Medicaid Revalidation for Practitioners

NEW YORK STATE | Department of Health | Medicaid Program

Key Objectives

Familiarize Practitioners with the Revalidation Process and the NY Medicaid Provider Enrollment Form

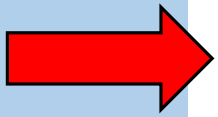
Key Objectives

1. GENERAL INFORMATION
2. REVALIDATION STEPS
3. ENROLLMENT FORM OVERVIEW
4. IMPORTANT REMINDERS
5. REFERENCE & CONTACT INFO

General Information

eMedNY Website – www.emedny.org

General Information



REVALIDATION

Revalidation as of August 2024

The revalidation process that was suspended during the public health emergency has been restarted. Revalidation dates that are published on the *Medicaid Enrolled Provider Listing* and those appearing on provider files are **estimated dates that may be subject to change** based on factors such as a timing lag, updates made to an enrollment file, and the State's ability to extend the date for certain providers.

Providers should make sure the correspondence address on their enrollment file is current, and **providers should not send in a revalidation application until they receive a notice in the mail to do so.**

When is a provider due to revalidate?

Medicaid enrolled providers are required to revalidate at least every **five (5) years** and/or upon notification by the Department of Health to do so.

Stages of Revalidation:

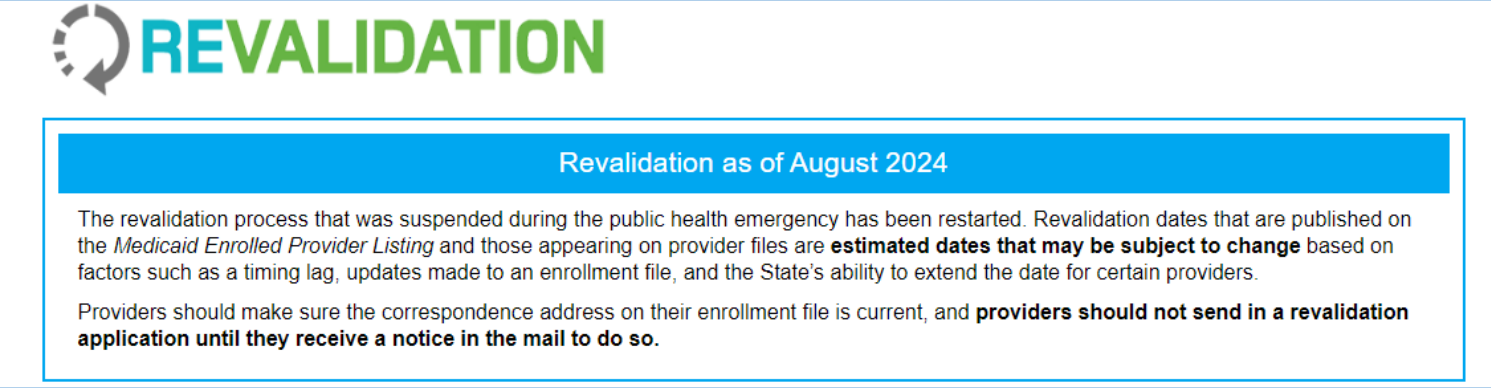
How to Revalidate Once You Receive Notification:

What Happens Next?

Frequently Asked Questions (FAQs)

