NEW YORK STATE
DEPARTMENT OF HEALTH

AIDS INSTITUTE

HIV UNINSURED CARE PROGRAMS

ADAP PLUS

LABORATORY
AGREEMENT FORM

1-800-832-5305

EMPIRE STATION
P.O. BOX 2052
ALBANY, NY
12220-0052

Program Description

The New York State Department of Health, AIDS Institute, in cooperation with the HIV planning councils of New York City, Long Island, Lower Hudson Regions and Dutchess County has implemented a program to provide reimbursement to qualified primary care providers who provide services to uninsured persons with Human Immunodeficiency Virus (HIV).

In order to assure comprehensive coverage for eligible individuals, the department invites eligible laboratories to participate in this program and receive reimbursement for specific laboratory and ancillary services ordered by participating providers.

General Program Requirements

Qualified labs that participate in Medicaid and are Certified by the New York State Department of Health are eligible to enroll. The enrollment process requires the lab to sign the Assurances and Agreement Form, and complete the Provider Enrollment Form. Make a copy for your records and return the originals to ADAP Plus:

ADAP PLUS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052

ADAP Plus will reimburse all enrolled labs at the standard Medicaid reimbursement rates for any lab or ancillary service included on the list that is; provided to an **ADAP Plus eligible participant.**

Client Eligibility

ADAP Plus serves HIV-Infected NYS residents who are uninsured or underinsured for primary care. Participants must meet the following criteria;

1	Residency	New York State residency (US citizenship is not required)
2	Medical	HIV-Infection
3	Financial	Annual Income less than $44,000 for a household of 1, $59,200 for a household of 2 and $74,400 for a household of 3 or more. Liquid Assets less than $25,000.

There are no co-payment requirements.

ADAP Plus staff determine eligibility and issue enrolled participants an ID card.

Billing

Standard Medicaid rate codes are required for billing eligible lab and ancillary services. A billing manual with a standard claim form will be provided. If a facility chooses to use an automated system or internal billing forms, in most cases any Medicaid acceptable claim form or format that includes all ADAP Plus required fields will be accepted upon review by program staff.

Notification

An informational packet and enrollment acceptance notification will be sent to each lab choosing to participate in ADAP Plus. This packet will include a detailed list of covered services, the billing manual and claim processing instructions and format.

Questions

If additional information is required regarding ADAP Plus please call program staff at 1-800-542-2437.

NEW YORK STATE DEPARTMENT OF HEALTH, AIDS INSTITUTE
ADAP PLUS LABORATORY
ASSURANCES AND AGREEMENT FORM

1. I, as ____________________ of __________________________ recognize that I continue to be bound by the rights, obligations, duties or interests accrued, occurred or conferred as a result of my enrollment in the New York State ADAP Plus Program.

2. I, recognize that the State may determine new service types, covered products and rates during the term of this agreement.

3. I recognize that the New York State Department of Health may cancel the businesses participation in the ADAP Plus at any time, giving not less than thirty (30) days written notice that on or after the date therein specified, the Firms participation will end. I accept that cause for cancellation of my participation in the ADAP Plus Program will include but not be limited for my failure to substantially comply with the terms of participation including, but not limited to failure to (a) permit access for patient record reviews or (b) accurately and appropriately bill ADAP Plus under the reimbursement methodology.

4. I recognize that the Firm may request cancellation of my participation in the ADAP Plus Program giving to the NYS Department of Health not less than thirty (30) days written notice. I assure that such cancellation will accompany a description of the basis for the request. I agree to continue to provide and, or arrange services for currently served patients up to the date of termination. I assure that I will assist patients to maintain continuity of care; to provide them with information to assist them in transferring their care and to make timely transfer of their records upon request.

5. I assure that I will abide by all ADAP Plus policies, procedures, and instructions provided by the State and I agree to bill ADAP Plus in accordance with the reimbursement methodology established by the State.

LABORATORY/CORPORATE NAME: ____

PRINT NAME: ____

TITLE: ____

SIGNATURE: ____

DATE: ____

Please return this agreement to:

ADAP PLUS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052

Rev. 9/2007

New York State Department of Health
UNINSURED CARE PROGRAMS
Empire Station . PO BOX 2052 . Albany, NY 12220
Phone: 1-800-542-2437 Fax: 518-459-2749

Laboratory Provider Enrollment Form

Please print clearly

MMIS Provider Number: ☐☐☐☐☐☐☐☐ MMIS Locator Code: ☐☐☐

NPI Number: ☐☐☐☐☐☐☐☐☐☐ Tax ID Number: ☐☐ - ☐☐☐☐☐☐☐☐

Laboratory Name: ______________________________

Address: ______________________________

City: ____________________ State: ☐☐ Zip Code: ☐☐☐☐☐

Main Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: ☐☐☐☐

Administrative Contact: ____________________ Title: ______________

Patient Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: ☐☐☐☐

Billing Address (if different from above):

Company Name: ______________________________

Address: ______________________________

City: ____________________ State: ☐☐ Zip Code: ☐☐☐☐☐

Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: ☐☐☐☐

ADDITIONAL LOCATIONS FOR THIS FACILITY:

MMIS Locator Code: ☐☐☐ Facility Name: ______________________________

Address: ______________________________

City: ____________________ State: ☐☐ Zip Code: ☐☐☐☐☐

Main Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: ☐☐☐☐

Patient Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: ☐☐☐☐

MMIS Locator Code: ☐☐☐ Facility Name: ______________________________

Address: ______________________________

City: ____________________ State: ☐☐ Zip Code: ☐☐☐☐☐

Main Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: ☐☐☐☐

Patient Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: ☐☐☐☐