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 (i.e., Title 18). Title 18 can be found by choosing the Laws and Regulations link of the Department of Health's website, www.health.ny.gov.
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You will be at financial risk if you render services to Medicaid beneficiaries before successfully completing the enrollment process. Payment will not be made for any claims submitted for services, care, or supplies furnished before the enrollment date authorized by the Department of Health. If you have any questions, contact the eMedNY Call Center at (800) 343-9000.

Consider printing the **Instructions to Complete Enrollment Form** before continuing. **Please complete pages 2 through 9; 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
GROUPS

☐ Billing Provider ☐ Managed Care Only (Non Billing)

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	☐ Change of Ownership
(not currently enrolled)	(enrolled; required to revalidate)	(enrolled, complying with 42CFR Part 455.104) NY Provider ID # _____

☐ 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.

Group's / Applicant's Name (exactly as it appears on your IRS assignment letter)

NPI	FEIN
Are you enrolled in Medicare? ☐ Yes ☐ No	Group's / Applicant's e-Mail Address - **REQUIRED**:

Ownership Code: ☐ 16-Sole Proprietorship ☐ 17-Partnership ☐ 18-Professional Corporation ☐ 73-Voluntary / Not-for-Profit

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 digits)
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 digits)
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 digits)
County (if in New York)	Telephone Number (w/ extension)	e-Mail Address - **REQUIRED**

{**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 digits)
County (if in New York)	*Telephone Number (w/ extension)	Fax Number
Place of Service (Check One) ☐ Private Office (1)	☐ Hospital/Nursing Home (2)	☐ Freestanding Clinic (3)

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 digits)
County (if in New York)	*Telephone Number (w/ extension)	Fax Number
Place of Service (Check One) ☐ Private Office (1)	☐ Hospital/Nursing Home (2)	☐ Freestanding Clinic (3)

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 digits)
County (if in New York)	*Telephone Number (w/ extension)	Fax Number
Place of Service (Check One) ☐ Private Office (1)	☐ Hospital/Nursing Home (2)	☐ Freestanding Clinic (3)

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 digits)
County (if in New York)	*Telephone Number (w/ extension)	Fax Number
Place of Service (Check One) ☐ Private Office (1)	☐ Hospital/Nursing Home (2)	☐ Freestanding Clinic (3)

List all Physicians and Practitioners (Members) in the Group who will provide services to Medicaid enrollees.

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

Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #
Member's Name	Member's License #
Member's NPI	Member's NY Medicaid Provider #

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 (Entity named on page 2 of this application)

Entity Name (exactly as it appears on your IRS assignment letter)	
FEIN	NPI (if exempt, leave blank)

Ownership in Applicant (per 42 CFR, Part 455.104(b)(1)(i) – (Entities and/or Individuals) Copy this page to report additional owners.

Name of Individual or Entity		Title (if individual)	Date of Birth (if individual)(MM/DD/YYYY)
Address (**Home Address** if Individual; Primary Address if Corporation) – **Street**			City, State & Zip Code (9 digit)
SSN (if individual)	FEIN (if entity)	% of Ownership (if none, put 0%)	NPI or NY Medicaid ID (if none, write None)

For Individuals Only: If you are related* to another person with an ownership or control interest in the Applicant, complete the following:

Name of other Owner: _____ Relationship to other Owner (parent, child, sibling, spouse): _____

_____ _____

_____ _____

For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):

1)_____ 2)_____ 3)_____

_____ _____ _____

_____ _____ _____

Name of Individual or Entity		Title (if individual)	Date of Birth (if individual))(MM/DD/YYYY)
Address (**Home Address** if Individual; Primary Address if Corporation) – **Street**			City, State & Zip Code (9 digit)
SSN (if individual)	FEIN (if entity)	% of Ownership (if none, put 0%)	NPI or NY Medicaid ID (if none, write None)

For Individuals Only: If you are related* to another person with an ownership or control interest in the Applicant, complete the following:

Name of other Owner: _____ Relationship to other Owner (parent, child, sibling, spouse): _____

_____ _____

_____ _____

For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):

1)_____ 2)_____ 3)_____

_____ _____ _____

_____ _____ _____

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	Subcontractor's Name	Name & Familial Relationship
Owner's Name	Subcontractor's Name	Name & Familial Relationship

SECTION 5:

Agents, Managing Employees & Those with a Control Interest – Including, but not necessarily limited to, the following: Facility Administrator, all Members of the Board of Directors, Managing Employees, Compliance Officer, Laboratory Director, Supervising Pharmacist *(although unusual, if None, indicate **NONE** in the first "Name" field below).* Include familial relationship to the Applicant (spouse, parent, child, sibling), if any.

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

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

Agents, Managing Employees & Those with a Control Interest – (continued)

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

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

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 Questions 5 through 7.

5. Has there been a change of ownership or control within the last 12 months to any of the entities (1, 2 and 3)?
☐ Yes ☐ No
If "Yes", provide:
NY Medicaid ID or NPI _____
Date of Ownership Change _____(MM/DD/YYYY)

6. Do you anticipate a change of ownership within the next 12 months to any of the above entities (1, 2 and 3)?
☐ Yes ☐ No
If "Yes", when do you anticipate the ownership change will occur: _____ (MM/DD/YYYY)

7. Does the Applicant/Provider have any unpaid balances owed to the NY Medicaid Program related to this Business or another entity owned by the Applicant? ☐ 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.

Print or Type the Name of Person Signing Below _____ Title _____

Signature of Owner or Board Member (original; no stamps) _____ Date (MM/DD/YYYY) _____

Name & Telephone Number of Person who Prepared Application _____