optional **Add Supporting Documents**
- Step 11 **Submit Modification Request for Review**

Manage Provider Checklist * Mandatory Fields

Enrollment checklist required for submission

Instructions Show

Provider Checklist

Do you want to provide EIN/FEIN information? If yes, please enter the EIN/FEIN, Legal Entity Name, and Entity Business Name (DBA - Doing Business As) in the comments field. You will also be required to upload the IRS FEIN Assignment Letter in the Federal Tax step. If the EIN/FEIN is not in the individual provider's own name, e.g., Jane Doe, the applicant must also supply a copy of their certified DBA (Doing Business As), e.g., Jane Doe Chiropractic, from a government entity (county/state) in which they operate.

Yes No

If you wish to Terminate your participation with NYS Medicaid, select "Yes" and comment "I agree". By doing so, you acknowledge that you will be ineligible to receive reimbursement for services provided to, or order/refer/prescribe/attend for, all Medicaid fee for service, Medicaid Managed Care (MMC) and Children's Health Insurance Program (CHIP) beneficiaries. You will also be precluded from participating in all MMC and CHIP networks, per Section 5005(b)(2) of the 21st Century Cures Act and Section 1932(d) of the Social Security Act. The effective date of this status change will be the date this form is processed by DOH.

Yes No

Nurse Practitioners - Pursuant to Education Law Section 6902(3)(b), Nurse Practitioners that do not have 3,600 hours of relevant practice experience must be associated/affiliated to an enrolled collaborating physician. If you have less than 3,600 hours of experience, select "Yes" and enter your accumulative practice hours in the comments field. You must update the "Associate Billing Provider/Other Associations" step to affiliate with your collaborating physician. Additionally, a signed copy of the Collaborative Physician Agreement must be uploaded as part of that step that includes the collaborating physician entered on your submission. If you have more than 3,600 hours of relevant practice experience select "No."

Yes No

Independent Nurses (RN/LPN), select "Yes" and comment "I agree", if you agree to participate in the Private Duty Nursing (PDN) Medically Fragile Provider Directory for the purpose of promoting the availability and ensuring delivery of fee for service nursing services to medically fragile children and adults. This directory is available to the public and will be updated weekly. I acknowledge that the information provided above is accurate and I will immediately notify the NY Medicaid program if there are changes to my address, phone number or email address. Approval for participation in the Directory will authorize enhanced reimbursement for private duty nursing

Previous Step
Next Step

Click Save at the bottom right of the page.

Click Next Step.

Step 10 provides an opportunity to *Add Supporting Documents*. Follow instructions and cues for uploading, as done in previous milestones.

Step 11 is the final step to *Submit Modification Request for Review* and approval.

Submit Modification Request for Review * Mandatory Fields
 Agreement to terms and conditions, signature, and final application submission

Instructions Show ▾

Medical Assistance Provider Enrollment

Terms and Conditions

It is my intent, to sign this document and submission by clicking the box marked "I agree to the above certification," and to electronically submit this document to the New York State Department of Health.

As the provider/applicant I attest that I have fully disclosed all required information pursuant to 42 CFR §455.104 and 18 NYCRR, §504.1. I understand that by utilizing the electronic process, which includes data entry of the fields in this application, my user ID, password, and clicking the "submit" button, I am electronically signing and submitting this document filed on my own behalf (if an individual practitioner) or on behalf of this provider (if a group, business, or institution), and that my electronic signature has the same legal force and effect as having placed my handwritten signature on the submitted document and this affirmation.

I understand and agree, under penalty of perjury, that my e-signature is an attestation that I have examined the information contained in this transaction, including any accompanying documentation or attachments uploaded, and certify that my electronic submission is true, correct, and complete. I am aware that this certification may later be used as documentary evidence against me, and/or the provider on behalf of whom I am signing, in, including but not limited to, administrative audits and audit proceedings, and civil and criminal legal actions in federal and State court by the Medicaid Fraud Control Unit (MFCU) of the NYS Attorney General's Office, the U.S. Attorney, or a District Attorney. I hereby register for a Provider Enrollment account and agree to abide by the Terms of Service.

First Name * Last Name *

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. *

IMPORTANT: If you are preparing this modification on behalf of the provider and you are NOT the provider, STOP HERE.

The provider must sign and submit the modification by logging into the Provider Services Portal with their own credentials. The modification submission page can be accessed by opening the dropdown in the *Provider* tab, clicking on *Manage Provider Information*, and selecting *Step 11*. To submit the modification, the provider must read the terms and conditions, check the box at the bottom of the screen to indicate agreement with the terms and conditions, and then click the *Submit* button.

Once submitted, the following screen will display. Notice of a successful submission will appear at the top in red. A notification of successful submission will also be sent by email to the email address previously entered in the Basic Information step 1.

Provider Portal

Warning
The Modification Request has been submitted for State review. Return to here to track the status of your request.

Provider ID	Name	NPI	Business Status	Request Number	Request Status	Business Eligibility Date Range	Revalidation Period	Options ▾
			Active	19382	Submitted	07/10/2025 - 12/31/2999	03/01/2030 - 07/31/2030	

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Milestone 2					
Step 4 Education/Training/Work History Optional	12/09/2025	12/09/2025	Complete		
Step 5 Payment Details	12/10/2025	12/09/2025	Complete	In Review	
Step 6 Locations/Doing Business As	12/10/2025	12/09/2025	Complete	In Review	
Milestone 3					