COVER SHEET FOR PROVIDER ENROLLMENT PACKET

PROVIDER INFORMATION-Please complete in full.

Provider Name: _____
(First Name) (MI) (Last Name) (Suffix)

Title:_____
(i.e. MD, DO, CRNA, PA, NP etc.)

Date of Birth:_____ SS#_____

Providers Home Address:

_____
(Address Line One)

_____
(Address Line Two)

_____
(City) (State) (Zip Code)

Telephone: _____ Email: _____

Department/Division:

_____
(Dept.) (Division)

Provider First Day of Billing:_____

Providers Specialty:_____

Collaborating Physician:_____

AMC PRIMARY SERVICE LOCATION:

_____
(Address Line One - Department)

_____
(Address Line Two)

_____
(City) (State) (Zip Code)

Telephone:_____

Fax:_____

PLEASE LIST ALL ESTABLISHED PROVIDER NUMBERS:

MEDICAID:_____

MEDICARE PROVIDER NUMBER:_____

DOWNSTATE MEDICARE:_____

RAILROAD MEDICARE:_____

WORKERS COMP/NO FAULT:_____

NPI NUMBER:_____

DEA NUMBER:_____

NY STATE NP LICENSE NUMBER:_____

NY STATE RN LICENSE NUMBER: _____

ALBANY MEDICAL CENTER

APPLICATION FOR MEDICAL STAFF APPOINTMENT

INSTRUCTIONS: Please complete this application in full; submit this form with your signature.
In no area of the form does the statement "See CV" meet the requirements for a completed application.

This application cannot have any blank or unaddressed areas. Each request for information must be responded to, even if that response is Not Applicable. For your ease of completion, ☐ This Section Not Applicable check boxes, have been logically placed within the application to assure your compliance in completion of the entire application.

Personal Information

Last Name	First Name	Middle Name or Middle Initial	Title

Other Names By Which You Have Been Known Professionally	Degree	NPI #

Home Street Address	Home City/State/Zip

Home Phone Number (**Required**)	Cell Phone Number	Pager Number

Date of Birth	Sex	Social Security #
	☐ Male ☐ Female	

Birth City/State	Birth Country	Citizenship

Medicaid # **<MUST COMPLETE>**	Medicare #	No Fault / Workers Compensation #

Primary Care Practitioner ☐ Yes ☐ No Referral Specialist ☐ Yes ☐ No Accepting New Patients ☐ Yes ☐ No

Age Group(s) You Treat: E-Mail Address*(**Required**):

Office Information

AMCH Primary Practice Site Location

Office Name	Tax ID

Office Street Address

Office City	Office State/Zip	Office Hours	Handicap Access
			☐ Yes ☐ No

Office Phone 1	Office Phone 2	Office Fax

Office Contact/Office Manager	Email Address

Practicing in Association With:

Office Information *Continued*

AMCH Primary Mailing Address, Fax and E-mail Address to Receive Business Correspondence
* Required for Receipt of Business Correspondence / Critical Value Notification

☐ **Same as Primary Office Site Information Above**

Street Address		
City		
State	Zip Code	Email Address
Phone	Fax	Pager

Additional Practice Site Location ☐ **This Section Not Applicable**

Office Name		Tax ID	
Office Street Address			
Office City	Office State/Zip	Office Hours	Handicap Access
			☐ Yes ☐ No
Office Phone 1	Office Phone 2	Office Fax	
Office Contact/Office Manager		Email Address	

Types of Patient Seen

Information shared in this section of the application would be used in communications about you (Albany Medical Center's Website and Direct Mailings as examples). Please list your current areas of expertise, types of unique procedures you perform and/or conditions you treat as you would like them to appear in such communications.

Patients Seen	Special Interests

AMC Practice – Participation

Have you admitted patients to AMC?	☐ Yes ☐ No
If "Yes" to above what is your average number of admissions to AMC per year?	# / Year

Check your preference for Committee area of interest, if you are requested to participate:

☐ Bylaws	☐ Credentials	☐ Cancer	☐ Ethics	☐ OR
☐ Transfusion	☐ Surgical Review	☐ Infection Control	☐ Pharmacy and Therapeutics	

Professional Growth and Development History

◘ Medical Education ◘ Internship ◘ Residency

Medical Education or Professional School **Foreign Medical School Graduates: Attach Copy of ECFMG**

Name Of Institution	Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
	/ /	/ /

Complete Address	E-Mail Address

Phone Number	Fax Number	Degree Obtained

Internship ☐ **This Section Not Applicable**

Name Of Institution	Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
	/ /	/ /

Complete Address	Program Director Name

Phone Number	Fax Number	Specialty	E-Mail Address	Program Director Contact Number

Completed ☐ Yes ☐ No **If No please outline circumstances**

Internship ☐ **This Section Not Applicable**

Name Of Institution	Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
	/ /	/ /

Complete Address	Program Director Name

Phone Number	Fax Number	Specialty	E-Mail Address	Program Director Contact Number

Residency ☐ **This Section Not Applicable**

Name Of Institution	Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
	/ /	/ /

Complete Address	Program Director Name

Phone Number	Fax Number	Specialty	E-Mail Address	Program Director Contact Number

Completed ☐ Yes ☐ No **If No please outline circumstances**

Professional Growth and Development History (Continued)

◘ Residency ◘ Fellowship ◘ Hospital Affiliations ~ Work Experience

Residency ☐ This Section Not Applicable

Name Of Institution				Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
				/ /	/ /
Complete Address				Program Director Name	
Phone Number	Fax Number	Specialty	E-Mail Address	Program Director Contact Number	

Fellowship ☐ This Section Not Applicable

Name Of Institution				Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
				/ /	/ /
Complete Address				Program Director Name	
Phone Number	Fax Number	Specialty	E-Mail Address	Program Director Contact Number	

Completed ☐ Yes ☐ No If No please outline circumstances

Fellowship ☐ This Section Not Applicable

Name Of Institution				Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
				/ /	/ /
Complete Address				Program Director Name	
Phone Number	Fax Number	Specialty	E-Mail Address	Program Director Contact Number	

Current Employer ☐ This Section Not Applicable
If Locum, please complete with name and address of Locum Tenens Company

Name				Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
				/ /	/ /
Street Address				City, State and Zip Code	
Phone Number		Fax Number		Affiliation Status	
Hospital Chief of Service and/or Work Contact Name		E-Mail Address		Contact Number	Fax Number

Reason For Discontinuance or Termination:

◘ Hospital Affiliations ~ Work Experience

☐ **Hospital Affiliation** ☐ **Employer** ☐ **Both** ☐ **This Section Not Applicable**

Name				Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
				/ /	/ /
Street Address				City, State and Zip Code	
Phone Number	Fax Number			Affiliation Status	
Hospital Chief of Service and/or Work Contact Name		E-Mail Address		Contact Number	Fax Number
Reason For Discontinuance or Termination:					

☐ **Hospital Affiliation** ☐ **Employer** ☐ **Both** ☐ **This Section Not Applicable**

Name				Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
				/ /	/ /
Street Address				City, State and Zip Code	
Phone Number	Fax Number			Affiliation Status	
Hospital Chief of Service and/or Work Contact Name		E-Mail Address		Contact Number	Fax Number
Reason For Discontinuance or Termination:					

☐ **Hospital Affiliation** ☐ **Employer** ☐ **Both** ☐ **This Section Not Applicable**

Name				Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
				/ /	/ /
Street Address				City, State and Zip Code	
Phone Number	Fax Number			Affiliation Status	
Hospital Chief of Service and/or Work Contact Name		E-Mail Address		Contact Number	Fax Number
Reason For Discontinuance or Termination:					

Professional Growth and Development History (Continued)

◘ Hospital Affiliations ~ Work Experience

☐ **Hospital Affiliation** ☐ **Employer** ☐ **Both** ☐ **This Section Not Applicable**

Name	Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
	/ /	/ /

Street Address	City, State and Zip Code

Phone Number	Fax Number	Affiliation Status

Hospital Chief of Service and/or Work Contact Name	E-Mail Address	Contact Number	Fax Number

Reason For Discontinuance or Termination:

☐ **Hospital Affiliation** ☐ **Employer** ☐ **Both** ☐ **This Section Not Applicable**

Name	Start Date: MM/DD/YYYY	Finish Date: MM/DD/YYYY
	/ /	/ /

Street Address	City, State and Zip Code

Phone Number	Fax Number	Affiliation Status

Hospital Chief of Service and/or Work Contact Name	E-Mail Address	Contact Number	Fax Number

Reason For Discontinuance or Termination

Please include additional sheets if necessary to list all your previous Hospital Affiliations and/or Work Experience.

