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 18NYCRR (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.

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.

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

Physicians Enrolled in CAQH:

1. Complete this form in its entirety. Type/print legibly. Enrollment is not guaranteed.
2. Mail completed form to **Computer Sciences Corporation**
   PO Box 4603
   Rensselaer, NY 12144-4603

Physicians Not Yet Enrolled in CAQH:

1. Go to www.CAQH.org and complete a CAQH Registration Kit and CAQH Provider ID. This will allow you to complete the on-line application in the Universal Provider Datasource (UPD).
2. To complete the CAQH application you will need:

- CAQH Provider ID (included in the registration kit sent from CAQH)
- Previously completed credentialing application (for reference)
- List of all previous practice locations
- Copies of:
  - → Curriculum vitae (resume)
  - → Current Medical License
  - → Current DEA certification (if applicable)
  - → IRS Form W-9
  - → Malpractice insurance face sheet
  - → Summary of any pending settled malpractice cases

3. Verify your data entry and Attest.
4. Fax supporting documents to (866) 293-0414
5. For help completing the CAQH application, please contact the CAQH Help Desk at 1-888-599-1771 or by e-mail: caqh.updhelp@acsgs.com.
6. Once your CAQH enrollment is complete, follow the instructions above for "Physicians Enrolled in CAQH".

NY MEDICAID PROVIDER ENROLLMENT FORM for **PHYSICIANS**	Mail to: Computer Sciences Corporation PO Box 4603 Rensselaer, NY 12144-4603

Category of Service: 0460

☐ New Enrollment	☐ Revalidation	☐ Reinstatement/Reactivation
(not currently enrolled)	(enrolled; required to revalidate) NY Provider ID # _____ (from Letter)	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

Applicant Name (exactly as it appears on your license/registration) **Last, First, MI**		
Date of Birth (MM/DD/YYYY)	SSN	Are you enrolled in Medicare? ☐ Yes ☐ No
NPI (Individual)	NPI (Group-if affiliated with a Group)	If affiliated with a Group, do you have a Private Practice as well? ☐ Yes ☐ No ☐ N/A
Specialty	CAQH Provider ID - **REQUIRED**	
License #	State of Licensure if not New York	Limited License? ☐ Yes ☐ No

CONTACT ADDRESS: (for questions during the Application Process)		
Attention:	Street Address	Suite / Department / Floor
City	State	Zip Code (9 digits)
e-Mail Address - **REQUIRED**	Telephone Number (w/ extension)	Fax Number

CORRESPONDENCE ADDRESS: (where letters and claims forms, if any, should be sent) – **PO Box not acceptable** *PLEASE NOTE*: This address will be used by NY Medicaid but may be replaced if CAQH provides a different address in the future		
Attention:	Street Address	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number

FOR HOSPITALISTS AND EMERGENCY ROOM PHYSICIANS ONLY

CAQH does not request a "Pay to" Address for your enrollment. Please complete the following for your enrollment file with NY Medicaid:

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 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number

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***.
Visit www.health.ny.gov **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 (Individual named on page 2 of this application)

Name		NPI
Home Address - Street	City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	

Ownership in Applicant (if required by 18NYCRR, Section 504.1(d)(18)(iv)). Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104(b)(1)(i) for more information).

Name of Individual or Entity		% of Ownership	NPI
Address (**Home Address** if individual)		City & State	Zip Code (9 digits)
SSN (if individual)	FEIN (if entity)	Date of Birth (if individual) (MM/DD/YYYY)	Familial Relationship (if individual, if any)

SECTION 2:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104(b)(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 (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 5:

Agents and Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider. *Although unusual, if None, indicate **NONE** in the first "Name" field below.* Include familial relationship to the Applicant (spouse, parent, child, sibling), if any. **If additional space is needed, copy form; all entries must be on the form.**

Name			Association Type (see instructions)
Home Address - **Street**		City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name			Association Type (see instructions)
Home Address - **Street**		City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name			Association Type (see instructions)
Home Address - **Street**		City & State	Zip Code (9 digits)
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: If you answered "Yes" to any of the questions above, you must complete and submit the "Prior Conduct Questionnaire" available at www.emedny.org.

5. Do you, including any entity in which you have ownership, have any unpaid balances owed to the NY Medicaid Program? ☐ 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 (see www.OMIG.ny.gov), the Provider has certified via the Office of the Medicaid Inspector General's web site referenced above that the provider and its affiliates have adopted, implemented and maintains an effective compliance program that meets the requirements of Social Service Law Section 363-d & 18NYCRR, Part 521. A copy of the certification confirmation is included with this enrollment.
- 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.

_____ _____

Applicant / Provider's Signature (original; no stamps) Date (MM/DD/YYYY)

_____

Name & Telephone Number of Person who Prepared Application