Physician Revalidation Application
Quick Reference Guide

If you received a letter advising you to revalidate, you must complete the Practitioner Enrollment form and applicable additional forms, and send the packet to eMedNY for initial processing. You may find these forms on www.emedny.org on the Revalidation page. Failure to submit your application for revalidation before the date stated on your letter may result in disenrollment from NYS Medicaid.

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- For Physicians, enter *Category of Service* 0460 in the first field.
- Please choose the option for Revalidation.

Category(s) of Service: Enter the 4-digit code(s) given in the instructions:		
☐ New Enrollment (not currently enrolled)	☐ Revalidation (enrolled; required to revalidate)	☐ Reinstatement/Reactivation If Applicant was previously excluded/terminated from the Medicaid Program, complete the Prior Conduct Questionnaire found at www.eMedNY.org and include it with this Enrollment Form

- Fill in the requested information below, including physician's name, NPI, SSN and license number.
- For the question "If affiliated to a group, do you have a private practice as well", answer:
  - Yes if you are affiliated to a group AND have your own Practice
  - No if you do not have your own Practice (*Please Note: if you select No, you will not be able to bill or receive payment from Medicaid under your individual NPI.*) or
  - N/A if you are not affiliated to a group.
  - If you answered Yes or No, enter the group / organization's name and their NPI. If linked to more than one group, you will need to complete the Request for Participation as a Group Member form for each additional group.

Applicant Name (exactly as it appears on your license/registration) **Last, First, MI**		
NPI (Individual) – if incorporated, completion of a Group application is also necessary.		SSN
License #	State of Licensure if not New York	Limited License? ☐ Yes ☐ No
Applicant's e-Mail Address - REQUIRED:		Are you enrolled in Medicare? ☐ Yes ☐ No
DEA Number (if required)	DEA Effective Date (MM/DD/YYYY)	DEA Expiration Date (MM/DD/YYYY)
If affiliated with a Group, do you have a Private Practice as well? ☐ Yes ☐ No ☐ N/A	If member of a group or organization: Group/Org Name:	If member of a group or organization: Group/Org NPI:

- Please enter the following addresses:
  - o Correspondence: If you have a private practice and are also affiliated with a group(s), you should enter the address which ensures you will receive correspondence from the Medicaid Program.
  - o Pay-To: This is where payments, remittances, etc. will be sent until EFT and e-Remits are in place. Note: If you have a private practice, enter the Pay-To address for that practice here, if not enter the group's Pay-To address.
  - o Corporate (if applicable): This is where 1099s will be mailed for any payments made under your individual NPI, if any.

CORRESPONDENCE: (indicate where letters and claims forms, if any, should be sent) – PO Box not acceptable		
Attention:	Street Address	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
PAY TO ADDRESS: (indicate where checks & remittance statements should be sent until EFT and e-Remits are in place):		
Attention:	Street Address or PO Box	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
CORPORATE ADDRESS: (indicate where Annual Tax Documents (Form 1099) should be sent)		
Attention:	Street Address or PO Box	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	e-Mail Address - **REQUIRED**

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- On page 3, list every address where you provide services. **If you do not, any addresses where you provide services that are not listed on this form will be removed from your file.**
- For type of practice and place of service, pick what you think fits best. Note: The call center cannot advise you.
- If you have more than four (4) service addresses to report, copy page 3 as needed and complete for all additional addresses. eMedNY and DOH will not accept addresses that are not recorded on the form.

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SERVICE ADDRESS: (where service is provided) – **DO NOT LIST A PATIENT'S ADDRESS** (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) ☐ Individual (1) ☐ Group (2)	Place of Service (Check One) ☐ Private Office (1) ☐ Freestanding Clinic (3) ☐ Hospital/Nursing Home (2)	

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- Section 1
  - For the Disclosing Entity/Applicant fill in your own information including your home address, social security number, NPI and date of birth.
  - For the Ownership in Applicant section: Completion of this section is required under limited circumstances. Please refer to 18NYCRR, Section 504.1(d)(18)(iv) to determine if this section applies to your enrollment.

DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. ***Failure to provide the information requested will cause the application to be returned.*** Click here **to review definitions and policy found at 18NYCRR, Section 504.1 before completing this form. {If additional space is needed, copy form; all entries must be on the form}.**

SECTION 1:

Disclosing Entity / Applicant (Individual named on page 2 of this application)

Name		NPI
Home Address (Street)	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	

Ownership in Applicant (if required by 18NYCRR, Section 504.1(d)(18)(iv)). Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104(b)(1)(i) for more information).