Professional Growth and Development History (Continued)

◘ Military Experience ◘ Clinical Teaching Appointments

Military Experience ☐ This Section Not Applicable

List all military experience that has occurred since completion of medical school

Name Of Institution			Supervisor's Name	
Complete Address			Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
			/ /	/ /
Phone Number	Fax Number	E-Mail Address	Rank - Job Title	

Military Experience ☐ This Section Not Applicable

Name Of Institution			Supervisor's Name	
Complete Address			Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
			/ /	/ /
Phone Number	Fax Number	E-Mail Address	Rank - Job Title	

Clinical Teaching Appointments ☐ This Section Not Applicable

List current and previous clinical teaching appointments

Name Of Institution			Supervisor's Name	
Complete Address			Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
			/ /	/ /
Phone Number	Fax Number	E-Mail Address	Job Title	

Clinical Teaching Appointments ☐ This Section Not Applicable

Name of Institution			Supervisor's Name	
Complete Address			Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
			/ /	/ /
Phone Number	Fax Number	E-Mail Address	Job Title	

Professional Growth and Development History (Continued)

◘ Work History Not Captured Previously

Additional History ☐ **This Section Not Applicable**

Name of Institution			Supervisor's Name
Complete Address		Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
		/ /	/ /
Phone Number	Fax Number	E-Mail Address	Job Title
Brief Description of Job Responsibilities			

Additional History ☐ **This Section Not Applicable**

Name of Institution			Supervisor's Name
Complete Address		Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**
		/ /	/ /
Phone Number	Fax Number	E-Mail Address	Job Title
Brief Description of Job Responsibilities			

Gap Explanation

Any time periods or gaps since graduation from medical school of greater than three (3) months which are not explained in the application thus far must be addressed here. Please explain any such gaps in the space provided below.

☐ **This Section Not Applicable**

Gap(s) Description	Start Date: **MM/DD/YYYY**	Finish Date: **MM/DD/YYYY**

Board Certification

* AMC Requires Board Certification within Five (5) Years from Employment

Board Certified Specialty and Subspecialty Name **Submit Certificates**		Year Certified/Recertified **MM/DD/YYYY**	Expiration Date **MM/DD/YYYY**
Primary:	Eligible ☐ Certified ☐		
	Eligible ☐ Certified ☐		
	Eligible ☐ Certified ☐		
	Eligible ☐ Certified ☐		

ID Numbers

State License: List all current and past state licenses.

State of Licensure	Number	Type	Expiration Date ***MM/DD/YYYY***
New York			
Current **NYS** DEA Number (Must be active for Appt.)			Expiration Date **MM/DD/YYYY**

Other ID – Certification Numbers ☐ This Section Not Applicable

Type	Number	Expiration Date ***MM/DD/YYYY***
Certification		
Certification		
Certification		

Professional Societies ☐ This Section Not Applicable

Society	Membership Type	From	To

Continuing Medical Education Credits ☐ This Section Not Applicable

I have included copies of my Continuing Medical Education certificates for the past two (2) years	☐ Yes ☐ No

Professional Liability Coverage

Albany Medical Center requires that coverage be in the amount of $1.3 million per incident and $3.9 million aggregate. If you have current malpractice insurance that meets these requirements please include a copy of the coverage "face sheet" or certificate that addresses the coverage requirements as outlined above.

FOR THOSE APPLYING FOR AMC EMPLOYMENT ONLY: I am or will be an AMC Employee. I am not required to include a copy of my AMC insurance coverage.	☐ Yes ☐ No
I am or will be an AMC Employee and I have additional malpractice insurance. If YES, please include the Face Sheet/Certificate that meets requirements.	☐ Yes ☐ No
I am not (nor will I be) employed by AMC and have current malpractice insurance. If YES, please include the Face Sheet/Certificate that meets requirements.	☐ Yes ☐ No

List all insurance carriers you have used for the past ten (10) years

USE ADDITIONAL PAGES IF NEEDED

Carrier Name:	Policy #:
Carrier Address:	Expiration Date: _____ (MM/DD/YYYY)
Policy Administrator/Entity Covered by Policy:	Phone #: _____ Fax #: _____
Carrier Name:	Policy #:
Carrier Address:	Expiration Date: _____ (MM/DD/YYYY)
Policy Administrator/Entity Covered by Policy:	Phone #: _____ Fax #: _____
Carrier Name:	Policy #:
Carrier Address:	Expiration Date: _____ (MM/DD/YYYY)
Policy Administrator/Entity Covered by Policy:	Phone #: _____ Fax #: _____

Has any liability carrier ever canceled or refused you coverage?	☐ Yes ☐ No
Are you, or have you been, the subject of any past or pending claims, suits or judgments OR have you and your insurance carrier(s) ever settled such a claim or action? **If you answered "Yes" to either of these questions please complete the narrative Malpractice History below.**	☐ Yes ☐ No

Malpractice History "Yes" to Above

Identify any medical malpractice actions in this state and / or in any other state; describe the following for each scenario:
√ substance of the allegations √ findings or actions √ other information regarding proceedings you believe appropriate

☐ **This Section Not Applicable**

Peer References

Include the names of three (3) individuals, one Department Chief/Chair, and 2 Licensed Independent Practitioners (Attending, PA, NP, etc) who can attest to your current clinical competence and professional performance. DO NOT INCLUDE current partners, residents, fellows or relatives as a peer reference. The peer names that you provide must have the same domain of professional expertise that you have and must have had exposure to your clinical practice within the past two (2) years. A copy of your requested delineation of privileges (DOP) will be included with the peer reference letters. A copy of your signed release will be included in your peer reference packets.

Department Chief / Chair Reference	Title, First Name, Last Name	Phone Number
Complete Address		Fax Number
Email:		
Peer (1) Reference Name	Title, First Name, Last Name	Phone Number
Complete Address		Fax Number
Email:		
Peer (2) Reference Name	Title, First Name, Last Name	Phone Number
Complete Address		Fax Number
Email:		

Physician Proctor

All new members of the Medical Staff require a Physician Proctor (Dentist/Podiatrist). If you would like to make a suggestion(s) for your proctor please indicate below. Suggested proctors **must be approved** by your Chief of Service. If you do not have a suggestion, your Chief of Service will assign you a proctor.

Suggested Proctor	Title, First Name, Last Name
Suggested Proctor	Title, First Name, Last Name

Chief of Service Assigned Proctor	**ASSIGNED**	**Title, First Name, Last Name**

Disciplinary Actions

The following questions **must** be answered.
Any questions answered with a "Yes" **must** be explained as to action taken and resolution.

1.	Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily or involuntarily relinquished:	
a.	Medical License in any state	☐ Yes ☐ No
b.	DEA Registration	☐ Yes ☐ No
c.	Academic appointment or education affiliation	☐ Yes ☐ No
d.	Membership and/or clinical privileges on hospital staff	☐ Yes ☐ No
e.	Professional society membership	☐ Yes ☐ No
f.	Professional board certification	☐ Yes ☐ No
g.	Participant or payment status under Medicare, Medicaid or any other state or federally funded health program	☐ Yes ☐ No
h.	Any other type of professional sanction or Reprimand Censure	☐ Yes ☐ No
2.	Have you ever been the subject of a professional disciplinary action before a licensing agency?	☐ Yes ☐ No
3.	Have you ever entered a plea of guilty or have you ever been convicted of a felony in any State or Federal Court?	☐ Yes ☐ No

Please provide a description of the circumstances for any of the questions above answered with a **"Yes"** response below

☐ **This Section Not Applicable**

Affirmation

You **must** initial next to each affirmation.

Initials	Affirmation Statement
	I pledge to provide for continuous care for my patients.
	I agree to familiarize myself with and abide by the Bylaws and Rules and Regulations of the Hospital and Medical Staff.
	I affirm my willingness to attend all Medical Staff / Departmental Meetings as **required by the Bylaws.**
	I affirm my willingness to participate in Medical Staff Committees and Subcommittees as **required by the Bylaws.**
	I affirm that I will not engage in unlawful division of professional fees under any guise whatsoever.
	I am aware of the requirement to completed medical records:
	I am aware that failure to do so will result in suspension of my privileges to practice at AMC.
	I am aware that four (4) such suspensions in one calendar year will result in automatic termination.
	I understand that submission of certificates of Continuing Medical Education activities must be done on an every other year basis.
	I understand that Albany Medical Center has a Corporate Compliance Plan which focuses on compliance with New York State and federal billing laws and regulations, as well as laws concerning other financial transactions (e.g., Stark law, anti-kickback). I further understand that, as a member of the Medical Staff of Albany Medical Center Hospital and Albany Medical Center - South Clinical Campus, if I become aware of possible non-compliance issues involving Albany Medical Center and/or its employees, I am obligated to report such issues by calling the confidential Compliance Hotline at 518-262-TIPP. Calls to the hotline may be made anonymously. Further information on AMC's Corporate Compliance Program and copies of AMC's Corporate Compliance Plan are available by calling the Corporate Compliance & Audit Department at 518-262-4692.
	I understand that the current photo ID submitted for my credentialing process will be utilized to ensure my identity. All facilities that I'm affiliated with will be sent a copy of the photo with all references/verifications used in the credentialing process.
	I authorize Albany Medical Center to fill medication orders by dispensing any generic or nonproprietary drug listed in the applicable Hospital formulary, in accordance with Education Department regulations, unless I personally specify in writing that only a particular brand-name drug may be supplied.
	I authorize Albany Medical Center to consult with governmental agencies, other hospitals, institutions and professional liability insurance carriers, in order to verify any information in this application or to obtain information which may be material to the evaluation of my qualifications for reappointment to the medical staff of Albany Medical Center. For the purpose of this evaluation, I waive any confidentiality provisions which may otherwise apply to such information
	I release from liability all representatives of Albany Medical Center and its affiliates for acts performed in good faith and without malice in connection with the evaluation of my credentials and qualifications. I also release from liability all individuals, institutions and organizations which provide information in good faith and without malice to the Hospital in connection with this application.
	I certify under penalty of perjury that the information in this application and all accompanying documents is complete, true and accurate. I waive any confidentiality rights which I may have concerning the information in this application and concerning other information material to the evaluation of this application.

