REQUEST FOR MEDICAID PARTICIPATION AS A GROUP MEMBER

NOTE:
Each member MUST complete and sign this form. This form may be photocopied.

1. Group Member's Name: _____

2. Member's National Provider Identifier (NPI): _____ Medicaid # _____
   (You must enroll to participate.)

3. Name of Group: _____

4. List the Service Address(es) where you work as a group member. Do not list private practice service addresses.

(a) _____
_____
_____

(b) _____
_____
_____

(c) _____
_____
_____

(d) _____
_____
_____

I agree to participate in the Medicaid Program as a member of the above named group. I realize that I continue to remain personally responsible for all claims billed to NYS Medicaid using both the Group National Provider Identifier (NPI)/Medicaid # and my Individual National Provider Identifier (NPI)/Medicaid #. I may have my name withdrawn from the above named group upon written request to the Office of Health Insurance Programs.

Print full name.

NAME _____
FIRST **MIDDLE** **LAST**

SIGNATURE _____ **DATE** _____