| STATUS CHANGE<br><br>**ORDER-PRESCRIBE-REFER-ATTEND (OPRA) TO BILLING PROVIDER** | Mail to:<br><br>eMedNY<br>PO Box 4610<br>Rensselaer, NY 12144 |
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| **Provider Name:** | |
| **Provider NPI:** | **NY Medicaid ID (if known):** |
| **Pay To Address:** (for receipt of checks and remittance statements until EFT and e-Remits are in place) | |
| **Street** / **City/State** / **Zip** | |

When submitting this change to the PO Box noted above, you **must** also send item #1 **and** #2a **OR** #2b with this form.
If appropriate to your situation, items 3 through 5 must be completed and submitted separately:

1. ETIN Certification Statement (EMEDNY-490602)
2. a. Practitioners in Groups (EMEDNY-426801) *(complete if your service to Medicaid members is limited to the group setting)*

   **OR**

   b. Electronic Funds Transfer (EFT) Authorization Form (EMEDNY-701101)
3. Application as a Specialist (EMEDNY-490301)
4. Request for Participation as a Group Member (EMEDNY-610202)
5. Change of Address Form for Practitioners, Businesses and Groups (EMEDNY-610101)

By signing this form, the Provider understands and agrees to the following:

- The effective date of this status change will be the date this form is verified by eMedNY.
- There has been NO CHANGE to the following information supplied on my OPRA enrollment form: 1) any ownership related information, and 2) managing employees, those with a control interest, and agents. **IF CHANGES HAVE OCCURRED, DO NOT SUBMIT THIS FORM. INSTEAD, YOU MUST COMPLETE A NEW ENROLLMENT FORM FOR BILLING PROVIDERS**.
- 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 disclosure document as well as impending ownership changes or any other 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.

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Provider's Signature (original; no stamps) Date