_____ Date _____

Signature of Applicant

_____

Printed Name of Applicant

Applicant Name _____

I have reviewed all of the documents presented by the applicant for medical staff membership, which includes:

- **Completed Initial Application and Attestation Form**
- **Appointment Reference Form(s)**
- **Selected Proctor**

By signing below, I am affirming my recommendation of this applicant for AMCH medical staff membership.

_____ _____

Chief of Service **Date**

==========

2nd SERVICE CHIEF (If applicable)

By signing below, I am affirming my recommendation of this applicant for AMCH medical staff membership.

_____ _____

2nd Chief of Service **Date**

RECOMMENDED BY CREDENTIALING COMMITTEE (COMMUNITY STAFF ONLY):

_____ _____

Credentialing Committee Member **Date**

RECOMMENDED BY EXECUTIVE COMMITTEE:

_____ _____

Secretary of Executive Committee **Date**

APPOINTED BY GOVERNING BOARD:

_____ _____

Secretary of Governing Board **Date**

TO BE EFFECTIVE ON: _____/ _____/_20_____

APPLICANT MUST SPECIFY MEDICAL STAFF STATUS BEING REQUESTED (AMCH)

Date of Hire/Start: _____

☐ **Attending** (Physicians, Dentists & Podiatrists) shall consist of individuals who are actively practicing medicine, dentistry of podiatry in the Hospital. They must be available for teaching assignment and at the discretion of the Service Chief and the Medical Director, to be "On Call" in the AMCH Emergency Department.

☐ **Consultant** (Physicians, Dentists & Podiatrists) shall consist of specialists whose services are required by the Hospital. They are required to pay dues, but not required to attend Medical Staff meetings or take call in the AMCH Emergency Department.

☐ **Community Staff** (Physicians, Dentists & Podiatrists) shall consist of local practitioners who refer their patients to the Hospital. They shall not have any clinical functions within the Hospital. They may have access to records of patients with whom they have documented, currently active practitioner-patient relationships, but may not make entries into such records. They are not required to pay dues or take call in the AMCH Emergency Department.
NOTE: **NO Delineation of Privilege (DOP) From is required for this status category.**

☐ **Affiliate** (Non Physicians) please select one category from below & Status:

☐Physician Assistant ☐ Nurse Practitioner ☐ Certified Registered Nurse Anesthetist (GNA/CRNA)
☐ Clinical Psychologist-PhD ☐ Nurse Midwife ☐ Specialist Assistant
☐ Other (as approved by the AMCH Medical Director:_____

Status: ☐ **Faculty** ☐ **Hospital** ☐ **Non-Faculty** ☐ **Full-time** ☐ **Non-GME Fellow** ☐ **Other** _____

AMCIDS

APPLICATION COMPLETION JUNCTURE

These two (2) Health related questions apply to your application as an individual who will be BILLING through Albany Medical Center

Health Related

Answer the two (2) **Billing via AMC** questions below using the "Yes" or "No" check boxes.

1.	Are you able to perform the essential functions of clinical practice with or without accommodations?	☐ Yes ☐ No
2.	Do you currently use drugs illegally?	☐ Yes ☐ No

Applicant Must Complete (AMCIDS)

Date of Hire/Start: _____

Specify status:

☐ **Faculty** (Physicians & Dentists) please select your category(ies) from below:
☐ Full-time ☐ Part-Time ☐ Per-Diem ☐ Paid ☐ Not Paid ☐ Other _____

☐ **Non-Faculty** (Physicians & Dentists) please select your category(ies) from below:
☐ Full-time ☐ Part-Time ☐ Per-Diem ☐ Delegated Credentialing Only ☐ Other _____

☐ **Ancillary** (All providers that do not fall under Faculty/Non-Faculty) please select one category from below & Status:

☐ Audiologist	☐ Certified Diabetes Educator	☐ Certified Registered Nurse Anesthetist	☐ Certified Social Worker
☐ Clinical Psychologist-PhD	☐ Nurse Practitioner	☐ Optometrist	☐ Occupational Therapist
☐ Physical Therapist	☐ Physician Assistant	☐ Registered Dietitian	☐ Speech/Language Pathologist

☐ Other _____

Status: ☐ **Faculty** ☐ **Hospital** ☐ **Non-Faculty** ☐ **Full-time** ☐ **Non-GME Fellow** ☐ **Other** _____

AMCIDS

APPLICATION COMPLETION JUNCTURE

The following one page Release and Attestation apply to your application as an individual who will be BILLING through Albany Medical Center

Please Print, Complete and Return by Mail

Release

I Authorize Albany Medical Center to consult with other hospitals, institutions, and professional liability insurance carriers, in order to obtain information that may be material to the evaluation of my qualifications for appointment or re-appointment to the Albany Medical Center Integrated Delivery Systems Managed Care Credentialing Network and affiliated institutions. Information required for AMC IDS Managed Care Credentialing includes but is not limited to demographic data, licensure, education and training, professional liability claims history, and National Practitioner Data bank queries. For the purpose of this evaluation, I waive any confidentiality provisions which may otherwise apply to such information.

I release from liability all representatives of Albany Medical Center and its affiliates for acts performed in good faith and without malice in connection with evaluating my credentials and qualifications. I also release from liability all individuals and organizations who provide information to Albany Medical Center concerning my qualifications for re-appointment in good faith and without malice.

I understand that the current photo ID submitted for my credentialing process will be utilized to ensure my identity. All facilities that I'm affiliated with will be sent a copy of the photo with all references/verifications used in the credentialing process.

I understand that managed care organizations and third-party payors with which AMC has participation agreements may be granted controlled access to certain practitioner information in the course of their credentialing activities, such as credentialing functions required for National Committee on Quality Assurance (NCQA) accreditation; however, information as to which confidentiality cannot be waived under New York State Law will not be voluntarily disclosed.

Attestation

All information submitted to the AMC Integrated Delivery Systems Managed Care Credentialing

is correct and complete to the best of my knowledge and belief.

_____ Date _____
Signature of Applicant

_____
Printed Name of Applicant

ALBANY MEDICAL CENTER

NURSE PRACTITIONER AGREEMENT

Instructions:
The agreement must be signed by both the Nurse Practitioner and the Collaborating Physician.
The Protocols and Clinical Pathways and Protocols must be listed below; they should also be reviewed periodically and updated as necessary.
The agreement must be re-executed within two (2) years of the date.

Nurse Practitioner ("NP") _____ Collaborating Physician ("Physician") _____
Specialty : _____ Specialty: _____
Certificate Number: _____

Protocols (*List*) _____
_____

Clinical Pathways and Protocols (*List*) _____
_____
_____

Practice Setting (*Check all that apply - note: Physician must be able to access medical records at all sites designated*)
☐ Albany Medical Center Hospital
☐ Albany Medical Center - South Clinical Campus
☐ Albany Medical College (Practice Plan)
☐ Other (List) _____

The undersigned have read and understood the contents of this agreement and agree to be bound by all of the terms and conditions of the agreement.

Dated: _____, 201__

_____ _____
Nurse Practitioner Collaborating Physician

This is a Practice Agreement (the "Practice Agreement") by and between the NP named above and the Physician named above, a licensed physician with privileges at the Practice Settings checked above.
Recitals: The NP is a registered professional nurse who has satisfactorily completed an advanced program of professional study for a nurse practitioner and who has been certified as a nurse practitioner by the New York State Education Department pursuant to Section 6910 of the Education Law of New York State (the "Education Law"), and as such may diagnose illness and physical conditions and perform therapeutic and corrective measures within a specialty area of practice in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols.
Specialty: The NP has been certified by the New York State Education Department with an area of specialty in the Specialty designated above for NP. The Physician has an area of specialty in the Specialty (designated above) for which the Physician is at least board eligible and is privileged at the Practice Settings designated above.
NP Qualifications: The NP represents that he or she has obtained all necessary licenses and certifications for his or her practice as a

(Continued on reverse)

Albany Medical Center Hospital

Mandatory HIPAA Training

To facilitate the training process, we have developed a web-based HIPAA Privacy course on the Albany Medical Center Website. All physicians who practice at Albany Medical Center must complete training.

In 1996, the Congress approved The Health Insurance Portability and Accountability Act (HIPAA). This federal legislation governs (among other things), the privacy and security of individually identifiable health information (termed Protected Health Information or PHI in the regulations). This legislation has clear implications for anyone working in health care and related research. **The law also requires that institutions train all members of its workforce on HIPAA policies and procedures with respect to PHI.** AMC's HIPAA training program will provide a general overview of HIPAA regulations.

To access the training website, please feel free to email either Pobletc@mail.amc.edu (Carmina Poblete) or Haddont@mail.amc.edu (Tina Hadden) and request access to the AMC HIPAA training module. In turn you will receive two e-mails, one with a link to access the module and a second e-mail providing you a Username & Password.

If you are unable to access the website please contact **Center for Learning and Development at 262-3705 with any questions or concerns.** The web-based training takes about 15 minutes to complete.

If you have completed HIPAA training elsewhere, please sign the bottom of this document, and return it to Credentialing Department, Albany Medical Center, MC 156, 43 New Scotland Ave, Albany, NY 12208.

Sincerely,

Dennis McKenna, MD
Medical Director

I have completed HIPAA training at _____ Date _____
and therefore do not require additional HIPAA training at Albany Medical Center

Name_____

Signature_____

ALBANY MEDICAL CENTER

RELEASE

I authorize Albany Medical Center to consult with other hospitals, institutions, and professional liability insurance carriers, in order to obtain information that may be material to the evaluation of my qualifications for appointment or re-appointment to the Medical Staff of Albany Medical Center Hospital and/or Albany Medical Center South Clinical Campus. For the purpose of this evaluation, I waive any confidentiality provisions which may otherwise apply to such information.

