LABORATORY INFORMATION REQUEST FORM

PLEASE NOTE:

- You must answer all questions. Only complete applications, containing all requirements and additional forms with all questions answered, will be accepted for processing. Applications with missing or incomplete information will be rejected and returned. If a question is not applicable, please explain why. Additional sheets of paper should be used where necessary.
- The NYS Medicaid Program does not reimburse a clinical laboratory for laboratory-designed panel tests. Medicaid reimbursement will only be made for laboratory tests ordered individually [18 NYCRR 505.7(g)(4) and 504.5(a)(13)].
- You must ensure that the test(s) you are offering, and are requesting reimbursement for, is covered under NYS Medicaid [18 NYCRR 505.7(a)]. To view tests presently covered, you must refer to our *NYS Laboratory Fee Schedule* and *NYS Medicaid Program Laboratory Procedure Codes Manual* on the eMedNY web page, titled "Laboratory Manual," available at: Provider Manuals - Laboratory (emedny.org).

1. a. List the name of the owner(s) of the business and their Social Security Number(s), and percentage of ownership; all percentages of ownership should be clarified on this form. **The names listed must match the names given on question #5 of the Disclosure of Ownership and Control Form.** List any National Provider Identifiers (NPIs), Medicaid Provider Identification (PID) numbers, or professional licenses held by the owners, if applicable. If a corporation or partnership, list the names of the officers, directors, principal stockholders, and partners, as well as their SSNs, any NPIs, any Medicaid PID numbers, or any professional licenses held by those individuals.

Last Name, First Name	Social Security Number	Percentage of Ownership	NPI, Medicaid PID, or Professional License

b. Are any of the above named engaged in other businesses that provide services for Medicaid beneficiaries? ☐ Yes ☐ No **If yes,** please provide the information below:

Last Name, First Name	Profession	License Number	NPI or NYS Medicaid #

2. List **all** your current business locations, including all collecting stations. Provide the full address and length of time at location. Indicate if the location is a collecting station or a main site, and if it is a fixed or mobile facility (e.g., van).

Address	Main Site or Collecting Station	Fixed or Mobile	Length of Time at Location

3. Leasehold arrangements (must be provided for all locations utilized by your laboratory):

   a. Indicate whether rent is paid in equal monthly or yearly installments. Indicate site location.

_____

_____

_____

   b. Describe 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 of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, and partners, and their Social Security numbers.

Last Name, First Name	Address	Social Security Number

   d. If the building is owned by a corporation or partnership, list the name of the corporation or partnership; the names of its officers, directors, principal stockholders, and partners; the position each holds in the corporation; and the Social Security numbers for those individuals.

Name of Corporation or Partnership _____

Last Name, First Name	Position	Social Security Number

Provide the name and address to whom the rent is paid.

Last Name, First Name **Address**

4. If laboratory has been recently purchased or acquired by the current owners, copies of promissory notes, sales agreements, and any other documents pertaining to the purchase or acquisition must be included with this form.

5. Personnel:

   a. Identify in-house personnel, specifically laboratory director(s) and laboratory supervisor(s). Include names, titles, professional qualifications, professional license numbers, and Social Security numbers for **all** individuals listed, as well as the hours and days each is scheduled to work. ***(Use In-house Personnel Attachment 5A to complete this question).***

   b. Provide a list of your licensed employees, a description of their relevant professional and/or technical licenses and corresponding license numbers, and their Social Security numbers. Provide hours of employment and location. Provide copies of all licenses and/or Laboratory Personnel Qualification appraisal. ***(Use Licensed Employees Attachment 5B to complete this question).***

   c. Provide the staffing pattern of your laboratory facility. Identify support staff, technical/professional personnel, and administrative personnel. Identify employees' names, job titles, Social Security numbers, and hours employed. ***(Use Staffing Pattern Attachment 5C to complete this question).***

   d. List any individuals who are employed or compensated by the laboratory and who provide outside services in areas other than the main laboratory. ***(Use Outside Personnel Attachment 5D to complete this question).***

6. List any services or supplies (e.g., waste disposal, telefax) that your laboratory provides to physicians/clinics or others who order tests from your laboratory. Provide details on the type(s) of service(s) provided, and supply the names, addresses, and NPIs or NYS Medicaid PIDs of the physicians/clinics or others who order and receive these services/supplies. Designate at whose expense these services/supplies are provided.

7. a. Does your laboratory **employ** sales agents? ◯ Yes ◯ No

   If yes, how are they compensated (e.g., commission, salary, both)? Please provide the name and Social Security number of each sales agent. **If there is a contract, attach a copy.**

Last Name, First Name	Social Security Number	Salary, Commission or Both	Percent of Commission
			%
			%
			%

b. Does your laboratory use **independent** sales agents? ◯ Yes ◯ No

If yes, how are they compensated? Include percentage of commission paid. Provide the name and Social Security number of each sales agent. **If there is a contract, attach a copy.**

Last Name, First Name	Social Security Number	Salary, Commission or Both	Percent of Commission
			%
			%
			%

c. If no sales agents are utilized, how does the laboratory market its services?

