



Provider Services Portal-Milestone 2

Overview

This document overviews Milestone 2 of a new application being submitted in the Provider Services Portal. Applications are broken down into 4 milestones that must be completed before submission of an application for review.

Note: At this time the portal is only allowing enrollment for providers who have never been enrolled in NYS Medicaid and is currently limited to individual practitioners. Groups, businesses and institutions will come at a later date.

Milestone 2 of an application

Milestone 2 of an application is broken down into steps 4-6. Steps that are optional will be marked as so on the left-hand menu next to the step number.

Step 4 of Milestone 2 is for adding education/training/work history. This is an optional step. **Click** the show button arrow on the purple instructions banner to display instructions relating to this step.

Milestone 1

Milestone 2

Step 4 Optional Add Education/Training/Work History

Step 5 Add Payment Details

Step 6 Add Locations/Doing Business As

Milestone 3

Milestone 4

Education/Training/Work History

Information about provider education, training and work experience

Instructions Show

Step Requirements

Education Add

Training Add

Work History Add

Supporting Documents Add

Step 5 of Milestone 2 is for adding payment details. **Click** Add at the bottom right to begin this step.

Milestone 1

Milestone 2

Step 4 Optional Add Education/Training/Work History

Step 5 Add Payment Details

Step 6 Add Locations/Doing Business As

Milestone 3

Milestone 4

Payment Details

Information on how and where claims will be reimbursed

Instructions Show

Step Requirements

Payment Details Add

Information like the Social Security Number/EIN/FEIN and Provider Name will be imported based on what was entered



Provider Services Portal-Milestone 2

to generate the application. Payment method will be automatically selected as Electronic Funds Transfer (Direct Deposit). Fields marked with a red asterisk are required fields.

Milestone 2

Step 4 Optional

Add Education/Training/Work History

Step 5

Add Payment Details

Step 6

Add Locations/Doing Business As

Milestone 3

Milestone 4

Payment Details

Information on how and where claims will be reimbursed

Instructions

Show

Step Requirements

Mode of Payment

SSN/EIN/FEIN

Provider Name *

Payment Method

Electronic Funds Transfer (Direct Deposit)

Start Date *

08/04/2025

End Date

MM/DD/YYYY

Financial Institution Information

Financial Institution Name *

Routing Number *

Account Number *

Type of Account *

Select

Pay-To Contact Details

Contact Name *

Phone Number *

(000) 000 - 0000

Email Address *

example@email.com

Fax Number

(000) 000 - 0000

The EFT agreement must be read in full by scrolling down, and then signed. The signature boxes will remain greyed out until the entire EFT agreement has been read. **Click** the box that acknowledges that the EFT agreement has been read and agreed to.

EFT Agreement

The Electronic Fund Transfer form will be pre-filled with the information provided on this page. But it must still be signed to signify the agreement with the terms on page 2 of the EFT form. Both pages must then be sent in along with any additionally required documentation. This information will appear on the form that gets created. However, the signature field will be empty in the form and must therefore be signed before sending in the EFT Agreement.

Agreement

Providers who receive payment of claims under the Title XIX (Medicaid) program in New York State Department of Health must agree to the following terms and conditions:

1. Legal Compliance: Provider shall abide by all federal and state laws governing the Medicaid program.

2. EFT information: Provider will submit the EFT information that includes the Payee, name of the bank, address of bank, transit number, account number, and a bank letter or voided check on the account to which funds will be transferred.

3. Acceptance of Funds: Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the New York State Medicaid program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. The provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

4. Notice of Change: Provider will notify the Department of any changes in Payee, Payee's name or address, or bank account details. This notification must be supported in writing on company letterhead and include the provider's number(s) (MMIS ID or NPI), new account number, routing number, and a brief explanation for the change. The letter must also be signed by the provider and their title must be indicated.

5. Alternate Payment Methods: For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the

First Name *

Last Name *

Date *

08/04/2025

☐ I hereby acknowledge that I have read and agreed to the terms and conditions stated in the EFT Agreement. (Authorization Agreement - By Selecting the Check Box)

Click on Save Details in the middle right of the page after checking the box to agree

Click on Add under Address Details to enter the Pay-To address. This is the address where paper checks (if necessary) and remittances will be sent to until Electronic or PDF Remits are set up. Fields marked with a red asterisk are required.

07/31/2025



Provider Services Portal-Milestone 2

Click on Validate Address. Click on Save after you validate the address.

Address Details

Type of Address *

Please make a selection for Type of Address.

Address


Address Line 1 *

Enter Street Address or PO Box Only

Address Line 2

Address Line 3


City/Town *


State/Province *

County

Country *

Zip Code *

Validate Address

Click on Add under Address Details again to enter the Financial Institute address details. Click on Validate Address and then Save under the Validate Address button.