I release from liability all representatives of Albany Medical Center for acts performed in good faith and without malice in connection with evaluating my credentials and qualifications. I also release from liability all individuals and organizations who provide information to the hospital concerning my qualifications for appointment or reappointment in good faith and without malice.

Signature _____

Print Name _____

Date _____

*Must be handwritten

Albany Medical Center

Physician Acknowledgment Statement

Notice to Physicians

Payment to hospitals for inpatient services is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, and for neonates, upon birthweight or admission weight as well. This data must be documented by the patient's medical record. Anyone who misrepresents, falsifies, or conceals this information may be subject to fine, imprisonment, or civil penalty under applicable Federal and New York State Laws.

Medicare/CHAMPUS payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal Laws.

SIGNATURE _____

PRINT NAME* _____

DATE* _____

*Must be handwritten

Albany Med Faculty Physicians

Over 300 Experts Practicing What They Teach

Meaningful Use Attestation Query

Provider Name: _____

Department / Division: _____

NPI: _____

Previous Employer:	
Previous Employer MU Contact:	
Attested under: Medicare / Medicaid	
Meaningful Use Attestation Year:	
Or, how many years have you attested for previously?	

Website	**User ID**	**Password**
Medicare / Medicaid Registration (NPPES)		

MU Team Use ONLY		
EPs Stage & Year		
Date JIRA Opened		
IT Use ONLY	**IS Team Member Responsible**	**Date**
Jira Ticket Received		
Added to MU Group & DB in MU Trending DB		
UMP Set Up & Quality report selections specified		
Jira Ticket Closed with this form attached and filled out		

Reviewed by: _____ Date Physician added to SharePoint: _____

NY MEDICAID PROVIDER ENROLLMENT FORM
for
PRACTITIONERS
(not including Physicians)

Mail to:

Computer Sciences Corporation
PO Box 4603
Rensselaer, NY 12144-4603

Category(s) of Service: Enter the 4-digit code(s) given in the instructions: 0469 _____

☐ 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**		
NPI (Individual) – if incorporated, completion of a Group application is also necessary.		SSN
License #	State of Licensure if not New York	Limited License? ☐ Yes ☐ No
Applicant's e-Mail Address - **REQUIRED**:		Are you enrolled in Medicare? ☐ Yes ☐ No
DEA Number (if required)	DEA Effective Date (MM/DD/YYYY)	DEA Expiration Date (MM/DD/YYYY)
If affiliated with a Group, do you have a Private Practice as well? ☐ Yes ☐ No ☐ N/A	If member of a group or organization: Group/Org Name: _____	If member of a group or organization: Group/Org NPI: _____

CORRESPONDENCE: (indicate where letters and claims forms, if any, should be sent) – PO Box not acceptable		
Attention: Albany Medical College	Street Address 618 Central Ave.	Suite / Department/ Floor
City	State	Zip Code (9 digit) 12206-1916
County (if in New York) Albany	Telephone Number (w/ extension) 518-262-9600	Fax Number 518-262-9723
PAY TO ADDRESS: (indicate where checks & remittance statements should be sent until EFT and e-Remits are in place):		
Attention: Albany Medical College	Street Address or PO Box Po Box 416760	Suite / Department/ Floor
City Boston	State Massachusetts	Zip Code (9 digit) 02241-6760
County (if in New York)	Telephone Number (w/ extension) 518-262-9600	Fax Number 518-262-9723
CORPORATE ADDRESS: (indicate where Annual Tax Documents (Form 1099) should be sent)		
Attention: Albany Medical College	Street Address or PO Box Po Box 416760	Suite / Department/ Floor
City Boston	State Massachusetts	Zip Code (9 digit) 02241-6760
County (if in New York)	Telephone Number (w/ extension) 518-262-9600	e-Mail Address - **REQUIRED**

{**If additional space is needed, copy form; all entries must be on the form**}

SERVICE ADDRESS: (where service is provided) – **DO NOT LIST A PATIENT'S ADDRESS** (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) ☐ Individual (1) ☐ Group (2)	Place of Service (Check One) ☐ Private Office (1) ☐ Freestanding Clinic (3) ☐ Hospital/Nursing Home (2)	

SERVICE ADDRESS: (where service is provided) – **DO NOT LIST A PATIENT'S ADDRESS** (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) ☐ Individual (1) ☐ Group (2)	Place of Service (Check One) ☐ Private Office (1) ☐ Freestanding Clinic (3) ☐ Hospital/Nursing Home (2)	

SERVICE ADDRESS: (where service is provided) – **DO NOT LIST A PATIENT'S ADDRESS** (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) ☐ Individual (1) ☐ Group (2)	Place of Service (Check One) ☐ Private Office (1) ☐ Freestanding Clinic (3) ☐ Hospital/Nursing Home (2)	

SERVICE ADDRESS: (where service is provided) – **DO NOT LIST A PATIENT'S ADDRESS** (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) ☐ Individual (1) ☐ Group (2)	Place of Service (Check One) ☐ Private Office (1) ☐ Freestanding Clinic (3) ☐ Hospital/Nursing Home (2)	

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 digit)
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 digit)
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:

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 (e.g., 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	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address	City & State		Zip Code (9 digit)
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

Return To: Computer Sciences Corporation
PO Box 4610
Rensselaer NY 12144-4610

COLLABORATING PHYSICIAN CERTIFICATION FORM

This form must be completed and signed by your collaborating physician.

Physician Name: _____

Physician License Number: _____

Physician National Provider Identifier (NPI) (Required): _____

Physician Medicaid Provider # (Required): _____

Physician Current Address: _____

_____

_____

Certification Statement:

In accordance with the requirements of the laws and regulations of the State Department of Education, I have established a collaborative agreement and practice protocols with

_____. Effective _____.
(Name of Nurse Practitioner) (Date of Agreement)

Nurse Practitioner National Provider Identifier (NPI) (Required): _____

Nurse Practitioner Medicaid Provider # (Required): _____

Physician Signature _____ Date _____

MAIL TO: Computer Sciences Corporation
P.O. Box 4610
Rensselaer, NY 12144-4610

Date___/___/___

MEDICAID FEE FOR SERVICE PROVIDER CHANGE OF ADDRESS FORM

Medicaid Provider Number (Required)	**National Provider Identifier (Required, unless NPI exempt)**	**Category of Service**

Provider Name: _____

I wish to change the address to which my Correspondence and Claim Forms are sent.

LOCATOR 01: **CORRESPONDENCE ADDRESS –** Must specify a street address. Cannot be a P.O. Box unless accompanied by an actual street address.

Begin date: _____
M M D D Y Y

ATTENTION: Albany Medical College

STREET: 618 Central Ave

CITY: Albany

STATE: NY ZIP: 12206 - _____ COUNTY CODE: 01

TELEPHONE: 518-262-9600

Please send my MEDICAID CHECKS to the address below.

LOCATOR 02: **PAY TO ADDRESS**

Begin date: _____
M M D D Y Y

STREET: Po Box 416760

CITY: Boston

STATE: MA ZIP: 02241 - 6760 COUNTY CODE: ____

PRINT NAME: _____

►PROVIDER SIGNATURE:_____

NOTE: Photocopy or stamp is *unacceptable* for signature.
If this change is for a Group**,** then the Administrator or Owner must sign and declare title**.**
If this is a business or corporation, then Owner must sign**.**

SERVICE ADDRESSES

Each address where you see Medicaid beneficiaries must be listed on our file. If no service address changes are necessary, leave this blank. Any addresses to be changed, closed or added should be listed below. Please write **CHANGE, CLOSE** or **ADD** next to that address and Locator number, if known. *A Service Address must be a street address and cannot be a P.O. Box.*

Begin date: ______________
M M D D Y Y

ATTENTION: ______________

STREET: ______________

CITY: ______________

STATE: ______________ ZIP: ______ - ______ COUNTY CODE: ______

TELEPHONE: ______________

Begin date: ______________
M M D D Y Y

ATTENTION: ______________

STREET: ______________

CITY: ______________

STATE: ______________ ZIP: ______ - ______ COUNTY CODE: ______

TELEPHONE: ______________

Begin date: ______________
M M D D Y Y

ATTENTION: ______________

STREET: ______________

CITY: ______________

STATE: ______________ ZIP: ______ - ______ COUNTY CODE: ______

TELEPHONE: ______________

Begin date: ______________
M M D D Y Y

ATTENTION: ______________

STREET: ______________

CITY: ______________

STATE: ______________ ZIP: ______ - ______ COUNTY CODE: ______

TELEPHONE: ______________

PHOTOCOPIES OF THIS PAGE MAY BE USED WHEN REPORTING MORE THAN 4 SERVICE ADDRESSES

MAIL TO: Computer Sciences Corporation
P.O. Box 4610
Rensselaer, NY 12144

REQUEST FOR MEDICAID PARTICIPATION AS A GROUP MEMBER
Form must be completed in <u>black</u> ink.

1. Individual Provider Name: _____

2. Individual Provider Number: _____
(You must enroll to participate) 10-digit NPI (Required)

_____
8-digit Medicaid ID (Required)

3. Name of Group: _____

4. Group's Provider Number: _____
10-digit NPI (Required)

_____
8-digit Medicaid ID (Required)

5. List the Service address(es) (for the above named group only) where you will work as a member. Do not list private practice service addresses.