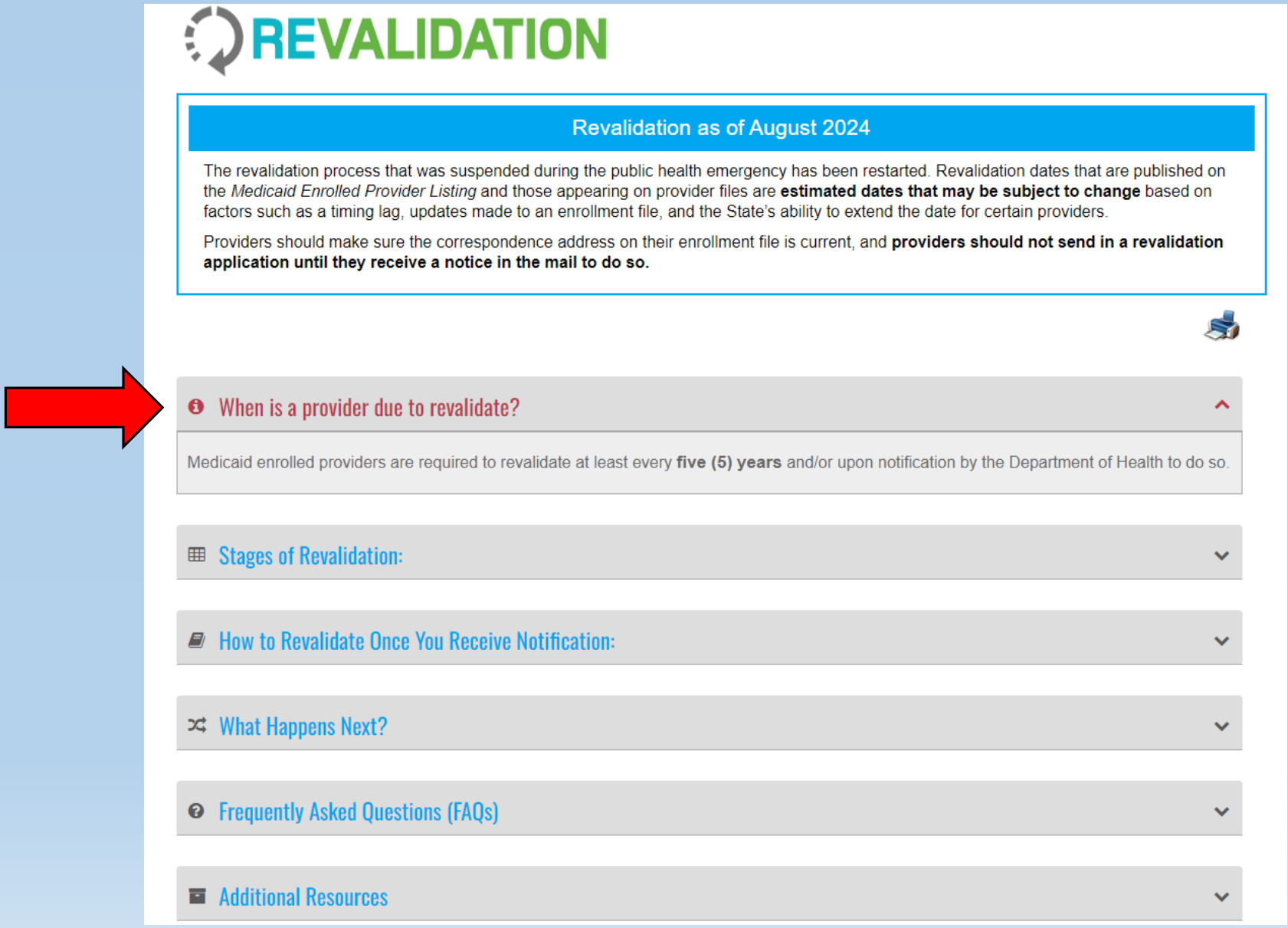
Additional Resources

General Information



- The revalidation process that was suspended during the public health emergency has been restarted
- Revalidation dates published on the Medicaid Enrolled Provider Listing and those appearing on provider enrollment files are **estimated dates that may be subject to change**
- Make sure the correspondence address on your enrollment file is current
- Providers **should not send in a revalidation application** until they receive a notice in the mail to do so