Address Details

<input type="checkbox"/> Address Type ↑↓	Address ↑↓	Actions
<input type="checkbox"/> Pay-To Address		 
1-1 of 1 item		1  of 1 page  

Supporting Documents

<input type="checkbox"/> Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date
----------------------------------------	---------------	-----------	---------	-------------	---------------

No records found!

Back

Save

Once the Pay-to Address and Financial Institution Address have been entered and validated, scroll up to the EFT



Provider Services Portal-Milestone 2

agreement to download the EFT agreement. **Note:** This download button will not be available until both addresses have been entered. **Click** on Download.

EFT Agreement

The Electronic Fund Transfer form will be pre-filled with the information provided on this page. But it must still be signed to signify the agreement with the terms on page 2 of the EFT form. Both pages must then be sent in along with any additionally required documentation. This information will appear on the form that gets created. However, the signature field will be empty in the form and must therefore be signed before sending in the EFT Agreement.

Agreement		Download
<p>Providers who receive payment of claims under the Title XIX (Medicaid) program in New York State Department of Health must agree to the following terms and conditions:</p> <ol style="list-style-type: none">1. Legal Compliance: Provider shall abide by all federal and state laws governing the Medicaid program.2. EFT information: Provider will submit the EFT information that includes the Payee, name of the bank, address of bank, transit number, account number, and a bank letter or voided check on the account to which funds will be transferred.3. Acceptance of Funds: Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the New York State Medicaid program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. The provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.4. Notice of Change: Provider will notify the Department of any changes in Payee, Payee's name or address, or bank account details. This notification must be supported in writing on company letterhead and include the provider's number(s) (MMIS ID or NPI), new account number, routing number, and a brief explanation for the change. The letter must also be signed by the provider and their title must be indicated.5. Alternate Payment Methods: For good cause (including but not limited to requesting payments from subsequent requests for claims payments), the		
First Name *	Last Name *	

Once the EFT Agreement has been downloaded, it must be physically signed and saved to then upload under the Supporting Documents section of this step.

MODE OF PAYMENT

Payment Method

☒ Electronic Funds Transfer(EFT)

AUTHORIZED SIGNATURE

Original Signature of Practitioner/Authorized Representative

Click on Add under Supporting Documents. A new screen will pop up that allows you to upload supporting documents for this step. File formats allowed: .gif, .jpg, .jpeg, .html, .htm, .pdf, .xls, .tif, .doc, .docx, .xlsx, .txt. **Click** on Upload document. **Click** on Close when you have uploaded the documents



Provider Services Portal-Milestone 2

Supporting Documents
×

Application ID	Enrollment Type	Applicant Type	Name	Application Status
	Individual	Fee For Service (Billing)	I	In Process

Required Documents

- Bank Letter or Cancelled Check
- EFT Agreement

Document Type *

Select

Document Name *

Select

File Name *

Choose

Remarks

File must be under 10 MB in size

Upload document

Added Documents

<input type="checkbox"/>	Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date
No records found!						

Close

Click on Save at the bottom right once all details of this page have been completed. **Click** on Next Step at the bottom right of the page.

Step 6 of Milestone 2 is for adding locations/doing business as. **Click** the show button arrow on the purple instructions banner to display instructions relating to this step. **Click** Add at the bottom right.

Milestone 1

Milestone 2

Step 4 Optional

Add Education/Training/Work History

Step 5

Add Payment Details

Step 6

Add Locations/Doing Business As

Milestone 3

Milestone 4

Locations/Doing Business As

Information on the locations where the provider practices

Instructions

- Familiarize yourself with the 'Step Requirements' link located immediately after the Instructions section. Here you will find any required documentation that will need based on the STEP you are completing. Some requirements will include hyperlinks (URLs) to forms that will need to be downloaded, filled out, uploaded along with your submission.
- Provide required information to add locations and associated information.
- Using a patient's address as the location address is not permitted.

Hide

Locations

Add

The next screen that will display is the Location Details page. Fields marked with red asterisks are required.



