New York State Medicaid Enrollment Form

Thank you for your interest in enrolling with the New York State Medicaid Program. 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 18 NYCRR which can be found at the Department of Health's website, www.health.ny.gov.

This enrollment form should be used by practitioners seeking enrollment as:

1. An ordering referring, attending or prescribing practitioner (attending providers should use this form if their name and NPI will only appear on the hospital's claim). These providers will not submit claims to Medicaid and, therefore will not receive payment from the Medicaid Program or,
2. A Medicaid Managed Care Network provider.

If you will also provide medical services to patients, or as an attending provider will submit a separate claim to Medicaid for your service, do not complete this form. Visit www.eMedNY.org and complete the enrollment form appropriate for your license/certification.

Consider printing the **Instructions to Complete Enrollment Form** before continuing. **Please complete pages 2 through 5; form must be completed in its entirety.**

New York State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting information and how we will use it. The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities. This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider. The information will be maintained by the New York State Department of Health, Office of Health Insurance Programs, Division of OHIP Operations, Bureau of Provider Enrollment, Albany, New York.

NY MEDICAID PROVIDER ENROLLMENT FORM
for those who ONLY
ORDER-REFER-ATTENDING-PRESCRIBE
or are in a Managed Care Network
(non-billers)

Mail to:

eMedNY
PO Box 4603
Rensselaer, NY 12144-4603

Category(s) of Service: Enter the 4-digit code(s) given in the instructions: _____ _____

New Enrollment	Revalidation	☐ Reinstatement/ Reactivation
Newly enrolling providers (never enrolled) must apply for enrollment through the New York State Medicaid Provider Services Portal (PSP) www.emedny.org/PSP/. Paper applications will be returned to providers who submit a paper application and are found eligible to apply using the PSP.	Paper revalidations are no longer being accepted since the revalidation process is transitioning to the Provider Services Portal. Providers will be contacted with instructions on how to revalidate once this transition is complete.	To select this box, you must have been previously enrolled in New York State Medicaid and currently be inactive. You must provide your 8-digit NYS Medicaid PID _____, or this application for reinstatement/reactivation will be returned. Soon, providers who are inactive but wish to reinstate must do so in the Provider Services Portal (PSP). At that time, this paper option will longer be accepted.

Applicant Name (exactly as it appears on your license/registration**) Last, First, MI**		
Date of Birth (MM/DD/YY)	SSN	Applicant's e-mail address - **REQUIRED**
NPI (Individual)	Specialty	
License #	State of Licensure if not New York	Limited License? ☐ Yes ☐ No

CORRESPONDENCE ADDRESS: 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

SERVICE ADDRESS: where service is provided) – **DO NOT LIST A PATIENT'S ADDRESS** (see instructions) ***Valid Telephone numbers are required for each service address.**		
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

SERVICE ADDRESS: where service is provided) – **DO NOT LIST A PATIENT'S ADDRESS** (see instructions) ***Valid Telephone numbers are required for each service address.**		
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

{**If additional space is needed, copy form; all entries must be on the form**}

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 digits)
SSN	Date of Birth	

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 digits)	
SSN (if indiv)/ FEIN (if entity)	Date of Birth (if individual)	Familial Relationship (if individual, if any)	

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

SECTION 5:

Managing Employees, Agents, & Those with a Control Interest - Including, but not necessarily limited to, the following: Compliance Officer, all Managing Employees (includes Employee/Lifestyle Coach(s), general, business and office managers; all persons who exercise operational or managerial control of a provider; all persons who directly or indirectly conduct the day-to-day operations of a provider). Include familial relationship to the Provider (spouse, parent, child, sibling), if any**. {If additional space is needed, copy form; all entries must be on the form}**

Completion of all fields 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. If additional space is needed, copy form; all entries must be on the form.

Name			Association Type (see instructions)
Home Address - Street		City & State	Zip Code (9 digits)
SSN	Date of Birth		Familial Relationship
Name			Association Type (see instructions)
Home Address - Street		City & State	Zip Code (9 digits)
SSN	Date of Birth		Familial Relationship
Name			Association Type (see instructions)
Home Address - Street		City & State	Zip Code (9 digits)
SSN	Date of Birth		Familial Relationship

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?
   ☐ 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: All questions must be answered. If you answered "Yes" to any of the questions above, you must complete and submit the "Prior Conduct Questionnaire" available at www.emedny.org.
Please continue and Answer Question 5.

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

SIGNATURE AND AFFIRMATION

By signing this enrollment form for participation in the New York State Medicaid Program, the Applicant/Provider understands and agrees to the following:

- 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, 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 (https://omig.ny.gov/compliance/compliance), the Provider has certified via the CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID that the provider adopted, and implemented, where applicable, an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations, 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 enrollment agreement, including impending ownership 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.

Applicant / Provider's Signature (original; no stamps) _____ Date _____

_____

Name & Telephone Number of Person who Prepared Application