8. Operations:

What was your total revenue from all sources for the previous calendar year? $_____

9. List all other third-party health insurers you are contracted or enrolled with.

Name of Company	Date of Contract or Enrollment

10. Estimate the percentage of business that will be billed to the NYS Medicaid Program. _____%

11. Are you seeking Medicaid enrollment for a specialized area of testing that your laboratory permit allows you to perform?

◯ Yes ◯ No

If yes, which area?

12. Provide the Current Procedural Terminology (CPT) code **for each specific test** offered by your laboratory (listed on your requisition forms) for which you will seek Medicaid reimbursement. This must be provided as a separate attachment.

13. Do you employ a third party to manage your laboratory? Provide the name(s), address(es) and method by which each is compensated (e.g., commission, salary, or both).

Last Name, First Name	Address	Salary, Commission or Both	Percent of Commission
			%
			%
			%

14. List the percentage of blood or other test specimens directly collected from beneficiaries at the primary laboratory sites. _____ %

List the percentage of blood or other test specimens taken at:

a. Collecting stations: _____%
b. Physicians' offices: _____%
c. Dialysis clinics: _____%
d. Other: _____%

Identify other: _____

15. What arrangements have been made to transport these specimens to your laboratory? Describe schedule pick-up(s) and delivery(ies), specifically, at approximately what time does the courier(s) arrive at the first stop (list time for each courier), how often and at what interval does the courier(s) transport specimens back to the laboratory, and what hour is the final site pick-up (list time for each courier). What is the method of transport(s), ownership of transport(s), and specimen storage protocol during transport? Where are the specimens spun?

16. Test result reporting:

a. How are the test result reports generated? If a computer is involved, provide the hardware (computer) and software (program) vendor name(s) and address(es); manufacturer (if different than vendor); and acquisition agreement (contract, invoice, etc.).

b. Is this a shared system (information, billing, etc.)? ◯ Yes ◯ No

If yes, who is the system shared with?

17. a. Identify the name(s), address(es) 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**

18. Identify the persons who will be authorized to sign NYS Medicaid Program claim forms and provide original examples of their signatures. Signature stamps, photocopies, etc., are not acceptable.

Last Name, First Name	**Signature**

19. If Medicaid claims will be submitted through a billing service, identify by name(s), address(es), and NPI or NYS Medicaid PID, if known.

Name of Billing Service	**Address**	**NPI or NYS Medicaid Number (if known)**

20. Does your laboratory receive referral work from other laboratories? ◯ Yes ◯ No

If yes, provide the information below.

Name of Laboratory	Address	NPI or NYS Medicaid Number (if known)

21. Does your laboratory refer work to other laboratories? ◯ Yes ◯ No

If yes, provide the information below.

Name of Laboratory	Address	NPI or NYS Medicaid Number (if known)

22. Do you anticipate a change(s) in your policy regarding referral work if enrolled in the New York State Medicaid Program? ◯ Yes ◯ No

If yes, what change(s) do you anticipate?

23. Have any of the laboratory's officers, principals, laboratory director or laboratory supervisor been affiliated with any other laboratories (whether they were a Medicaid provider), or any other businesses that provide or provided services related to Medicaid beneficiaries in the last five years?

◯ Yes ◯ No

If yes, provide an explanation below, including the affiliation, the name of the individual(s), the name of the laboratory(s) or other business(es) and location(s), National Provider Identifier(s), MEDICAID provider identification number (if any) and length of affiliation.

24. **Documentation Checklist:** Attach to, or include, with this form the following documents:

- ☐ A signed copy of the current lease. (Related to question 3)
- ☐ Promissory notes, sales agreements, and any other documents pertaining to the purchase or acquisition, if applicable. (Related to question 4)

- ☐ In-house Personnel Attachment 5A (Related to question 5)
- ☐ Licensed Employees Attachment 5B (Related to question 5)
- ☐ Use Staffing Pattern Attachment 5C (Related to question 5)
- ☐ Outside Personnel Attachment 5D (Related to question 5)
- ☐ Contracts with *employed* sales agents, if applicable. (Related to question 7)
- ☐ Contracts with *independent* sales agents, if applicable. (Related to question 7)
- ☐ Blank copies of ***all*** laboratory requisition/report forms for ***all*** areas of testing on your application (Related to question 11).
- ☐ Current Procedural Terminology (CPT) code **for each specific test** listed on your requisition forms. (Related to question 12).
- ☐ Blank copies of ***all*** current laboratory test result forms sent to ordering providers for ***all*** areas of testing on your application. (Related to question 16).
- ☐ Original examples of signatures for those who are authorized to sign NYS Medicaid Program claim forms. (Related to question 18).
- ☐ A copy of your current contract(s) with any billing service(s) used. (Related to question 19).

Owner's Name (Print): _____

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

Application Prepared by (Print):_____

Telephone Number: _____