(a) _____ (c) _____
_____ _____
_____ _____

(b) _____ (d) _____
_____ _____
_____ _____

6. List the first Date of Service that services were rendered to Medicaid patients as part of the Group.

_____
Month Day Year

I agree to participate in the Medicaid Program as a member of the above listed group. I realize that I continue to remain personally responsible for all claims billed to Medicaid using both group Medicaid identification number and my individual provider number. I may have my name withdrawn from the above listed group upon written request to the above address.

Name (please print): _____
(First) (Full Middle Name) (Last)

Signature: _____

Date: _____

eMedNY/MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID

As of date signed below, all claims submitted electronically or on paper to the State's Medicaid fiscal agent, for services or supplies furnished.

(1) by (provider name) _____

(2) (10-digit National Provider ID (NPI) -- REQUIRED unless exempted from NPI)

(3) (Tax ID if NPI exempt)

will be subject to the following certification.

I am (or the business entity named in this form of which I am a partner, officer, or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the persons providing services, care and supplies have the necessary licensing, certification, training and experience to perform the claimed services; I have reviewed these claims; I (or the entity) have furnished or caused to be furnished the care, services, and supplies itemized and done so in accordance with applicable federal and state laws and regulations; I have read the eMedNY Provider Manual and all revisions thereto; all claims are made in full compliance with the pertinent provisions of the Manual and revisions; all claims for care, services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the manual and revisions. All care, services and supplies for which claim is made are medically necessary for the treatment of the named recipient, the amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any other source other than the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL STATEMENTS, DATA AND INFORMATION TRANSMITTED ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE FINED AND/OR PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY VIOLATION OF THE TERMS OF THIS CERTIFICATION, INCLUDING BUT NOT LIMITED TO FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding these claims and payment therefor shall be promptly furnished upon request to the local Department of Social Services, the State Department of Health, the Office of the Medicaid Inspector General, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirement of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to claims submitted under this agreement to enable its automated processing, subject to reversal by the provider, and (2) accept the claim under this agreement as original evidence of care, services and supplies furnished.

In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health and the Office of the Medicaid Inspector General as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulation of New York State and other publications of the Department, including eMedNY Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of the law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or my entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I UNDERSTAND THAT MY SIGNATURE HEREON THE ABOVE CERTIFICATION WILL APPLY TO ALL CLAIMS SUBMITTED ELECTRONICALLY OR ON PAPER, USING MY (OR THE ENTITY'S) NPI OR MEDICAID PROVIDER IDENTIFICATION NUMBER. THIS CERTIFICATION REMAINS IN EFFECT AND APPLIES TO ALL CLAIMS UNTIL SUPERSEDED BY ANOTHER PROPERLY EXECUTED CERTIFICATION STATEMENT.

(4) (Signature) _____(5) (Date) _____

(6) (Print Name and Title) _____

(7) (Telephone #) _____ (8) (eMail, if available) _____

STATE OF _____
COUNTY OF _____ (9)

On this _____ day of _____, 20____, before me personally came

_____, to me know and known to me to the individual described in and who executed the foregoing instrument, and (s)he acknowledge to me that (s)he executed the same.

(SEAL)

_____
NOTARY PUBLIC

MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 26 TO FIND THE LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

WHO SHOULD COMPLETE THIS APPLICATION

Physicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855I).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll/*.

Physicians and non-physician practitioners who are enrolled in the Medicare program, but have not submitted the CMS 855I since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855I) as an initial application when reporting a change for the first time.

All physicians, as well as all non-physician practitioners listed below, must complete this application to initiate the enrollment process:

Anesthesiology Assistant
Audiologist
Certified nurse midwife
Certified registered nurse anesthetist
Clinical nurse specialist
Clinical social worker
Mass immunization roster biller
Nurse practitioner
Occupational therapist in private practice
Physical therapist in private practice
Physician assistant
Psychologist, Clinical
Psychologist billing independently
Registered Dietitian or Nutrition Professional
Speech Language Pathologist

If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete this application if you are an individual practitioner who plans to bill Medicare and you are:

- An individual practitioner who will provide services in a private setting.
- An individual practitioner who will provide services in a group setting. If you plan to render all of your services in a group setting, you will complete Sections 1-4 and skip to Sections 14 through 17 of this application.
- Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location).
- An individual who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.

If you provide services in a group/organization setting, you will also need to complete a separate application, the CMS-855R, to reassign your benefits to each organization. If you terminate your association with an organization, use the CMS-855R to submit that change.

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare healthcare supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at *https://NPPES.cms.gov*. For more information about NPI enumeration, visit *www.cms.gov/NationalProvIdentStand*.

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare Legacy Number, is a generic term for any number other than the NPI that is used to identify a Medicare supplier.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

Type or print all information so that it is legible. Do not use pencil.

- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.
- Send the completed application with original signatures and all required documentation to your designated fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the correspondence address shown in Section 2 is the supplier's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Send the completed application with all supporting documentation to your designated fee-for-service contractor.

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll*.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

Certain information you provide on this form is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to *www.cms.gov/MedicareProviderSupEnroll*.

SECTION 1: BASIC INFORMATION

A. Check one box and complete the required sections.

Since physician assistants do not complete Section 4, all physician assistants must furnish their Medicare Identification Number (if issued) and their NPI here:

Medicare Identification Number(s):_____ NPI:_____

If you are reassigning all of your Medicare benefits per section 4B1 of this application, furnish your Medicare Identification Number (if issued) and your individual (Type 1) NPI here:

Medicare Identification Number(s):_____ NPI:_____

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **enrolling with another fee-for-service contractor**	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**
☐ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued)*: National Provider Identifier *(if issued)*:	Sections **1A, 13** and **15** Physician Assistants must complete Sections **1A, 2F, 13** and **15** Employers terminating Physician Assistants must complete Sections **1A, 2G, 13** and **15**
☐ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	Go to Section **1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number *(if issued)* and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections**

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections.

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13** and **15**
☐ Final Adverse Actions/Convictions	**1, 2A, 3, 13 and 15**
☐ Practice Location Information, Payment Address and Medical Record Storage Information	**1, 2A, 3, 4** (complete only those sections that are changing), **13** and **15**
☐ Individuals Having Managing Control	**1, 2A, 3, 6, 13,** and **15**
☐ Billing Agency Information	**1, 2A, 3, 8** (complete only those sections that are changing), **13** and **15**

SECTION 2: IDENTIFYING INFORMATION

A. Personal Information: Your name, date of birth, and social security number must coincide with the information on your social security record.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Other Name, First	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Type of Other Name

☐ Former or Maiden Name ☐ Professional Name ☐ Other *(Describe)*:_____

Date of Birth *(mm/dd/yyyy)*	State of Birth	Country of Birth

Gender	Social Security Number
☐ Male ☐ Female	

Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*	DEA Number *(if applicable)*

License Information

☐ License Not Applicable

License Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

New Patient Status Information

Do you accept new Medicare patients? ☒ Yes ☐ No

B. Correspondence Address

Provide contact information for the person shown in Section 2A above. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(518) 262-1333		

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. Resident/Fellow Status

1. Are you currently in an approved training program as:
   a. A resident? ☐ YES ☐ NO
   b. In a fellowship program? ☐ YES ☐ NO

   - If NO, skip to Section 2D.
   - If YES to either of the above questions, provide the name and address of the facility where you are a resident or fellow on the following lines:

   _____

   _____

   _____

2. Are the services that you render at the facility shown in Section 2C1 part of your requirements for graduation from a formal residency or fellowship program? ☐ YES ☐ NO

   Date of Completion:_____. If your completion date is prior to the beginning date for your practice in Section 4, skip to Section 2D.

3. Do you also render services at other facilities or practice locations? IF YES, you must report these practice locations in Section 4. ☐ YES ☐ NO

4. Are the services that you render in any of the practice locations you will be reporting in Section 4 part of your requirements for graduation from a residency or fellowship program? ☐ YES ☐ NO

IF YES, has the teaching hospital reported in Section 2C1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility. ☐ YES ☐ NO

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. 1. Physician Specialty

Designate your primary specialty and all secondary specialty(s) below using:
P=Primary S=Secondary

You may select only one primary specialty. You may select multiple secondary specialties. A physician must meet all Federal and State requirements for the type of specialty(s) checked.

- ☐ Addiction medicine
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac surgery
- ☐ Cardiovascular disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal surgery (Proctology)
- ☐ Critical care (Intensivists)
- ☐ Dermatology
- ☐ Diagnostic radiology
- ☐ Emergency medicine
- ☐ Endocrinology
- ☐ Family practice
- ☐ Gastroenterology
- ☐ General practice
- ☐ General surgery
- ☐ Geriatric medicine
- ☐ Gynecological oncology
- ☐ Hand surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hospice
- ☐ Infectious disease
- ☐ Internal medicine
- ☐ Interventional Pain Management
- ☐ Interventional radiology
- ☐ Maxillofacial surgery
- ☐ Medical oncology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral surgery (Dentist only)
- ☐ Orthopedic surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Palliative Care
- ☐ Pathology
- ☐ Pediatric medicine
- ☐ Peripheral vascular disease
- ☐ Physical medicine and rehabilitation
- ☐ Plastic and reconstructive surgery
- ☐ Podiatry
- ☐ Preventive medicine
- ☐ Psychiatry
- ☐ Psychiatry (geriatric)
- ☐ Pulmonary disease
- ☐ Radiation oncology
- ☐ Rheumatology
- ☐ Sports Medicine
- ☐ Surgical oncology
- ☐ Thoracic surgery
- ☐ Urology
- ☐ Vascular surgery
- ☐ Undefined physician type

(Specify):_____

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

D. 2. Non–Physician Specialty

If you are a non-physician practitioner, check the appropriate box to indicate your specialty.

