eMedNY PROVIDER ENROLLMENT FORM

INSTITUTIONAL / RATE - BASED PROVIDERS

Computer Sciences Corporation
P.O. Box 4603
Rensselaer, NY 12144

1 APPLICATION DATE: ____ (m m d d y y)

2 FEDERAL EMPLOYER I.D. #: ____

ATTACH COPY OF FEIN LETTER ONLY - A W-9 FORM IS NOT SUFFICIENT

3 PROVIDER NAME: **If pre-filled, DO NOT alter.**

Type of Entity

☐ Sole Proprietorship ☐ Unincorporated Association ☐ Partnership

☐ Corporation ☐ Governmental ☐ LLC ☐ Other (specify) _____

4 DOING BUSINESS AS (DBA) NAME: (If this facility does business under an assumed name, enter that name here.)

5 NPI (National Provider Identifier): ____ **ATTACH COPY OF NPI VERIFICATION EMAIL ONLY (NOT NPPES PRINTOUT)**

Note: Complete a separate enrollment application for each NPI. Contact the Rate Based Provider Bureau if you need additional applications.

Major ***Taxonomy*** codes associated with this NPI -- attach additional sheet, if needed.

6 LICENSE / OPERATING CERTIFICATE NUMBER(S) (ATTACH ADDITIONAL SHEET, IF NECESSARY)

#	AGENCY CODE:	BEGIN DATE:	EXPIRATION:	
#	AGENCY CODE:	BEGIN DATE:	EXPIRATION:	
#	AGENCY CODE:	BEGIN DATE: (m m d d y y)	EXPIRATION: (m m d d y y)	

AGENCY CODES:

01 Department of Health 02 Office of Mental Health 03 State Education Department 04 Department of State
05 Office of Alcoholism & Substance Abuse Services 07 Office for People With Developmental Disabilities
08 Department of Social Services 09 Department of Transportation 99 Out of State

7 FISCAL YEAR END DATE: ____

ENTER THE END DATE OF YOUR FISCAL YEAR - MONTH / DAY EXAMPLE 06/30 OR 12/31

8 OWNERSHIP CODE: ____

CHOOSE THE APPROPRIATE CODE FROM THE CHOICES BELOW:

69 Public Federal 71 Public Municipal 73 Voluntary (not for profit) 75 Proprietary (Profit) Partnership
70 Public County 72 Public State 74 Proprietary (Profit) Corporation 76 Proprietary (Profit) Individual
19 Other

9 CONTROL OF FACILITY CODE: ____

SEE APPENDIX A (page 9) FOR CONTROL OF FACILITY CODES

10 DEA NUMBER: ____ BEGIN DATE: ____ (m m d d y y) EXPIRATION: ____ (m m d d y y)

IF THIS FACILITY IS LICENSED TO PRESCRIBE OR DISPENSE CONTROLLED DRUGS, ENTER THE FACILITY'S D.E.A. NUMBER.

ATTACH LEGIBLE COPY OF DEA CERTIFICATE COVERING BOTH THE APPLICATION DATE AND CURRENT DATE.

11 MEDICARE PARTICIPATION: DOES THIS FACILITY / ENTITY/ NPI PARTICIPATE IN MEDICARE? ☐Yes ☐ No

IF YES, ATTACH COPY OF AWARD OR PARTICIPATION LETTER.

12 # OF MEDICARE BEDS: ____ TITLE XVIII **# OF MEDICAID BEDS:** ____ TITLE XIX

13 ADDRESS INFORMATION * = MANDATORY FIELD

FOR COUNTY CODES, SEE APPENDIX B (page 8). PLEASE USE STANDARD POST OFFICE ABBREVIATIONS FOR STATE & LOCATIONS.

FOR EXAMPLE:

S for South	Blvd for Boulevard	Rd for Road
W for West	Ln for Lane	Rt for Route
Apt for Apartment	Pl for Place	RR for Rural route
Ave for Avenue	Plz for Plaza	St for Street
NY for New York State	*PA for Pennsylvania*	*FL for Florida*

a. **CORRESPONDENCE ADDRESS:**

ATTENTION LINE (Title or Department Name only - example "Accounts Manager" or "Business Office")

* STREET ADDRESS LINE 1 (For correspondence address, this cannot be a P.O. Box unless accompanied by a street address)

STREET ADDRESS LINE 2

* CITY * COUNTY CODE See Appendix B

* STATE * ZIP CODE - + 4 * ( ) AREA CODE PHONE NUMBER - EXTENSION

***E-mail address**

b. **PAY-TO ADDRESS:** (Complete even if EFT is chosen)

