Application Fee Exemption Form

(For providers seeking enrollment in the New York Medicaid Fee-for-Service Program)

I am exempt from paying the Application Fee to New York Medicaid because:
(Check one)

A. ☐ I am enrolled in Medicare.

B. ☐ I am enrolled in another State's Medicaid Program or Child Health Insurance Program (CHIP).

List State(s): _____

(Include a copy your Medicaid participation letter from each state listed)

C. ☐ I have paid the application fee to Medicare.

Provider Name: _____

National Provider Identification Number (NPI): _____

_____

Name and Telephone Number of Person Completing Form

_____ _____

Signature: Provider, Owner or Board Member Date Signed

Submit this document to the New York Medicaid Program with your completed Enrollment Form

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