All non-physician practitioners must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact the Medicare fee-for-service contractor.

Check only one of the following: If you want to enroll as more than one non-physician specialty type, you must submit a separate CMS-855I application for each.

- ☐ Anesthesiology assistant
- ☐ Audiologist
- ☐ Certified nurse midwife
- ☐ Certified registered nurse anesthetist
- ☐ Clinical nurse specialist
- ☐ Clinical social worker
- ☐ Mass immunization roster biller
- ☐ Nurse practitioner
- ☐ Occupational therapist in private practice
- ☐ Physical therapist in private practice
- ☐ Physician assistant
- ☐ Psychologist, clinical
- ☐ Psychologist billing independently
- ☐ Registered dietitian or nutrition professional
- ☐ Speech Language Pathologist
- ☐ Undefined non-physician practitioner type *(Specify)*:

_____

_____

_____

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

E. Physician Assistants: Establishing Employment Arrangement(s)

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

F. Physician Assistants: Terminating Employment Arrangement(s)

Complete this section if you are a physician assistant discontinuing your employment with a practice.

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	EMPLOYER'S NPI	EMPLOYER'S EIN

G. Employer Terminating Employment Arrangement with One or More Physician Assistants

This section should be used by an individual who has incorporated or is a sole proprietor, and who is discontinuing their employment arrangement with a physician assistant.

PHYSICIANS ASSISTANT'S NAME	EFFECTIVE DATE OF DEPARTURE	PHYSICIANS ASSISTANT'S MEDICARE IDENTIFICATION NUMBER A (IF ISSUED)	PHYSICIANS ASSISTANT'S NPI

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

H. Clinical Psychologists

Do you hold a doctoral degree in psychology? ☐ YES ☐ NO

If YES, furnish the field of your psychology degree_____

Attach a copy of the degree with this application.

I. Psychologists Billing Independently

1. Do you render services of your own responsibility free from the administrative control of an employer such as a physician, institution, or agency? ☐ YES ☐ NO
2. Do you treat your own patients? ☐ YES ☐ NO
3. Do you have the right to bill directly, and to collect and retain the fee for your services? ☐ YES ☐ NO
4. Is this private practice located in an institution? ☐ YES ☐ NO
   If YES to question 4 above, please answer questions "a" and "b" below.
   a) If your private practice is located in an institution, is your office confined to a separately identified part of the facility that is used solely as your office and cannot be construed as extending throughout the entire institution? ☐ YES ☐ NO
   b) If your private practice is located in an institution, are your services also rendered to patients from outside the institution or facility where your office is located? ☐ YES ☐ NO

J. Physical Therapists/Occupational Therapists in Private Practice (PT/OT)

The following questions only apply to your individual practice. They do not apply if you are reassigning all of your benefits to a group/organization.

1. Are all of your PT/OT services only rendered in the patients' homes? ☐ YES ☐ NO
2. Do you maintain private office space? ☐ YES ☐ NO
3. Do you own, lease, or rent your private office space? ☐ YES ☐ NO
4. Is this private office space used exclusively for your private practice? ☐ YES ☐ NO
5. Do you provide PT/OT services outside of your office and/or patients' homes? ☐ YES ☐ NO

If you respond YES to any of the questions 2–5 above, attach a copy of the lease agreement that gives you exclusive use of the facility for PT/OT services.

K. Nurse Practitioners and Certified Clinical Nurse Specialists

Are you an employee of a Medicare skilled nursing facility (SNF) or of another entity that has an agreement to provide nursing services to a SNF? ☐ YES ☐ NO

If yes, include the SNF's name and address.

Name

Street Address

City	State	Zip

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

L. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all individual practitioners that also furnish and will bill Medicare for ADI services. All individual practitioners furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI Modality that you will furnish and the name of the Accrediting Organization that accredited you for that ADI Modality.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET

Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against you?

☐ YES–Continue Below	☒ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 4: PRACTICE LOCATION INFORMATION

A. Establishing a Professional Corporation, Professional Association, Limited Liability Company, etc.
If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, complete this section 4A, skip to Section 4C, and complete the remainder of the application with information about your business entity.

Legal Business Name as Reported to the Internal Revenue Service	Tax Identification Number
Medicare Identification Number *(if issued)*	NPI
Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Services (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership ☐ Sole Proprietor ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. **(NOTE:** If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

FINAL ADVERSE LEGAL ACTION HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse legal actions listed on page 12 of this application imposed against it?

   ☐ YES–Continue Below ☒ NO–Skip to Section 4B

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

If you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, you do not need to complete a CMS-855R that reassigns your benefits to the business entity.

B. Individual Affiliations

Complete this section with information about your private practice and group affiliations.

Furnish the requested information about each group/organization to which you will reassign your benefits. In addition, either you or each group/organization reported in this section must complete and submit a CMS 855R(s) (Individual Reassignment of Benefits) with this application. Reassigning benefits means that you are authorizing the group/organization to bill and receive payment from Medicare for the services you have rendered at the group/organization's practice location.

If you are an individual who is reassigning all of your benefits to a group, neither you nor the group needs to submit a CMS-588 (Electronic Funds Transfer Authorization Agreement) to facilitate that reassignment.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

1. If you are reassigning all of your payments to another group or organization furnish the name, Medicare identification number(s) and NPI of each group or organization below and proceed to Section 13.
2. If any of your payments are part of your private practice and a group or organization furnish the name and Medicare identification number(s) and NPI of each group or organization below and continue to Section 4C (where you will enter your private practice information).
3. If you are not reassigning all or any of your payments to another group or organization, skip to Section 4C with information about your private practice.

a) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
Albany Medical College		
b) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
c) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
d) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier
e) Name of Group/Organization	Medicare Identification Number *(if issued)*	National Provider Identifier

C. Practice Location Information

- If you completed Section 4A, complete Section 4C through Section 17 for your business.
- All locations disclosed on claims forms should be identified in this section as practice locations.
- Complete this section for each of your practice locations where you render services to Medicare beneficiaries.

  However, you should only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you render services in a hospital and/or other health care facility, furnish the name and address of that hospital or facility.
- Each practice location must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box.
- If you only render services in patients' homes (house calls), you may supply your home address in this section if you do not have an office. In Section 4H, explain that this address is for administrative purposes only and that all services are rendered in patients' homes.
- If you render services in a retirement or assisted living community, complete this section with the names, telephone numbers and addresses of those communities.

If you have a CLIA number and/or FDA/Radiology Certification Number for this practice location, provide that information and submit a copy of the most current CLIA and FDA certification for each practice location reported.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

If you or your organization sees patients in more than one practice location, copy and complete this Section 4C for each location.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
518-262-1333		

Medicare Identification Number *(if issued)*	NPI

Date you saw your first Medicare patient at this practice location *(mm/dd/yyyy)*

Is this practice location a:

☒ Group practice office/clinic
☐ Hospital
☐ Retirement/assisted living community
☐ Skilled Nursing Facility and/or Nursing Facility
☐ Other health care facility
*(Specify):*_____

CLIA Number for this location *(if applicable)*	FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

D. Rendering Services in Patients' Homes

List the city/town, State, and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855I) for each Medicare fee-for-service contractor's jurisdiction.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Where Do You Want Remittance Notices or Special Payments Sent?

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4C). Skip to Section 4F.

☑ "Special Payments" address is different than that listed in Section 4C, or multiple locations are listed. Provide address below.

Furnish the address where remittance notices and special payments should be sent for services rendered at the practice location(s) in Section 4C. Note that payments will be made in your name; if an entity is listed in Section 4A of this application, payments will be made in the organization's name.

"Special Payment" Address Line 1 *(PO Box or Street Name and Number)*

Albany Medical College

"Special Payment" Address Line 2 *(Suite, Room, etc.)*

PO Box 32511

City/Town	State	ZIP Code + 4
Hartford	CT	06150-2511

F. Employer ID Number Information

NOTE: If you are a sole proprietor and you want Medicare payments to be reported under your EIN, list it below. Unless indicated in this section, payments will be made to your SSN. You cannot use both an SSN and EIN. You can only use one EIN to bill Medicare.

To qualify for this payment arrangement, you:

- Must be a sole proprietor,
- Cannot reassign all of your Medicare payments, and,
- Want your payments to be made to your EIN. Furnish IRS documentation showing your EIN.

Employer Identification Number (EIN)

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Where Do You Keep Patients' Medical Records?

If the patients' medical records are stored at a location other than the location shown in Section 4C, complete this section with the name and address of the storage location. This includes both current and former patients' records.

Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. The records must be your records, not those of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4C.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

H. Unique Circumstances

Explain any unique circumstances concerning your practice locations or the method by which you render health care services (e.g., you only render services in patients' homes [house calls only]).

SECTION 5: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 6: INDIVIDUALS HAVING MANAGING CONTROL

This section captures information about all managing employees. A managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

All managing employees at any of your practice locations shown in Section 4 must be reported in this section. If there is more than one managing employee, copy and complete this section as needed.