ATTENTION LINE (Title or Department Name only - example "Accounts Manager" or "Business Office")

* STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

* CITY * COUNTY CODE See Appendix B

* STATE * ZIP CODE - + 4 * ( ) AREA CODE PHONE NUMBER - EXTENSION

c. **SERVICE ADDRESS INFORMATION:** ***If pre-filled, do not alter***

ATTENTION LINE (NO MAIL IS SENT TO THIS ADDRESS)

* STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

* CITY * COUNTY CODE See Appendix B

* STATE * ZIP CODE - + 4 * ( ) AREA CODE PHONE NUMBER - EXTENSION

d. **CORPORATE ADDRESS INFORMATION: Annual tax documents will be sent to this address.**

NOTE: The address supplied here will be ignored if Medicaid already recognizes an address for the FEIN listed in Question # 2.

* ENTER THE NAME EXACTLY AS IT APPEARS ON THE FEIN DOCUMENTATION

ATTENTION LINE (Title or Department Name only - example "CFO" or "Accounting Office")

* STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

* CITY * COUNTY CODE See Appendix B

* STATE * ZIP CODE - + 4 * ( ) AREA CODE PHONE NUMBER - EXTENSION

***Email address**

14. OWNERSHIP / CONTROL Disclosure List

These questions pertain to the disclosure of ownership and control of the entity covered by this Enrollment / Revalidation application. **The accurate completion of this entire section is required by 42 CFR Part 455.104.** Failure to provide the information requested will cause the application to be returned. For Definitions of ownership, indirect ownership, managing employee, refer to NYCRR Title 18 Section 504.1 (rev 6/11)

This section for individual disclosure information:

Name:		Title:
Home Address:		
SSN:	DOB:	% Ownership
Type: (Check all that apply)	☐Owner ☐Stockholder (5% or more)	☐Facility Administrator ☐Board of Directors Member ☐Officer ☐Managing Employee ☐Compliance Officer ☐Lab Director ☐Supervising Pharmacist
Relationship Information:	Type of Relationship: (parent, child, sibling, spouse) __________ __________ __________	Name & Title of person related to: __________ __________ __________

Name:		Title:
Home Address:		
SSN:	DOB:	% Ownership
Type: (Check all that apply)	☐Owner ☐Stockholder (5% or more)	☐Facility Administrator ☐Board of Directors Member ☐Officer ☐Managing Employee ☐Compliance Officer ☐Lab Director ☐Supervising Pharmacist
Relationship Information:	Type of Relationship: (parent, child, sibling, spouse) __________ __________ __________	Name & Title of person related to: __________ __________ __________

Name:		Title:
Home Address:		
SSN:	DOB:	% Ownership
Type: (Check all that apply)	☐Owner ☐Stockholder (5% or more)	☐Facility Administrator ☐Board of Directors Member ☐Officer ☐Managing Employee ☐Compliance Officer ☐Lab Director ☐Supervising Pharmacist
Relationship Information:	Type of Relationship: (parent, child, sibling, spouse) __________ __________ __________	Name & Title of person related to: __________ __________ __________

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This section for corporate or Limited Liability Company (LLC) disclosure information:

Corporation or LLC Name:	FEIN:	NPI (if applicable):

Primary Business Address:	Attention Line
	Address 1
	Address 2
	City, State, Zip
List all other addresses associated with this corporation or LLC including P.O. Box information:	Attention Line
	Address 1
	Address 2
	City, State, Zip
	Attention Line
	Address 1
	Address 2
	City, State, Zip
	Attention Line
	Address 1
	Address 2
	City, State, Zip
	Attention Line
	Address 1
	Address 2
	City, State, Zip
	Attention Line
	Address 1
	Address 2
	City, State, Zip
	Attention Line
	Address 1
	Address 2
	City, State, Zip

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15 Respond to these questions on behalf of yourself and any individuals or organizations having a direct or indirect ownership or control interest of 5% or more (including stockholders) and any directors, administrators, officers, agents or managing employees of the above named agency, institution or organization.

Has any one listed in # 14 ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned under any of the programs established by Title XVIII (Medicare), XIX (Medicaid) or XX (Social Services) in any State?

☐ Yes ☐ No

Has anyone listed in # 14 ever been convicted of stealing, welfare fraud or public assistance fraud as a result of your involvement in any of the programs established by Titles XVIII (Medicare), XIX (Medicaid) or XX (Social Services) in any State?