General Information



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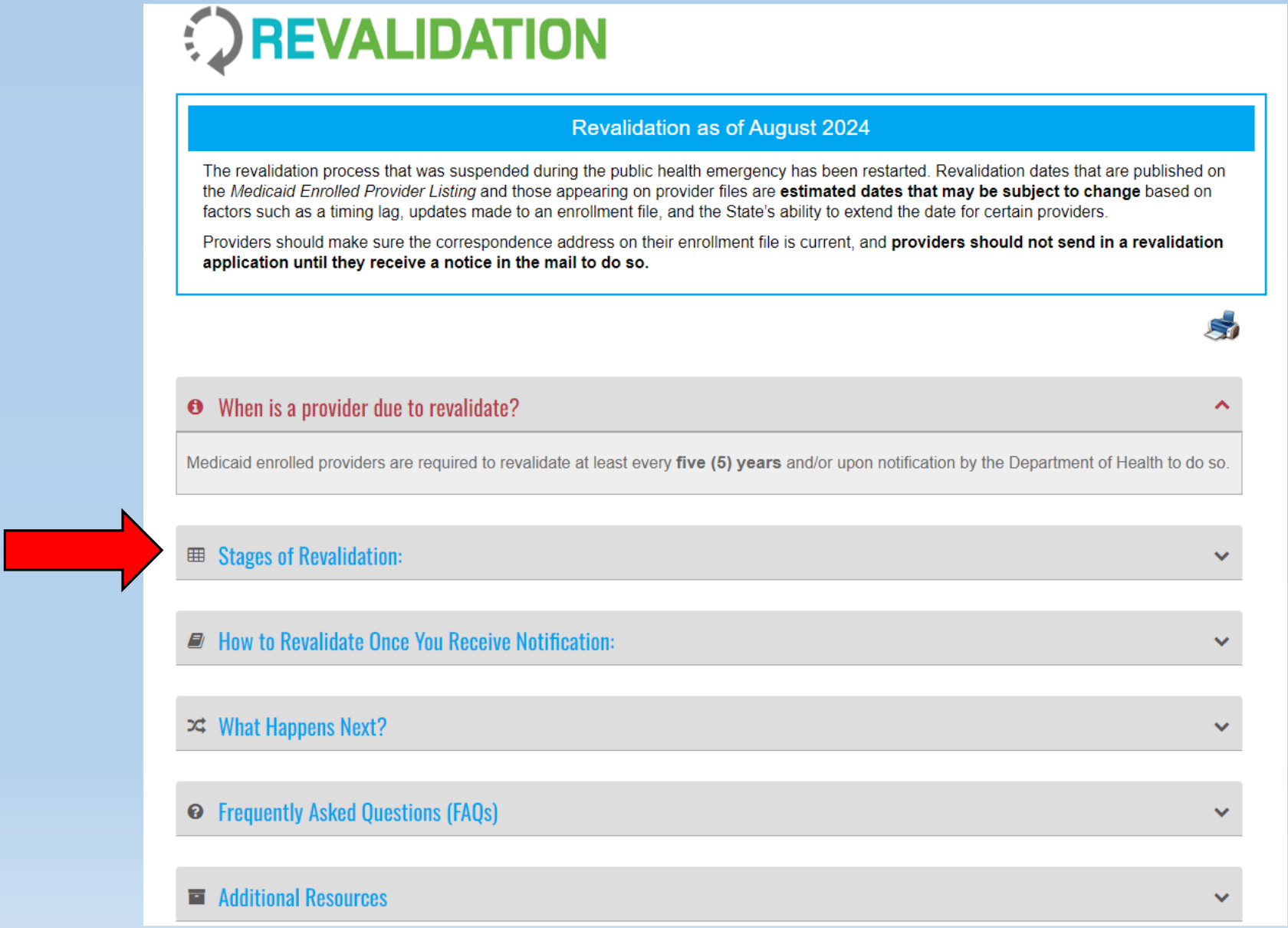


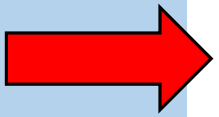
General Information

Initial Letter Sent	An initial notification to revalidate is sent to the provider's correspondence address on file. Upon notification, the application for revalidation should be submitted promptly.
Final Letter Sent	A final notification to revalidate is sent to the provider's correspondence address on file. The application for revalidation should be submitted promptly or the provider may be subject to termination.
Revalidation Received	Once the application for revalidation is received and screened by eMedNY, the application will be processed by the Department of Health's Bureau of Provider Enrollment. No further action is required unless contacted by the Bureau.
Completed	Once the application for revalidation is successfully processed, a letter is sent indicating the revalidation was successful. No further action is needed until notified by the Department of Health to revalidate again.
Termination	If the provider does not submit an application for revalidation by the deadline in the notification letters, their enrollment will be terminated. An application for reinstatement may then be required to enroll again.

Make Sure You Keep Your Addresses Up-To-Date

click here to change your address

General Information



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General Information

How to Revalidate Once You Receive Notification:

1 STEP 1

Navigate to your enrollment page by clicking on the appropriate provider link on the Provider Index page

2 STEP 2

Click on your Provider Type and Complete the Enrollment Form

- The Category of Service is listed in "Additional Instructions for the Enrollment Form" drop down menu OR in the Quick Reference Box in the upper right hand corner of the page.
- Check the REVALIDATION BOX
- Provider Number is in the Letter that was Sent
- Make sure you sign the form

3 STEP 3

Complete any additional requirements needed as specified in the "Requirements & Additional Forms" drop down menu.

