NY MEDICAID TEMPORARY PROVIDER ENROLLMENT **PHARMACY** PROVIDING SERVICES IN THE AFTERMATH OF HURRICANE SANDY Questions: Call 518-474-3575, Option 4	**Mail this completed form and required documents** to:** Bureau of Provider Enrollment Office of Health Insurance Programs NYS Department of Health 150 Broadway Albany, NY 12204-2736

Categories of Service – 0441 and 0442		
Applicant / Business Name (exactly as it appears on your license)		
Applicant's Address:		
NPI	FEIN **	
License # **	State of Licensure if not New York	License Begin Date (MM/DD/YY)
Doing Business as (DBA) Name(if any):		
DEA Number **	DEA Effective Date (MM/DD/YY)	DEA Expiration Date (MM/DD/YY)
Applicant's e-Mail Address:		

****Send a copy of your State License, DEA Certificate, and IRS Assignment Letter**

SIGNATURE AND AFFIRMATION:

By signing this enrollment form for participation in the New York State Medicaid Program, the Applicant 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.
- 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.
- This is a temporary enrollment approved to provide reimbursement for goods/services provided to NYS Medicaid beneficiaries after Hurricane Sandy. The Applicant understands that the enrollment is limited to certain patients and is effective on or after October 29, 2012 through the end of the State of Emergency or December 12, 2012, whichever is sooner.

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.

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Owner's Signature (original; no stamps) Date

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Name & Telephone Number of Person who Prepared Application

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, 150 Broadway, Albany, NY 12204