☐ Yes ☐ No

Has anyone listed in # 14 had their license or registration revoked, suspended, surrendered or, in any way, restricted by probation or agreement by a licensing authority in any State?

☐ Yes ☐ No

For anyone listed in # 14, are there currently pending any proceedings that could result in any of the above stated sanctions?

☐ Yes ☐ No

If you answered "yes" to any of the above questions, an additional disclosure questionnaire will be sent when the enrollment is received for review.

When completed and returned, it will be forwarded to the Office of the Medicaid Inspector General for review.

Has there been a change of ownership or control within the last year?

☐ Yes ☐ No If "yes", give date: _____

(NOTE: This enrollment is not automatically transferrable when there is a change in ownership. Contact the Department of Health for "CHOW" instruction.

Do you anticipate a change of ownership within the year?

☐ Yes ☐ No If "yes", when: _____

Is this facility operated by a management company, or leased in whole or part by another organization?

☐ Yes ☐ No If "yes" give date of Change of Operations: _____

Has there been a change in your lab director or supervising pharmacist within the last year?

☐ Yes ☐ No Not Applicable _____

Do you currently have any unpaid balances owed to the Medicaid Program?

☐ Yes ☐ No

If yes, then please indicate the amount: $_____

Has payment been arranged? ☐ Yes ☐ No If "Yes", please attach verification of the arrangement.

(If you have not arranged payment, this enrollment will be referred to the Office of the Medicaid Inspector General for review)

16 Are any of the owner(s) or corporations listed in # 14 also owner(s) or stockholders of other Medicare/Medicaid facilities?

☐ Yes ☐ No

If "yes", list names and NPIs or Medicaid ID #s. (Please indicate if Medicare and/or Medicaid). Attach additional sheets if necessary.

OWNER'S NAME	FACILITY NAME	NPI or MEDICAID ID

17 Are any of the owner(s) or corporations listed in # 14 also owner(s) or stockholders with an interest of 5% or more in a subcontractor providing service to the applicant?

☐ Yes ☐ No

If "yes", list names and Tax ID numbers. Attach additional sheets if necessary.

OWNER'S NAME	SUBCONTRACTOR NAME (*Individual or Corporation) & ADDRESS*	FEIN / SS#

18 Are any of the owner(s) or stockholders listed in # 14 related to an owner or stockholder of a subcontractor providing service to the applicant?

☐ Yes ☐ No (Parent, Child, Sibling, Spouse)

If "yes", list names and relationships. Attach additional sheets if necessary.

OWNER'S NAME	SUBCONTRACTOR NAME *& FEIN or SS#*	NAME & RELATIONSHIP

19 **Left blank Intentionally**

20 SIGNATURE AND AFFIRMATION

By signing this enrollment application with the New York State Medicaid Program, the prospective provider 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 18 NYCRR which can be found at the Department of Health's website, www.health.ny.gov.
- In addition, pursuant to 42 CFR § 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 & 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
- As a Medicaid provider you agree to notify this Department immediately of any changes to the information supplied in this enrollment agreement, including impending ownership changes.
- 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 maintain an effective compliance program that meets the requirements of Social Services Law §363-d & 18 NYCRR Part 521. A copy of the certification confirmation must be 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 percent interest) may be required to consent to criminal background checks including fingerprinting.

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.

Name of Authorized Representative (print or type) | Title

If prospective Provider is a legal entity other than a person, the person signing this enrollment document on behalf of the Provider warrants that he/she has legal authority to bind Provider.

Signature | Date

Preparer's Name & Title (print or type) | Contact Telephone Number

PERSONAL PRIVACY LAW NOTIFICATION TO MEDICAID PROVIDERS

The State's Personal Privacy Protection Law, which took effect September 1, 1984, requires us to inform every person from whom we request personal information why we are requesting the information and how we will use it. The information you have been asked for will enable us to make 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 audits before payment is made for the goods or services furnished and/or for any post payment audits considered by the State or Federal authorities to be necessary.

The information will also be used to satisfy the reporting requirements imposed upon us by State and Federal regulations (e.g. by IRS for payment information reporting purposes).

Your failure to provide us with the information requested may prevent us from establishing the necessary records to enroll you as a Medicaid provider.

The information will be maintained by the Department of Health, Division of Provider Relations & Utilization Management, Suite 6E, 150 Broadway, Albany, New York 12204-2736.