- ***NOTE:*** ETIN and EFT are **NOT** required for revalidation
- Make sure to include the application fee if one is required

4 STEP 4

MAIL TO:

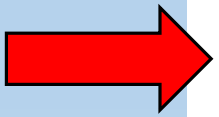
eMedNY
PO Box 4603
Rensselaer, NY 12144

For Expedited/Proiorty Mailing, please click here

Make Sure You Keep Your Addresses Up-To-Date
click here to change your address

Provider Index Page

General Information



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General Information

What Happens Next?

After submission of the revalidation application and additional required documents, continue to bill as normal. You will not receive a written notice that the revalidation packet was received.

1 Pre-screening by eMedNY:

- **If errors on the application form or the packet is incomplete (missing a required document):** The entire revalidation packet will be returned by mail, including a checklist which details what is required and missing. Resubmit the completed revalidation, including all requested information, or documents to eMedNY as soon as possible for re-screening.
- **If no errors are detected:** The revalidation application will be scanned and entered into the eMedNY system. This may take 2-3 weeks from receipt. You may contact the eMedNY Call Center to obtain and document the Enrollment Tracking Number (ETN) of the revalidation.

2 Review by the Bureau of Provider Enrollment:

eMedNY does not send any correspondence once a revalidation has been queued for review by the Bureau. There are no timeframes associated with the processing of revalidation applications. Continue to bill NY Medicaid as normal.

If additional information is required to process your revalidation, staff from the Department of Health's Bureau of Provider Enrollment will email the provider using the email address provided as the Applicant's Email Address on the enrollment form, i.e., not the email address in the Corporate Address section.

Once the revalidation is successfully processed, a letter indicating such will be mailed to the correspondence address on the enrollment form. You will be notified in the future when it is time to revalidate again.

Make Sure You Keep Your Addresses Up-To-Date

click here to change your address

General Information

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General Information

Frequently Asked Questions (FAQs)

ID	FAQ	ANSWER
R12	**What happens if I don't revalidate with NY Medicaid?**	Federal regulations require that your Medicaid enrollment be terminated if you fail to revalidate. This means you will no longer be paid for services rendered to, and/or you will no longer be eligible to order, refer, or prescribe for New York State Medicaid recipients.
R22	**I submitted my enrollment form for revalidation and contacted eMedNY 21 days later to verify my application is in process. What's my next step?**	You may continue to submit claims. There is nothing more you need to do unless DOH contacts you.
R24	**I recently received a notice that my enrollment has been terminated because I did not revalidate. How do I become an active Medicaid provider again?**	To request reinstatement more than 90 days after a termination for failing to revalidate, the provider must complete the enrollment form for their provider type, checking off the reinstatement/reactivation box toward the top, and mail to the eMedNY address on the form. If a provider is reinstated after failing to meet revalidation requiremetns, there may be a gap in enrollment.

ALL REVALIDATION FAQs

General Information

REVALIDATION

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Additional Resources

General Information

Additional Resources

FAQs

Presentation

Category of Service (COS) & Form Search Tool

Provider Training

WEBINARS

DATE	TITLE	TIME	REGISTRATION
10/24/2024	Medicaid Revalidation for Practitioners	1:30 PM - 2:30 PM	CLICK HERE TO REGISTER
11/20/2024	Medicaid Revalidation for Practitioners	10:30 AM - 11:30 AM	CLICK HERE TO REGISTER
12/13/2024	Medicaid Revalidation for Practitioners	9:30 AM - 10:30 AM	CLICK HERE TO REGISTER