A. Managing Employee Identifying Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

First Name	Middle Initial	Last Name	Jr., Sr., etc.	Title

Medicare Identification Number *(if issued)*	NPI *(if issued)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

What is the effective date this individual acquired managing control of the provider identified in Section 2A of this application? *(mm/dd/yyyy)*

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If you are changing or adding information, check the "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change

Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against him/her?

   ☐ YES–Continue Below ☒ NO–Skip to Section 8

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

CHECK HERE ☒ If this section does not apply and skip to Section 13.

If you are changing, adding, or deleting information, check the applicable box and furnish the effective date.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Billing Agency Name and Address

Complete the appropriate fields in this section.

Legal Business Name *(as Reported to the Internal Revenue Service)*	If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*
"Doing Business As" Name *(if applicable)*	Tax ID Number or Social Security Number *(required)*

Billing Agency Address Line 1 *(Street Name and Number)*

Billing Agency Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 12: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 13: CONTACT PERSON

This section captures information regarding the person you would like for us to contact regarding this application. If no one is listed below, we will contact you directly.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Emily	A	Snyder	

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(518) 262-9705	(518) 262-9738	snydere@mail.amc.edu

Address Line 1 *(Street Name and Number)*

618 Central Avenue

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Albany	NY 12206-1916	

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 1.18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met.

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.
2. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of a change in ownership, practice location and/or Final Adverse Action within 30 days of the reportable event. In addition, I agree to notify the Medicare contractor of any other changes to the information to this form within 90 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in business structure of this supplier may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 4A of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither I, nor any managing employee listed on this application, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to me (or to the organization listed in Section 4A of this application) by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0685

GENERAL INFORMATION

Physicians and non-physician practitioners can reassigning Medicare payments or terminate a reassignment of Medicare benefits after enrollment in the Medicare program or make a change in their reassignment of Medicare benefit information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855R).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll.*

NOTE: Physicians and non-physician practitioners who are enrolled in the Medicare program, but have not submitted the CMS 855I since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855I) as an initial application prior to completing a CMS 855R application.

Complete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments, or are terminating a reassignment of benefits. Reassigning your Medicare benefits allows an eligible supplier to submit claims and receive payment for Medicare Part B services that you have provided. Such an eligible supplier may be an individual, a clinic/group practice or other organization.

Both the individual practitioner and the eligible supplier must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible supplier and the CMS-855I for the practitioner) in the Medicare program before the reassignment can take effect. Generally, this application is completed by a supplier, signed by the individual practitioner, and submitted by the supplier. When terminating a current reassignment, either the supplier or the individual practitioner may submit this application with the appropriate sections completed.

The individual or authorized/delegated official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the reassignment in accordance with 42 C.F.R. 424.516(d)(2).

NOTE: An individual will not need to reassign benefits to a corporation, limited liability company, professional association, etc., of which he/she is the sole owner. See the CMS-855I Application for Physicians and Non-Physician Practitioners for more information.

NOTE: PHYSICAIN ASSISTANTS: This application should not be used to report employment arrangements. Employment arrangements must be reported in Sections 2E through 2G of the CMS-855I application.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Sign and date the certification statement.
- Keep a copy of your completed Medicare enrollment package for your own records and for updating your information.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

ADDITIONAL INFORMATION

The information you provide on this form will not be shared. It is considered to be protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the Privacy Act Statement located at the end of this application.

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll*.

The NPI is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare health care supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. For more information regarding NPI enumeration, visit *www.cms.gov/NationalProvIdentStand*.

The Medicare Identification Number is a generic term for any number, other than the NPI, that is used to identify a Medicare supplier.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor that services your State is responsible for processing your enrollment application. If you do not know who your fee-for-service contractor is, you can locate it on the Centers for Medicare & Medicaid Services (CMS) web site at *www.cms.gov/MedicareProviderSupEnroll*.

SECTION 1: BASIC INFORMATION

ADDING A NEW REASSIGNMENT

If you are:

- Enrolling for the first time in the Medicare program (and have completed the CMS-855I) and are reassigning your benefits to an eligible supplier.
- Currently enrolled in the Medicare program and are reassigning your benefits to an eligible supplier.

NOTE: The supplier must be enrolled or currently enrolling in Medicare (submitting the CMS-855B and/or CMS-855I) before the reassignment can take effect.

TERMINATING A CURRENT REASSIGNMENT

If you are an:

- Individual practitioner who is terminating a reassignment of benefits to the supplier identified in Section 2. No reassigned claims will be paid to the supplier for services rendered by the practitioner after the effective date of deletion.
- Organization that is terminating a reassignment of benefits from the individual practitioner identified in Section 3. No reassigned claims will be paid to the supplier for services rendered by the practitioner after the effective date of deletion.

NOTE: When adding a reassignment, Section 4A must be completed by the individual practitioner **and** Section 4B must be completed by an authorized or delegated official of the supplier. (If the supplier is an individual, that person must sign Section 4B.) When terminating a reassignment, **either** Section 4A must be completed by the individual practitioner **or** Section 4B must be completed by an authorized or delegated official of the supplier.

SECTION 1: BASIC INFORMATION

ALL APPLICANTS MUST COMPLETE THIS SECTION

Check the applicable box and complete the required sections.

REASON FOR APPLICATION	PROVIDE INFORMATION	REQUIRED SECTIONS
☐ You are enrolling or are currently enrolled in Medicare and will be **reassigning your benefits to this supplier for the first time**	Effective Date *(mm/dd/yyyy)*:	**Complete all sections**
☐ You are an individual practitioner **terminating a reassignment**	Effective Date *(mm/dd/yyyy)*:	Sections **1, 2, 3, 4A,** and **7**
☐ You are the organization **terminating a reassignment**	Effective Date *(mm/dd/yyyy)*:	Sections **1, 2, 3, 4B,** and **7**

SECTION 2: ORGANIZATION RECEIVING THE REASSIGNED BENEFITS

Organization/Group Identification

Provide the requested information below for the supplier to whom benefits are being reassigned, or with whom a reassignment is being terminated. If the supplier's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The supplier's name as reported to the IRS must be the same as reported on the supplier's CMS-855B when it enrolled.

Supplier's Legal Business Name *(as Reported to the Internal Revenue Service)*		
Albany Medical College		
Tax Identification Number	**Medicare Identification Number *(if issued)***	**National Provider Identifier**
141338310		

SECTION 3: INDIVIDUAL PRACTITIONER WHO IS REASSIGNING BENEFITS

Individual Practitioner Identification

Provide the information below for the individual who will be reassigning his/her benefits to this supplier, or who will be terminating such a reassignment. If your initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Social Security Number	Medicare Identification Number *(if issued)*	National Provider Identifier

SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R. 424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Authorized or Delegated Official of Group Practice/Clinic

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Vincent		Verdile	MD

Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 5: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 6: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 7: CONTACT PERSON

This section captures information regarding the person you would like for us to contact regarding this application.

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Emily	A	Snyder	

Address Line 1 *(Street Name And Number)*

618 Central Avenue

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	Zip Code +4
Albany	NY	12206-1916

Telephone	Fax Number *(optional)*
(518) 262-9705	(518) 262-9738

Email Address *(if available)*

snydere@mail.amc.edu

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

Health Net Federal Services

TRICARE North

TRICARE Non-Network Individual Application
Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Nurse Practitioner (NP)/Midwife

First Name: _____ MI: ____ Last Name: _____

Gen: _____ Title: _____

Social Security Number: _____NPI#_____

Physical Address (Street Address):
Albany Medical College
_____
_____

Billing Address (If Different):
Albany Medical College
Po Box 416760
Boston, MA 02241-6760

Telephone No: _____

Telephone No: 518-262-9600

Fax Number: 518-262-9723

Email Address: _____

** Please attach a list of additional office locations.

Do you maintain a solo practice? ____Yes ____No

If yes, Tax ID # of solo practice: _____

NPI#_____

Date you began using this Tax ID #: ____/____/____

Do you work with an established group practice or institution? X Yes ___No

If yes, practice name: Albany Medical College

Practice Tax ID #: _____

NPI#_____

Date you began practicing with this group number: ____/____/____

Do you sign your own claim forms? ___ Yes X No
If no, Signature Authorization forms are attached. Please complete these forms and have them notarized.

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Health Net Federal Services

TRICARE North

RN/LPN

In order to become TRICARE-certified as a RN or LPN, you must be licensed as such. Please attach a copy of your RN license or your LPN license.

RN or LPN License information:

RN or LPN License Number: _____

Original Issue Date: _____/_____/_____ Expiration Date: _____/_____/_____

Attach a copy of your state license.

Nurse Midwife

In order to become TRICARE-certified as a Nurse Midwife, you must be licensed as a RN in addition to certification by the American College of Nurse Midwives.

RN Midwife license and certification information:

License Number: _____ Certification Number: _____

Original Issue Date: _____/_____/_____ Expiration Date: _____/_____/_____

Attach a copy of your state license.

Nurse Practitioner

In order to become TRICARE-certified as a NP, you must also be licensed as a RN.

NP License Information:

License Number: _____ Certification Number: _____

Original Issue Date: _____/_____/_____ Expiration Date: _____/_____/_____

Attach a copy of your state license. If a state does not offer a NP license, attach RN license and copy of National Certification.