Name of Individual or Entity		% of Ownership	NPI
Address (**Home Address** if individual)		City & State	Zip Code (9 digit)
SSN (if individual)	FEIN (if entity)	Date of Birth (if individual) (MM/DD/YYYY)	Familial Relationship (if individual, if any)

- Section 2 Ownership in Other Disclosing Entities (ODE) (complete if applicable)
- Section 3 Ownership in Subcontractors (complete if applicable)
- Section 4 Familial Relationship in Subcontractors (complete if applicable)

SECTION 2:

Ownership in Other Disclosing Entities(ODE) (per 42 CFR, Part 455.104(a)(3)) - (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE

SECTION 3:

Ownership in Subcontractors If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor Name	Tax Identification Number

SECTION 4:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a *familial relationship with a person with ownership or control interest in one of the subcontractors identified in Section 3).
*parent, child, sibling, spouse

Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship

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- For the Agents and Managing Employees (Section 5), enter an office manager, administrator, director or other individuals who exercise operational or managerial control, or directly or indirectly conduct the day to day operations, of the provider. Enter the letter (B, F, H, M, P or U) which best corresponds to the individual's role (B: Board of Directors Member; F: Facility Administrator; H: Compliance Officer; M: Managing Employee; P: Supervising Pharmacist; U: Laboratory Director).
    - **Although rare**, if your situation is such that there are no managing employees to report, indicate "None" in the "Name" field in the first block.

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SECTION 5:

Agents and Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider). *Although unusual, if None, indicate **NONE** in the first "Name" field below.* Include familial relationship to the Applicant (e.g., spouse, parent, child, sibling), if any. **{If additional space is needed, copy form; all entries must be on the form}**

Name			Association Type (see instructions)
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name			Association Type (see instructions)
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name			Association Type (see instructions)
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

- Continue to Section 6
- Check yes or no to questions 1-5.
- If you answer "Yes" to any of the questions 1-4, then you must also complete and submit the Prior Conduct Questionnaire, available on the Provider Enrollment Physician page on emedny.org. Click here to access the form directly.

SECTION 6:

Respond to these questions on behalf of:
1. the Applicant
2. all individuals and entities identified in Sections 1 & 5
3. any entity in which the Applicant has a 5% or more ownership

1. Have any of the individuals/entities (1, 2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or in any other State, Medicare, or any other governmental or private medical insurance program?
☐ Yes ☐ No

2. Have any of the individuals/entities (1, 2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?
☐ Yes ☐ No

3. Have any of the individuals/entities (1, 2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?
☐ Yes ☐ No

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/ entities (1, 2 and 3)?
☐ Yes ☐ No

NOTE: If you answered "Yes" to any of the questions above, you must complete and submit the "Prior Conduct Questionnaire" available at www.emedny.org.

5. Do you, including any entity in which you have ownership, have any unpaid balances owed to the NY Medicaid Program? ☐ Yes ☐ No If yes, indicate amount $_____

If yes, has payment been arranged? ☐ Yes ☐ No If yes, attach verification of arrangement. If no, this enrollment will be reviewed by the OMIG

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- For the Signature and Affirmation section, the applicant must sign and date the application. Signatures must be original – no stamps.

- **Your application requires additional documents. Make sure you that you submit the following:**
  - ☐ Copy of your Professional License
  - ☐ Copy of your DEA Certificate (if you have one) or the facility DEA Certificate that you are authorized to use (if any).
  - ☐ If you are affiliated with more than one group, send a Request for Participation as a Group Member form for each additional group to which you are affiliated. If you do not, your affiliation to the group will be terminated.
  - ☐ If you have any specialties on file currently, you will need to send the applications for each of those specialties. If you do not they will be end-dated on your file. *Exception: The HIV specialty request form does not need to be submitted with the revalidation application if you already have the specialty on file.*
  - ☐ Please check the "Additional forms/information which may be REQUIRED to complete your enrollment" section of the enrollment page (add link to enrollment page) to see if any other forms apply to your application.

- Once all forms are completed and ready, mail everything to the address on page 2 of the enrollment form. This address is:

  eMedNY
  PO Box 4603
  Rensselaer NY 12144-4603

- The application will be reviewed for completeness and inclusion of required forms then submitted for review.

- Please Note: There is no set timeframe for how long it will take to process the application. If more information is needed you will be contacted by the DOH. While your revalidation is under review, billing/claiming should continue for the services you provide.

- If you have any questions not addressed in this reference guide, please call eMedNY at 800-343-9000.