Provider Services Portal-Milestone 2

Milestone 1

Milestone 2

Step 4 Optional
Add Education/Training/Work History

Step 5
Add Payment Details

Step 6
Add Locations/Doing Business As

Milestone 3

Milestone 4

Locations/Doing Business As

Information about the locations where the provider practices

Instructions

Location Details

Location Type *
Select

Place Of Service
Select

Doing Business As ⓘ

Contact Details

Phone Number *
(000) 000 - 0000

Extension

Public Phone Number *
(000) 000 - 0000

Extension

Fax Number
(000) 000 - 0000

Email Address *
example@email.com

Public Email Address
example@email.com

Web Page

Communication Preference *
Select

Office's Information

Offers Office Based Surgery
☐ Yes ☒ No

Accept New Patients
☐ Yes ☒ No

Is this Location TDD/TTY equipped? ⓘ
☐ Yes ☒ No

Handicap Accessible
☐ Yes ☒ No

Is this Location ASL capable? ⓘ
☐ Yes ☒ No

Pediatric Services
☐ Yes ☒ No

Age Restrictions
☐ Yes ☒ No

In Person/Telehealth *
Select

Disability Accommodations
Select

Maximum Clients

Offers OB-Gyn Services
Select

Languages Spoken

Selected Languages *
Select

Office Hours

☐ 24/7

☐ Sunday

☐ Monday

☐ Tuesday

☐ Wednesday

☐ Thursday

☐ Friday

☐ Saturday



Provider Services Portal-Milestone 2

Address

Address Line 1 *

Enter Street Address or PO Box Only

Address Line 2

Address Line 3

City/Town *

Select

State/Province *

Select

County

Select

Country *

UNITED STATES

Zip Code *

Latitude

Longitude

Validate Address

Back

Save

Once you enter the details of the address, **Click** on Validate Address in the bottom right-hand corner. **Click** on Save directly below Validate Address when all information is correct.

This will bring you back to the main page of the step. You will then need to **click** on the edit button of the address to add additional information before the step is complete.

Locations/Doing Business As

Information on the locations where the provider practices

Instructions
Show

Locations

Add
Delete
Show Filter
Actions

Location	Location Type	Location Address	End Date	Actions
<input type="checkbox"/> 01-Main Office	Primary Practice Location		12/31/2999	

1-1 of 1 item
1 of 1 page

This will bring you into the address details you just entered. Now there will be a ribbon at the top which will have two sections that require additional information. These will be marked with a red warning triangle.

Instructions
Show

Step Requirements

Previous Tab
View Summary
Next Tab

Location Details
Address
PT/SP/SSP
License/Certification
Optional
Insurance
Optional
Contacts
Optional
+2

Location Details



Provider Services Portal-Milestone 2

Click on the Address Tab first. This will bring you to a screen where you will select the Correspondence Address, which is where any paper communications will be sent. Fields marked with red asterisks are required.

Address Details

Location 01-Main Office	Type of Address * Select <small>Please make a selection for Type of Address.</small>
Start Date * MM/DD/YYYY	End Date MM/DD/YYYY

Location Address

☐ Use the same as Location Address

Address

Address Line 1 * Enter Street Address or PO Box Only		
Address Line 2	Address Line 3	
City/Town * Select	State/Province * Select	
County Select	Country * UNITED STATES	
Zip Code *	Latitude	Longitude

There is the option to have the Correspondence Address the same as, or different from the Location Address. Once you enter the address details, **click** Validate Address then **click** Save underneath that.

Click PT/SP/SSP tab next. Fields marked with red asterisks are required. **Select** the specialty(s) from the box on the left and **click** the arrow pointing to the right to move the specialty over. **Click** Save when you have moved all subspecialties over.

+2	PT/SP/SSP ▲	License/Certification Optional	Insurance Optional	Contacts Optional	Supporting Documents Optional	+1
----	-------------	--------------------------------	--------------------	-------------------	-------------------------------	----

Provider Type/Specialty/ Subspecialty

Location 01-Main Office	Start Date * MM/DD/YYYY	End Date MM/DD/YYYY
----------------------------	----------------------------	------------------------

Associate Provider Type/Specialty/ Subspecialty

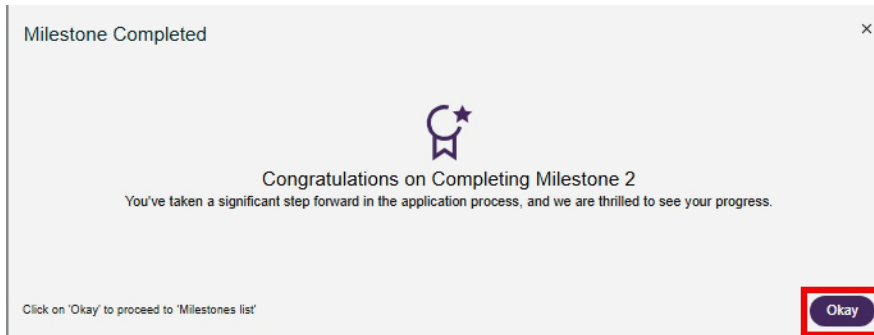
Available Subspecialty <input type="checkbox"/> Physician/Family Practice/No Subspecialty - 207Q00000X	<div>></div> <div><</div>	Associated Subspecialty * <div></div>
Add All >>		<< Remove All

Back	Save
------	------



Provider Services Portal-Milestone 2

Once you are completely satisfied with the information in Milestone 2, **click** on next step at the bottom right. A pop-up screen will display the following information



You are now complete with Milestone 2. **Click** Okay to acknowledge and move on to the remainder of the application.