Revalidation Steps

Step 1 – Go to the eMedNY Provider Enrollment page

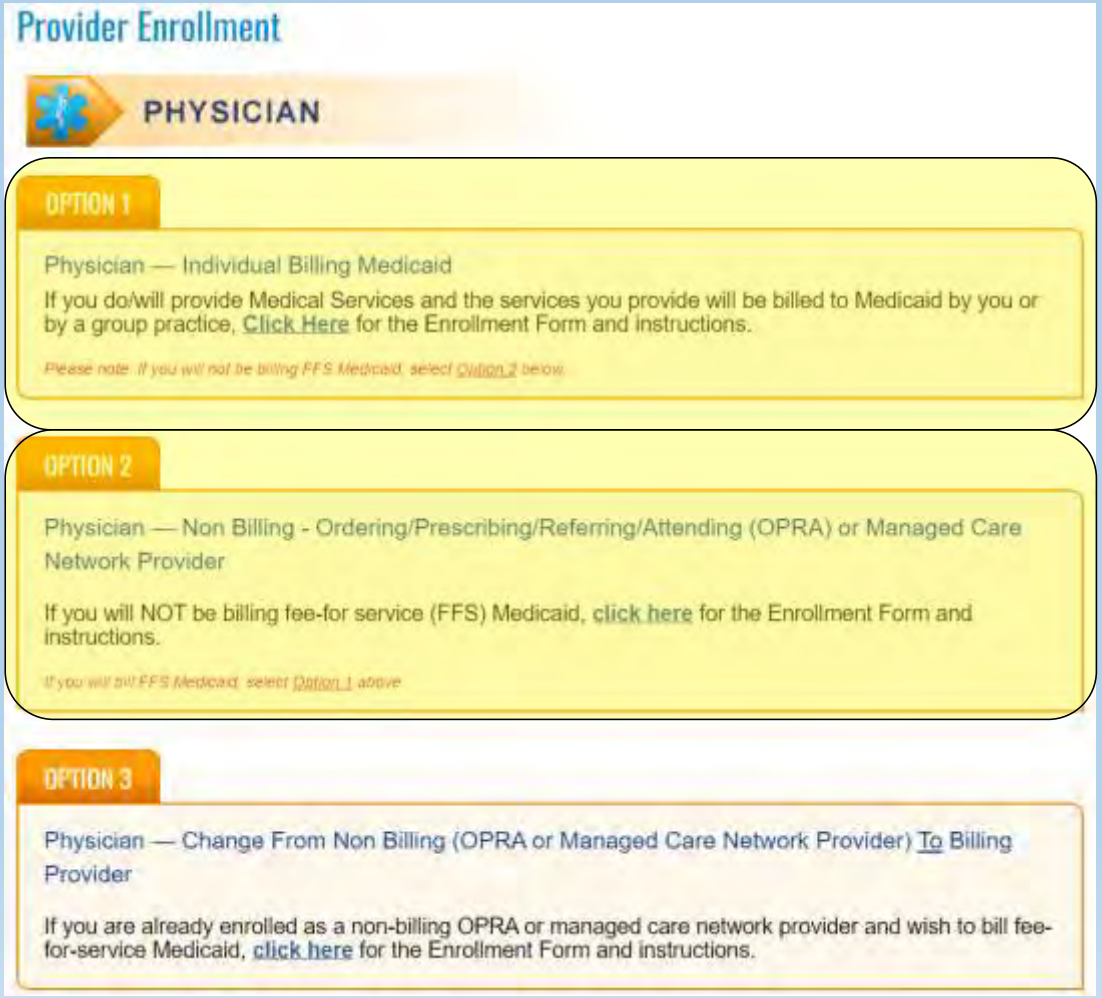
Revalidation Steps

Step 2 – Select Practitioner and the appropriate provider type

- Applied Behavior Analysis (ABA)
- Audiologist
- Certified Asthma Educator (CAE)
- Certified Diabetes Educator (CDE)
- Chiropractor
- Clinical Psychologist
- Clinical Social Worker
- Dentist
- Dietitian / Nutritionist
- Doula (Perinatal)
- Eye Prosthesis Supplier / Occularist
- Laboratory Director
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Mental Health Counselors (LMHCs)
- Medicare Cost Sharing Practitioner
- Midwife
- Nurse (LPN/RN)
- Nurse Practitioner
- Optician/Opthalmic Dispenser (OPD)
- Optometrist (OPT)
- Physician
- Physician Assistant
- Podiatrist
- Supervising Pharmacist
- Therapist

Revalidation Steps

Step 3 – Select Option 1 or Option 2



Step 4 – Complete Enrollment Form & Additional Documents

Additional Instructions *for the Enrollment Form*

Category(s) of Service: Enter the applicable 4-digit code(s) on the Enrollment Form **0460**

Choose ONE Application Type and check the corresponding box on the Enrollment Form:

- ✓ *Check New Enrollment if the NPI or Provider listed is not currently enrolled in NYS Medicaid*
- ✓ *Check Revalidation if the NPI or Provider is currently enrolled and you were notified that Revalidation is required per 42 CFR, Part 455.414. The Provider ID can be found on the Revalidation Letter you received*
- ✓ *Check Reinstatement/Reactivation if the provider was previously enrolled but is not currently active.*

Please note: You will be at financial risk if you render services to Medicaid beneficiaries before successfully completing the enrollment process.

