LABORATORY INFORMATION REQUEST FORM

You must answer all questions. If a question is not applicable, explain why. ***Use additional sheets of paper where necessary.***

1a. List the name of the owner(s) of the business and their social security number(s) and percentage of ownership. **The names listed must match the names given on question #5 of the Disclosure of Ownership and Control Form.** List any National Provider Identifiers (NPI's) or Medicaid Provider numbers or professional licenses held by the owners, if applicable. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their social security numbers and any National Provider Identifiers (NPI's) or Medicaid Provider numbers or professional licenses held.

Last Name, First Name	**Social Security Number**	**Percentage of Ownership**	**NPI or Medicaid # or Professional License**

b. Are any of the above named engaged in other businesses that provide services for Medicaid beneficiaries?

☐ Yes ☐ No

If yes,

Last Name, First Name	**Profession**	**License Number**	**NPI or NYS Medicaid #**

2. List **all** your current business locations, including all collecting stations. Provide the full address and length of time at location. Indicate if the location is a collecting station or a main site, and if it is a fixed or mobile facility. (e.g. van)

Address	**Main Site or Collecting Station**	**Fixed or Mobile**	**Length of Time At Location**

3. Leasehold arrangements (must be provided for all locations utilized by your laboratory):

a. Indicate whether rent is paid in equal monthly or yearly installments. **You must attach a signed copy of the current lease.** Indicate site location.

_____

_____

_____

b. Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

_____

_____

_____

c. Provide the name and address of the owner of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their social security numbers.

Last Name, First Name	**Address**	**Social Security Number**

d. If the building is owned by a corporation or partnership, list the name of the corporation or partnership and its officers, directors, principal stockholders, partners and their social security numbers.

Name of Corporation or Partnership _____

Last Name, First Name	**Position**	**Social Security Number**

Provide the name and address to whom the rent is paid.

Last Name, First Name **Address**

4. If laboratory has been recently purchased or acquired by the current owners, enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the acquisition.

5. Personnel:

   a. Identify in-house personnel, specifically laboratory director(s), laboratory supervisor(s). Include names, titles, professional qualifications, professional license numbers and social security numbers for each individual listed and hours and days employed. ***(Use In-house Personnel Attachment 5A to complete this question).***

   b. Provide a list of your licensed employees, a description of their appropriate professional and/or technical licenses, their corresponding license numbers and social security numbers. Provide hours of employment and location. Provide copies of all licenses and/or Laboratory Personnel Qualification appraisal. ***(Use Licensed Employees Attachment 5B to complete this question).***

   c. Provide the staffing pattern of your laboratory facility. Identify support staff, technical/professional personnel and administrative personnel. Identify employees' names, job titles, and social security numbers and hours employed. ***(Use Staffing Pattern Attachment 5C to complete this question).***

   d. List any individuals who are employed or compensated by the laboratory and who provide outside services in areas other than the main laboratory. ***(Use Outside Personnel Attachment 5D to complete this question).***

6. List any services or supplies (e.g. waste disposal, telefax) that your laboratory provides to physicians/clinics or other orderers of tests from your laboratory. Give details on the type of service, supply the names, addresses and National Provider Identifiers or NYS Medicaid provider numbers of the physicians/clinics or other orderers receiving these services/supplies and designate at whose expense these services/supplies are provided.

7a. Does your laboratory **employ** sales agents? ☐ Yes ☐ No

If yes, how are they compensated (e.g. commission, salary, both)? Please provide the name and social security number of each sales agent. **If there is a contract, attach a copy.**

Last Name, First Name	**Social Security Number**	**Salary, Commission or Both**	**Percent of Commission**
			%
			%
			%

b. Does your laboratory use **independent** sales agents? ☐ Yes ☐ No

If yes, how are they compensated? Include percentage of commission paid. Provide the name and social security number of each sales agent. **If there is a contract, attach a copy.**

Last Name, First Name	**Social Security Number**	**Salary, Commission or Both**	**Percent of Commission**
			%
			%
			%

c. If no sales agents are utilized, how does the laboratory market its services?

