Durable Medical Equipment
Provider Information Request

If you are only seeking enrollment for Medicare crossover (co-pay and deductibles) claims only, check the yes box below and sign this form.

☐ Yes

If yes, you do not need to complete this form.

Are you an out of state provider of durable medical equipment services interested in participating in the NYS Medicaid Program? ☐ Yes ☐ No

Is this application for one NYS Medicaid Program beneficiary? ☐ Yes ☐ No

If yes, please provide the first and last date of service for this beneficiary. ___/___/___/___/___/___ (M M D D Y Y) ___/___/___/___/___/__ (M M D D Y Y)

The following information **must** be provided to process your enrollment application. Failure to submit required information may result in your application being returned to you and will delay the enrollment process. **Attach additional sheets when necessary.**

Are you presently open? ☐ Yes ☐ No

If yes, when did you open ___/___/___/___/___/___ (M M D D Y Y)

If no, when do you anticipate opening? ___/___/___/___/___/___ (M M D D Y Y)

1. List the name of the owner(s) of the business and their social security number(s) and percentage of ownership. **The names listed must match the names given on question #5 of the Disclosure of Ownership and Control Form.** List any National Provider Identifiers (NPI) or New York State Medicaid Program provider numbers or professional licenses held by the owners. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their social security numbers and any National Provider Identifiers or New York State Medicaid Program provider numbers or professional licenses held.

Last Name, First Name	**Social Security Number**	**% of Ownership**	**NPI or NYS Medicaid # or Professional License**

2. Leasehold arrangements:

   a. Indicate whether rent is paid in equal monthly or yearly installments. **You must attach a signed copy of the current lease.**

   _____

b. Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

c. Provide the name and address of the owner(s) of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their social security numbers.

Last Name, First Name	**Social Security Number**

d. Provide the name and address to whom the rent is paid. Attach a copy (front and back) of the most recent cancelled rent check.

e. If rent is paid to a corporation or partnership, list the names of the officers, directors, Principal stockholders, partners and their social security numbers and any National Provider Identifier (NPI) or NYS Medicaid Program provider numbers or professional licenses held.

Last Name, First Name	**Social Security Number**	**NPI or NYS Medicaid # or Professional License**

3. How does your establishment provide access to the handicapped (ramps, parking, adequate passage)?

4. List the name of any other medical providers in the building. If none, state none.

5. If the business location was previously a place at which NYS Medicaid services were rendered, list the National Provider Identifier (NPI) or NYS Medicaid Number of the prior owner(s).

6. Enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the sale.

7. a. List the top 10 items you supply.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

b. Will different DME items be provided to Medicaid beneficiaries.

☐ Yes ☐ No

If yes, list what items you plan to provide to Medicaid beneficiaries.

c. Estimate the dollar value of the stock and medical supplies currently on hand.

d. List the name and address of all suppliers of your stock.

Name **Address**

8. a. Attach a statement explaining in detail how your Durable Medical Equipment supplies are marketed. For example, are physicians, nurses, or therapists used.

b. If your marketing plan includes the use of sales representatives, provide the following:

Are your sales representatives employees? ☐ Yes ☐ No

If yes, please submit copies of their most recent W-2 forms.

Are your sales representatives independent Sales contractors? ☐ Yes ☐ No

If yes, submit a copy of the contract.

9. If you are a provider of orthopedic footwear, provide a copy of your certification as listed on the Durable Medical Equipment Form Checklist. (EMEDNY-4272, Page 3)

10. If you are not certified, do you employ others who are certified? ☐ Yes ☐ No

11. List all orthotists and prosthetists in your service and attach a copy of their certification as listed on the Durable Medical Equipment Form Checklist (EMEDNY-4272, Page 3)

Last Name, First Name	Title	Social Security Number	Hours/Week

12. a. List all managerial and technical employees.

Last Name, First Name	Title	Social Security Number	Hours/Week

b. List all DME training programs completed by the above individuals and attach a copy of their certification.

Last Name, First Name	Training Course

13. a. Identify the name, address and account number(s) of the bank(s) to be used by the business.

Name of Bank	Address	Account Number

b. Provide the names and social security numbers of all personnel authorized to sign Corporate checks against those accounts.

Person(s) Authorized to Sign Checks	Social Security Number

14. Attach a statement identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signatures. Signature stamps, photocopies, etc., are not acceptable.

15. Indicate whether bills to Medicaid will be submitted directly by you or through a billing service. If a billing service, provide the name, address and NYS Medicaid provider number of the billing service.

_____
_____

16. List the top six referring practitioner's names and license numbers who currently order Durable Medical Equipment through your business.

	Last Name, First Name	License Number
1.		
2.		
3.		
4.		
5.		
6.		

17. Estimate the percentage of total business that will be billed to the NYS Medicaid Program.
_____

18. Estimate the percentage of services that are ordered by out of state providers. _____

19. Do you maintain a profile or patient history that would identify ordered services that would be considered duplicative or medically unnecessary? ☐ Yes ☐ No

20. How do you ascertain the medical necessity for the items ordered?
_____
_____

21. Do you have a contract with a nursing home? ☐ Yes ☐ No

If yes, provide the following:

Name of Nursing Home	**Address**	**Telephone Number**

22. Indicate the days and corresponding hours your durable medical equipment store will be open.

Monday	_____ to _____	Friday	_____ to _____
Tuesday	_____ to _____	Saturday	_____ to _____
Wednesday	_____ to _____	Sunday	_____ to _____
Thursday	_____ to _____		

23. Do you have a walk-in storefront location? Y ☐ N ☐

a. Where do the New York State Medicaid recipients that you plan to provide services to reside? At home _____ Nursing homes _____ Hospital _____

b. Of the DME services that you plan to provide to New York State recipients, what percentage of services do you expect to provide via mail-order? _____

c. If your service address is located out of state and you do not plan on providing services to New York State recipients via mail-order, please explain how services will be provided:
_____
_____
_____

Owner's Name (Print): _____

Owner's Signature: _____ Date Signed: _____
(Signature Stamps Are Not Permitted)

Application Prepared By (Print): _____

Telephone Number: _____