NPI: This field is required.

Specialty: If you are recognized as a Specialist, complete Form EMEDNY-490301 and include with your completed enrollment form.

DEA Number & Dates: Complete if you are licensed to prescribe or dispense controlled substances

Type of Practice: For each service address, check the box from the list which best describes your type of practice at that address.

Place of Service: For each service address, check the box from the list which best describes the site.

Association Types: Enter the letter (B, F, H, I, M, P or U) which best corresponds to the individual's role: *Note: ALL lifestyle coaches providing NDPP services for your organization must be listed in Section 5 of the application as a I-Employee/Lifestyle Coach*

B: Board of Directors Member F: Facility Administrator H: Compliance Officer I: Employee/Lifestyle Coach
M: Managing Employee P: Supervising Pharmacist U: Laboratory Director

Enrollment Form

Category of Service

Application Fee

Requirements & Additional Forms

- Application as a Specialist - form #490301 if applicable
- **DEA Certificate**
  - If you do NOT prescribe, administer, or dispense controlled substances, then you do NOT need to submit a DEA certificate. You must, however, complete and submit the DEA Form (EMEDNY #610301) found below.
  - If you DO prescribe, administer, or dispense controlled substances, then you must submit a copy of your DEA certificate or a web-based printout from the Office of diversion Control website at https://www.deadiversion.usdoj.gov/webforms/dupeCertLogin.jsp and complete the DEA Form (EMEDNY #610301). If employed by an institution and authorized to use the institution's DEA, you must submit a copy of the institution's DEA certificate and proof of the suffix/identifier assigned to you by the institution.
- DEA Form - form #610301 Completion is required, failure to complete this form may cause your application to be rejected and returned.Additional Instructions for form completion:
  - If you are licensed to and DO prescribe, administer, or dispense controlled substances, you are required to complete only Sections A and C.
  - If you are licensed to but do NOT prescribe, administer, or dispense controlled substances, you are only required to complete only Sections A and B.

  Note for practitioners: If employed by an institution and authorized to use the Institution's DEA, submit a copy of that DEA and proof of the suffix/identifier assigned to you by the Institution.
- ETIN Certification Statement for New Enrollments - form #490602 (NOT REQUIRED for revalidation, reinstatement, reactivation, or if you are enrolling as a Managed Care Only non-billing provider). If you already have an existing ETIN that you wish to affiliate with, submit the Certification Statement for Existing ETINs (EMEDNY 490601) **after you receive your Provider ID.** This form is available here.
- Electronic Funds Transfer (EFT) Authorization - form #701101 NOT REQUIRED IF:
  - submitting a revalidation, reinstatement/reactivation (i.e., if EFT is already in place and no changes are requested).
  - you answered "No" to the question, "If affiliated with a Group, do you have a Private Practice as well?" on page 2 of the Enrollment Form.
- Group Member Affiliation/Disaffiliation Request - form #610202 (If participating in more than one group, this form must be completed for each additional group).
- MOMS Application Addendum - form #405201
- MOMS Info For Providers - form #405101 To apply for Medicaid Obstetrical and Maternal Services (MOMS) complete this form.
- NDPP Recognition Attestation - form #434901 To receive payments for NDPP Services, complete this form and include any and all relevant documents received from the CDC stating that you have achieved National Diabetes Prevention Recognition Program (DPRP) certification.
- Office Based Surgery Program - form #432501 To apply for Office Based Surgery, complete this form
- PPAC Phys Addendum For Enrollment as a Specialist - form #406201 Applicants to PPAC MUST complete this ADDENDUM to Application for Enrollment as a Medical or Dental Specialist.
- PPAC Physician Program Description - form #406101 To apply for the Preferred Physicians and Children Program (PPAC), also complete this form.
- Physician Office Lab - CLIA Information - form #408501 To apply for Physician Office Laboratory-CLIA, complete this form
- Prior Conduct Questionnaire - form #431001 If you answer "Yes" to questions 1-4 in section 6 of the enrollment application, you must complete this form. Note: If upon Department review of your application an exclusion is found, you will be required to complete this form.
- **Proof of current license / registration** Examples: 1) Copy of license with future expiration date, 2) Copy of license registration/renewal, or 3) Printout of your license status from the licensing agency's website.