8. Operations:

What was your total revenue from all sources for the previous calendar year? $_____

9. List all other third party health insurers you are contracted or enrolled with.

Name of Company	**Date of Contract or Enrollment**

10. Estimate the percentage of business that will be billed to the NYS Medicaid Program. _____%

11. Are you seeking Medicaid enrollment for a specialized area of testing in which you are permitted to perform?

☐ Yes ☐ No

If yes, which area?

_____

_____

12. Do you employ a third party to manage your laboratory? Provide the name(s), address(es) and method by which each is compensated (e.g. commission, salary or both).

Last Name, First Name	**Address**	**Salary, Commission or Both**	**Percent of Commission**
			%
			%
			%

13. List the percentage of blood or other test specimens directly collected from beneficiaries at the primary laboratory sites. _____ %

Also, list the percentage of blood or other test specimens taken at:

a. Collecting stations: _____%
b. Physicians' offices: _____%
c. Dialysis clinics: _____%
d. Other: _____%

Identify other: _____

14. Attach blank copies of all test order forms currently used.

15. What arrangements have been made to transport these specimens to your laboratory? Describe schedule pick-up(s) and delivery(ies), specifically, at approximately what time does the courier(s) arrive at the first stop (list time for each courier), how often and at what interval does the courier(s) transport specimens back to the laboratory and what hour is the final site pick-up (list time for each courier). What is the method of transport(s), ownership of transport(s), and specimen storage protocol during transport? Where are the specimens spun?

_____

_____

_____

16. Test Result Reporting:

a. Attach blank copies of the current test result reporting forms sent to ordering providers.

b. How are the test result reports generated? If a computer is involved, provide the hardware (computer) and software (program) vendor name(s) and address(es), and manufacturer (if different than vendor) and acquisition agreement (contract, invoice, etc.)

_____

_____

c. Is this a shared system (information, billing, etc.)? ☐ Yes ☐ No

If yes, who is the system shared with?

_____

_____

17. a. Identify the name, address and account number(s) of the bank(s) to be used by the business.

Name of Bank	**Address**	**Account Number**

b. Provide the names and social security numbers of all personnel authorized to sign corporate checks against those accounts.

Person(s) Authorized to Sign Checks	**Social Security Number**

18. Identify the persons who will be authorized to sign NYS Medicaid Program claim forms and provide original examples of their signatures. Signature stamps, photocopies, etc., are not acceptable.

Last Name, First Name	**Signature**

19. If Medicaid claims will be submitted through a billing service, identify by name(s) and address(es) and National Provider Identifier or NYS Medicaid Provider Number, if known. Also, include a copy of your current contract(s) with the billing service(s).

Name of Billing Service	**Address**	**NPI or NYS Medicaid Number (if known)**

20. Does your laboratory receive referral work from other laboratories? ☐ Yes ☐ No

If yes,

Name of Laboratory	**Address**	**NPI or NYS Medicaid Number (if known)**

21. Does your laboratory refer work to other laboratories? ☐ Yes ☐ No

If yes,

Name of Laboratory	**Address**	**NPI or NYS Medicaid Number (if known)**

22. Do you anticipate a change(s) in your policy regarding referral work if enrolled in the New York State Medicaid Program?

☐ Yes ☐ No

If yes, what change(s) do you anticipate?

23. Have any of the laboratory's officers, principals, laboratory director or laboratory supervisor been affiliated with any other laboratories (whether or not they were a Medicaid provider), or any other businesses that provide or provided services related to Medicaid beneficiaries in the last five years?

☐ Yes ☐ No

If yes, provide an explanation below, including the affiliation, the name of the individual(s), the name of the laboratory(s) or other business(es) and location(s), National Provider Identifier(s), MEDICAID provider identification number (if any) and length of affiliation.

_____

_____

_____

Owner's Name (Print): _____

Owner's Signature: _____ Date Signed: _____
(Signature Stamps Are Not Permitted)

Application Prepared by (Print): _____

Telephone Number: _____