FOR STATE USE ONLY

1 LICENSE / CERT # _____ AGENCY CODE ____

Begin Date ____ (M M D D Y Y Y Y) End Date ____ (M M D D Y Y Y Y)

2 LICENSE / CERT # _____ AGENCY CODE ____

Begin Date ____ (M M D D Y Y Y Y) End Date ____ (M M D D Y Y Y Y)

3 LICENSE / CERT # _____ AGENCY CODE ____

Begin Date ____ (M M D D Y Y Y Y) End Date ____ (M M D D Y Y Y Y)

4 LICENSE / CERT # _____ AGENCY CODE ____

Begin Date ____ (M M D D Y Y Y Y) End Date ____ (M M D D Y Y Y Y)

CATEGORY OF SERVICE: ____ ____ ____ ____ ____

SPECIALTY CODES: ____ ____ ____ ____ ____ ____

____ ____ ____ ____ ____ ____

STATE TRACKING #: _____

ENTITY ID #: _____

CROSS REFERENCE NUMBER: _____

CHOW EFFECTIVE DATE: _____

MAIL SUPPRESSANT: ____ Program:

NOTE: RETURN ALL PAGES OF THIS ENROLLMENT PACKAGE, INCLUDING THIS PAGE

APPENDIX A

CONTROL OF FACILITY CODES

ALL COUNTIES

01 Federal Facility
02 State Teaching Facility
03 State Non-Teaching Facility
04 County Teaching Facility
60 – Federally Qualified
61 – Provisionally Federally Qualified
62 – Prepaid Health Plans (PHP)
63 – State Defined Plans
64 – Physician Case Management Plan

ALL COUNTIES EXCLUDING NEW YORK CITY

05 County Non-Teaching Facility
06 State Non-Teaching Facility - NYSMH
50 Municipal Teaching Facility
51 Municipal Non-Teaching Facility
52 Private, Non-Profit, Charitable or Religious Teaching Facility
53 Private, Non-Profit, Charitable or Religious Non-Teaching Facility
54 Private, Non-Profit, Teaching Facility, Other Than Charitable or Religious
55 Private, Non-Profit, Non-Teaching Facility, Other Than Charitable or Religious
56 Proprietary Teaching Facility
57 Proprietary Non-Teaching Facility
58 Other

NEW YORK CITY ONLY (CIB - city inter-burrough HHC - Health Hospital Corporation)

10 Municipal Teaching Facility - HHC
11 Municipal Non-Teaching Facility - HHC
12 Other - HHC
20 Private, Non-Profit, Charitable or Religious Teaching Facility - CIB
21 Private, Non-Profit, Charitable or Religious Non-Teaching Facility CIB
22 Private, Non-Profit, Teaching Facility, Other Than Charitable or Religious - CIB
23 Private, Non-Profit, Non-Teaching Facility, Other Than Charitable or Religious - CIB
24 Other - CIB
29 CIB - Inpatient & Nursing Home, DSS, Other
30 Municipal Teaching Facility - DOH
31 Municipal Non-Teaching Facility - DOH
32 Other - DOH
40 Municipal Non-Teaching Facility - DSS
41 Private, Non-Profit, Charitable or Religious Teaching Facility - DSS
42 Private, Non-Profit, Charitable or Religious Non-Teaching Facility DSS
43 Private, Non-Profit, Teaching Facility, Other Than Charitable or Religious - DSS
44 Private, Non-Profit, Non-Teaching Facility Other Than Charitable or Religious - DSS
45 Proprietary Teaching Facility - DSS
46 Proprietary Non-Teaching Facility - DSS
47 Other - DSS

APPENDIX B

COUNTY CODES

01 Albany	17 Fulton	33 Orange	49 Tioga
02 Allegany	18 Genesee	34 Orleans	50 Tompkins
03 Broome	19 Greene	35 Oswego	5l Ulster
04 Cattaraugus	20 Hamilton	36 Otsego	52 Warren
05 Cayuga	21 Herkimer	37 Putnam	53 Washington
06 Chautauqua	22 Jefferson	38 Rensselaer	54 Wayne
07 Chemung	23 Lewis	39 Rockland	55 Westchester
08 Chenango	24 Livingston	40 St. Lawrence	56 Wyoming
09 Clinton	25 Madison	4l Saratoga	57 Yates
10 Columbia	26 Monroe	42 Schenectady	58 Bronx
11 Cortland	27 Montgomery	43 Schoharie	59 Kings (Brooklyn)
12 Delaware	28 Nassau	44 Schuyler	60 New York (Manhattan)
13 Dutchess	29 Niagara	45 Seneca	61 Queens
14 Erie	30 Oneida	46 Steuben	62 Richmond (Staten Island)
15 Essex	3l Onondaga	47 Suffolk	99 Other
16 Franklin	32 Ontario	48 Sullivan	