Enrollment Form

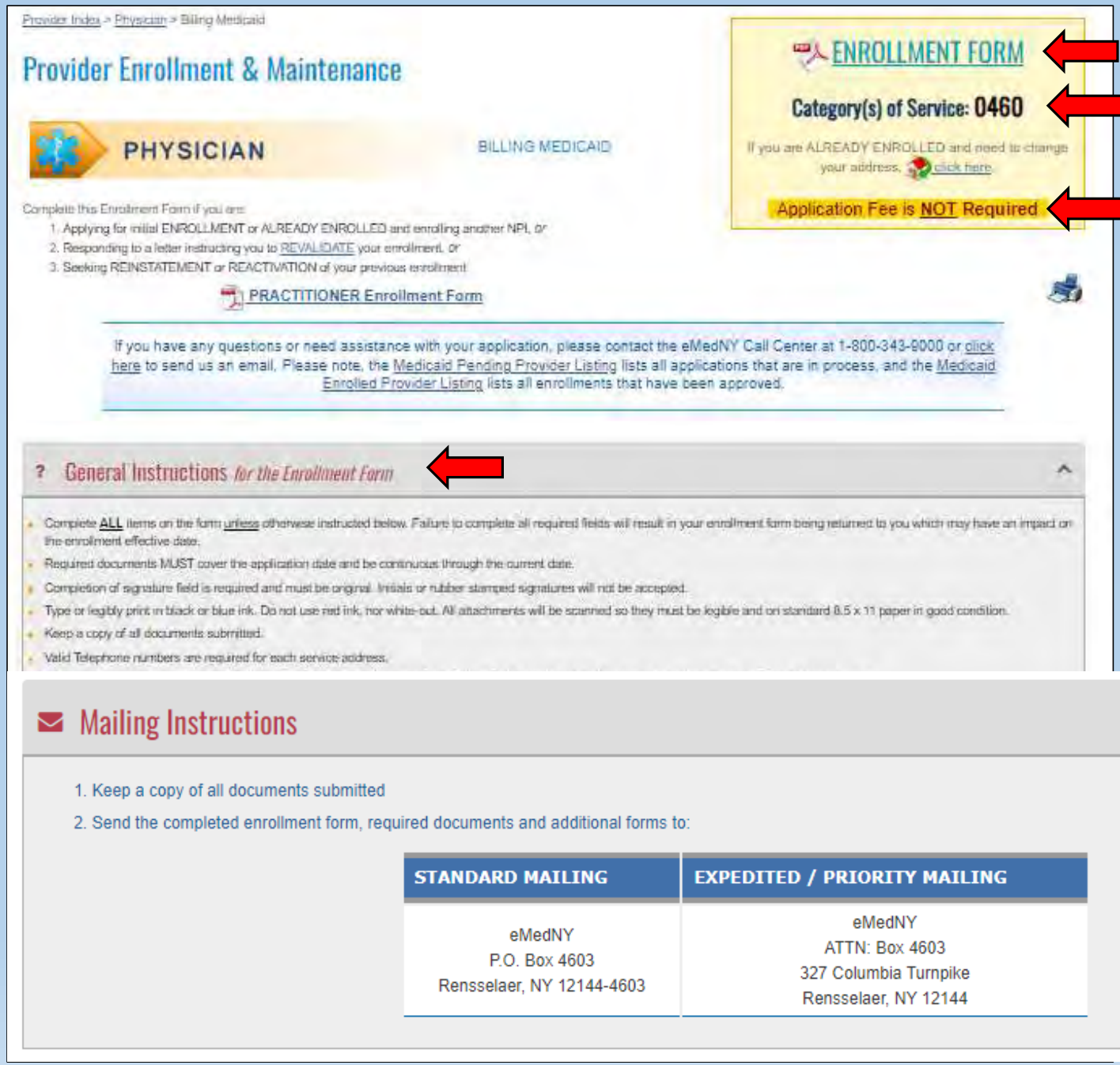
Category of Service

Application Fee Information

Maintenance Forms

- Application as a Specialist - form #490301 — Complete on the PE Portal
  if applicable
- Change of Address - form #610101 — Complete on the PE Portal
- DEA Form - form #610301 — Complete on the PE Portal
  Completion is required, failure to complete this form may cause your application to be rejected and returned.Additional Instructions for form completion:
  - If you are licensed to and DO prescribe, administer, or dispense controlled substances, you are required to complete only Sections A and C.
  - If you are licensed to but do NOT prescribe, administer, or dispense controlled substances, you are only required to complete only Sections A and B.

