New York State Medicaid Program
Affiliation/Disaffiliation Request Form
For Optical Practitioners and Establishments

- Practitioners must complete this form to affiliate to an Optical Establishment.
- If applying for Medicaid enrollment, upload this form with your application submission.
- If updating an enrollment file, you will be prompted to upload a signed copy of this form with your affiliation submission.

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CHOOSE ONE:

Request to Affiliate to an Optical Establishment, must complete Sections A and B)

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SECTION A:

Optician/Optometrist's Information:

Name: _____ *(required)*

Medicaid ID: _____ *(optional)* NPI: _____ *(required)*

Optical Establishment's Information:

Name *(required)*: _____ Address *(required)*: _____

NPI: *(required)* _____ City:_____State ____Zip _____

Medicaid ID: *(optional)* _____ Phone Number *(required)*:_____

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SECTION B:

I agree to participate in the Medicaid Program as a member of the optical establishment listed above. I understand that I am personally responsible for all claims billed to Medicaid using both the optical establishments and my personal Medicaid identification numbers. I will notify the Medicaid Program if I am no longer affiliated with this optical establishment.

Requested Affiliation Effective Date: _____ *(required)*

*NOTE: The assigned effective date of the affiliation will be no earlier than **90 days** prior to the date this form is **received** by the Medicaid Program.*

Optician/Optometrist's Signature: _____ Date Signed: _____

Name of Optical Establishment's Authorized Representative (print): _____

Signature of Optical Establishment's
Authorized Representative: _____ Date Signed: _____