INSTITUTIONAL/RATE BASED-STATUS CHANGE FORM **Fee- For-Service(FFS) Billing Provider TO Managed Care Only**(Cannot Bill FFS)**/ Voluntary Withdrawal**	Mail to: eMedNY PO Box 4610 Rensselaer, NY 12144
Provider Name:	
Provider NPI:	**NY Medicaid ID (if known):**

Category of Service Code(4-digits)	**Category of Service Code(4-digits)**	**Category of Service Code(4-digits)**

Select the appropriate box below to update your provider enrollment file: ***(ONLY SELECT ONE OPTION BELOW)***

☐ **We do not wish to participate as a Medicaid FFS Billing Provider. We would like to remain enrolled as a Managed Care Only(Non-Billing) Provider with NYS Medicaid and will continue to be eligible to participate in MMC and CHIP networks.**

☐ **We wish to Terminate our participation with NYS Medicaid. We are aware that we 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. We 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.**

By signing this form, the Provider understands and agrees to the following:

- The effective date of this status change will be the date this form is processed by DOH.
- There has been NO CHANGE to the following information supplied on my enrollment form: 1) any ownership related information, and 2) managing employees, those with a control interest, and agents. **IF CHANGES HAVE OCCURRED, DO NOT SUBMIT THIS FORM. INSTEAD, YOU MUST COMPLETE A CHANGE OF OWNERSHIP FORM AS A MANAGED CARE ONLY (Non-Billing) PROVIDER**.
- 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 18NYCRR which can be found at the Department of Health's website at https://www.health.ny.gov
- In addition, pursuant to 42 CFR, Part 455.105, by enrolling in the Medicaid Program you agree to disclose the following regarding business transactions within the next 35 days upon request of the Department or the Secretary of Health and Human Services.

  (1) Information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, and

  (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the 5-year period ending on the date of the request.
- As a Medicaid Provider you agree to abide by all applicable Federal and State laws as well as the rules and regulations of other New York State agencies particular to the type of program covered by this enrollment application.
- For those providers for whom the Mandatory Compliance Law applies (see www.OMIG.ny.gov), the Provider has certified via the Office of the Medicaid Inspector General's web site referenced above that the provider and its affiliates have adopted, implemented and maintains an effective compliance program that meets the requirements of Social Service Law Section 363-d & 18NYCRR, Part 521.
- Unannounced site visits by Medicaid, CMS or their agents/designated contractors may be a condition of initial and continued enrollment. In addition, the provider and/or owners (defined as at least a 5 % interest) may be required to consent to criminal background checks including fingerprinting.
- As a Medicaid Provider you agree to notify this Department immediately of any changes supplied in this disclosure document as well as impending ownership changes or any other changes.
- The Department may deny or terminate enrollment as a provider in the Medicaid program if it is determined that executive compensation, bonuses, incentives and costs of administration exceed reasonable levels.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR SECRETARY, AS APPROPRIATE.

_____ _____

Print or Type the Name of Person Signing Below **Title**

_____ _____

Signature(original; no stamps) of Providers Authorized Representative (Owner, Managing Employee or Board Member) **Date (MM/DD/YYYY)**