  Note for practitioners: If employed by an institution and authorized to use the Institution's DEA, submit a copy of that DEA and proof of the suffix/identifier assigned to you by the Institution.
- Disclosure Form for Practitioners - form #380104 — Complete on the PE Portal
- EFT Attestation Form - form #701102 — Complete on the PE Portal
- Group Member Affiliation/Disaffiliation Request - form #610202 — Complete on the PE Portal
  (If participating in more than one group, this form must be completed for each additional group).
- HIV Enhanced Fee Payment Program - form #432601 — To apply for HIV Enhanced Fee Payment, also complete this form.
- MOMS Application Addendum - form #405201 — Complete on the PE Portal
- MOMS Info For Providers - form #405101 — Complete on the PE Portal
  To apply for Medicaid Obstetrical and Maternal Services (MOMS) complete this form.
- NDPP Recognition Attestation - form #434901 — Complete on the PE Portal
  To receive payments for NDPP Services, complete this form and include any and all relevant documents received from the CDC stating that you have achieved National Diabetes Prevention Recognition Program (DPRP) certification.
- Notification of Status as Group-only Practitioner - form #426801
- Office Based Surgery Program - form #432501 — Complete on the PE Portal
  To apply for Office Based Surgery, complete this form
- Physician Office Lab - CLIA Information - form #408501 — Complete on the PE Portal
  To apply for Physician Office Laboratory-CLIA, complete this form



Enrollment Form

Category of Service

Application Fee Information

Mailing Instructions

1. Keep a copy of all documents submitted
2. Send the completed enrollment form, required documents and additional forms to:

STANDARD MAILING	EXPEDITED / PRIORITY MAILING
eMedNY P.O. Box 4603 Rensselaer, NY 12144-4603	eMedNY ATTN: Box 4603 327 Columbia Turnpike Rensselaer, NY 12144

NYS Medicaid Provider Enrollment Form

Practitioner Revalidation

Overview

Provider Enrollment Form – PRACTITIONERS

NY MEDICAID PROVIDER ENROLLMENT FORM
for
PRACTITIONERS

Mail to:

eMedNY
PO Box 4603
Rensselaer, NY 12144-4603

Category(s) of Service: Enter the 4-digit code(s) given in the instructions: **0460** _____

☐ 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

Provider Enrollment Form – PRACTITIONERS

NY MEDICAID PROVIDER ENROLLMENT FORM
for
PRACTITIONERS

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eMedNY
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Rensselaer, NY 12144-4603

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

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(not currently enrolled)	(enrolled; required to revalidate)	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

Provider Enrollment Form – PRACTITIONERS

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: _____

Note: This is a fillable form. Entry of information into the fillable form will prevent errors due to illegibility.

Provider Enrollment Form – PRACTITIONERS

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**

Provider Enrollment Form – PRACTITIONERS

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

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
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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Provider Enrollment Form – PRACTITIONERS

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) (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	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	

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: 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 (MM/DD/YYYY)

_____

Name & Telephone Number of Person who Prepared Application

Important Information and Reminders

- Do not send in a revalidation application until you receive notification in the mail to do so
- Omissions will delay the process
- Respond to requests for additional information when received
- Documentation is available on the eMedNY website to help you through the revalidation process
- Carefully review the enrollment form found on the eMedNY website, including instructions, prior to completing and submitting the enrollment form

Important Information and Reminders

- Complete all required forms
- Be sure to keep a copy of everything
- Mailing Options
  - Standard:

STANDARD MAILING

eMedNY
P.O. Box 4603
Rensselaer, NY 12144-4603

  - Expedited/Priority:

EXPEDITED / PRIORITY MAILING

eMedNY
ATTN: Box 4603
327 Columbia Turnpike
Rensselaer, NY 12144

Reference and Contact Information

1) eMedNY Website:
   www.emedny.org

2) eMedNY Enrollment Forms:
   www.emedny.org/info/providerenrollment/index.aspx

3) Bureau of Provider Enrollment:
   providerenrollment@health.ny.gov

4) eMedNY Call Center:
   800-343-9000

Conclusion

NYS Medicaid Revalidation for Practitioners