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Health Net Federal Services

TRICARE North

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF _____

COUNTY OF _____

_____ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below

(Facsimile, stamp or computer-generated signature as it will appear on the claim form)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

_____
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS ___ DAY OF ____ 20 ____

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF _____ STATE OF _____

(SEAL)

MY COMMISSION EXPIRES: _____

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Health Net Federal Services

TRICARE North

PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

STATE OF _____

COUNTY OF _____

Know all persons by these presents:
That I, _____ have made, constituted and appointed and by these presents do make, constitute and appoint Albany Medical College my true and lawful attorney-in-fact for me and in my name, place and stead to sign my name on claims for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claim forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____day of _____ 20_____.

_____
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS ____ DAY OF ____ 20____

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF _____ STATE OF_____

(SEAL)

MY COMMISSION EXPIRES _____

PGBA, LLC
Provider Data Management
P.O. Box 870156
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www.myTRICARE.com by PGBA

Commonwealth of Massachusetts
Department of Public Welfare

Medical Assistance Program
Provider Application
for

PHYSICIANS

PHY-001 (REV 10/90)

Commonwealth of Massachusetts
Department of Public Welfare

Medical Assistance Program
Provider Application

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.N.
PROVIDER TYPE

1. DATE OF APPLICATION

SECTION 1 - GENERAL INFORMATION

LEGAL ENTITY

2. TYPE | 3. LAST NAME | FIRST NAME | M.I. | TITLE

4. NUMBER AND STREET

5. CITY | STATE | ZIP CODE

6. ATTENTION LINE
A T T N

7. SOCIAL SECURITY NUMBER/FEIN | TYPE | 8. LEGAL ENTITY | 9. OWNERSHIP | 10. CRIM. CONVIC. YES NO | EMPLOYEE/AGENTS YES NO

11. CHAIN YES NO | 12. CHAIN NAME AND ADDRESS

13. NURSING YES NO | 14. SNF/ICF YES NO | 15. PROVIDER YES NO

SECTION 2 - "DOING BUSINESS AS" NAME/SERVICE LOCATION ADDRESS

16. TYPE | 17. LAST NAME | FIRST NAME | M.I. | TITLE
Albany Medical College

18. NUMBER AND STREET
47 New Scotland Avenue

19. CITY | STATE | ZIP CODE
Albany | NY | 12208

20. ATTENTION LINE
A T T N Department of

SECTION 3 – ADMINISTRATION INFORMATION

22. CITY/TOWN CODE	23. AREA CODE/TELEPHONE NO.–SERVICE	24. AREA CODE/TELEPHONE NO.–BILLING
99100	5182629702	5182629702

25. GROUP PRACTICE		26. BILLING AGENCY	
YES	NO	YES	NO
X		X	

SECTION 4 – CHECK MAILING AND INFORMATION MAILING ADDRESS

CHECK MAILING

27. NUMBER AND STREET: PO Box 416760

28. CITY	STATE	ZIP CODE
Boston	MA	02241-6760

29. C/O LINE: C/O Department of

INFORMATION MAILING

30. TYPE	31. LAST NAME	FIRST NAME	M.I.	TITLE
I	ALBANY MEDICAL COLLEGE			

32. NUMBER AND STREET: 618 Central Avenue

33. CITY	STATE	ZIP CODE
ALBANY	NY	12206–

34. ATTENTION: ATTN Brian Rigney

SECTION 5 - ELIGIBILITY INFORMATION FOR PHYSICIANS

YOU SHOULD HAVE RECEIVED A PROVIDER MANUAL APPLICABLE TO THE PROVIDER TYPE INDICATED IN ITEM 38 AND, IF APPLICABLE, THE CERTIFIED SPECIALTIES INDICATED IN ITEM 44. IF YOU HAVE NOT RECEIVED THIS PROVIDER MANUAL, PLEASE REQUEST ONE BEFORE RETURNING THIS PROVIDER APPLICATION TO THE DEPARTMENT.

PROVIDER ELIGIBILITY INFORMATION

34. NAME: Albany Medical College

36. MEDICARE NO:

37. CARRIER NAME: U P S T A T E M E D I C A R E

38. PR. TYPE: 0 1

39. LICENSE NO:

40. BOARD CODE:

41. BEGIN DATE:

42. END DATE:

43. STATUS:

CERTIFIED SPECIALTIES

44. SPEC.	45. BOARD CODE	46. CERTIFICATION NO.	47. BEGIN DATE	48. END DATE	49. STATUS

INDIVIDUAL PRACTITIONER SERVICE INFORMATION

INFORMATION SPECIALTIES

50. PRIM. SPEC.:

51. SUB. SPEC.:

52. MID-WIFE:

53. SIZE:

54. DEA NUMBER:

54.A DEA BEGIN DATE:

54.B DEA END DATE:

55. LAB X-RAY:

56. N.H. PRACTICE: YES NO

57. PRIM. CARE: YES NO

58. GRAD. MED.:

59. UPIN NO:

60. INST. SALARY: YES NO

	61. INSTITUTION/FACILITY NAME	62. MEDICAID PROV. NO
1.	Albany Medical College	9766804
2.		

Commonwealth of Massachusetts
Department of Public Welfare

OFFICE USE ONLY
MEDICAID PROV. NO.
A.CDL

MEDICAL ASSISTANCE PROGRAM
APPOINTMENT OF BILLING INTERMEDIARY:
PROVIDER APPOINTMENT OF GROUP PRACTICE ORGANIZATION

GROUP PRACTICE ORGANIZATIONS

1.
1. NAME	2. GROUP PRACTICE NO.	3. EFFECTIVE DATE	4. ADDRESS
Albany Medical College	9766804	02 27 92	47 NEW SCOTLAND AVE, ALBANY NY 12208

2.
1. NAME	2. GROUP PRACTICE NO.	3. EFFECTIVE DATE	4. ADDRESS

3.
1. NAME	2. GROUP PRACTICE NO.	3. EFFECTIVE DATE	4. ADDRESS

4.
1. NAME	2. GROUP PRACTICE NO.	3. EFFECTIVE DATE	4. ADDRESS

5.
1. NAME	2. GROUP PRACTICE NO.	3. EFFECTIVE DATE	4. ADDRESS

The undersigned Provider authorizes the above-listed Group Practice Organizations to submit claims to the Department of Public Welfare (hereinafter the Department) on his/her/its behalf, in accordance with the applicable Department regulations. The Provider also authorizes the Department to issue payment checks on his/her/its behalf to the above-listed Group Practice Organizations, in accordance with applicable Department regulations.

The provider accepts full liability to the Department for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules, or regulations governing the Medical Assistance Program or the Provider's agreement with the Department, the Provider shall be fully liable to the Department as if such acts were the Provider's own acts.

The Provider agrees to notify the Department at least ten days prior to the effective date of the revocation of the Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

If the provider is a legal entity other than a person, the person signing this Appointment of Billing Intermediary on behalf of the Provider warrants that he/she has actual authority to do so.

Legal name of Provider _____ Title _____

Signature _____ Date _____

Typed or printed name _____ Medicaid Provider No. _____

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.H.

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
APPOINTMENT OF BILLING INTERMEDIARY:
PROVIDER APPOINTMENT OF GROUP PRACTICE ORGANIZATION

GROUP PRACTICE ORGANIZATIONS CONTINUED

6. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

7. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

8. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

9. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

10. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

The undersigned Provider authorizes the above-listed Group Practice Organizations to submit claims to the Department of Public Welfare (hereinafter the Department) on his/her/its behalf, in accordance with the applicable Department regulations. The Provider also authorizes the Department to issue payment checks on his/her/its behalf to the above-listed Group Practice Organizations, in accordance with applicable Department regulations.

The provider accepts full liability to the Department for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules, or regulations governing the Medical Assistance Program or the Provider's agreement with the Department, the Provider shall be fully liable to the Department as if such acts were the Provider's own acts.

The Provider agrees to notify the Department at least ten days prior to the effective date of the revocation of the Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

If the provider is a legal entity other than a person, the person signing this Appointment of Billing Intermediary on behalf of the Provider warrants that he/she has actual authority to do so.

Legal name of Provider _____ Title _____

Signature _____ Date _____

Typed or printed name _____ Medicaid Provider No. _____

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.N.

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
APPOINTMENT OF BILLING INTERMEDIARY:
PROVIDER APPOINTMENT OF BILLING AGENCY

BILLING AGENCY

1. NAME

2. BILLING AGENCY NO.

3. EFFECTIVE DATE

4. ADDRESS

The undersigned Provider authorizes the above-listed Billing Agency to submit claims to the Department of Public Welfare (hereinafter the Department) on his/her/its behalf in accordance with the applicable Department regulations. Check the following box "YES" if the provider authorizes the Department to deliver checks, made payable to the Provider, to the Billing Agency in accordance with the applicable Department regulations.

If checked yes, make sure you have entered the Billing Agency's address in the Provider Application, Section 4 - Check Mailing Address.

DELIVER	
YES	NO

The Provider warrants that he/she/it has entered into a written agreement with the Billing Agency as required by the Department's regulations. The Provider understands and agrees that his/her/its use of this Billing Agency does not in any manner relieve the Provider of full responsibility and liability for any violations by the Provider of the laws, regulations and rules which govern the Medical Assistance Program.

Moreover, the Provider accepts full liability to the Department for all actions of the Billing Agency within its actual or apparent authority to act on behalf of the Provider, not withstanding any contrary provisions in the agreement between the Provider and Billing Agency. In the case of any violations of the laws, regulations or rules governing the Medical Assistance Program which arise out of the actions of the Billing Agency, the Provider accepts full liability as though these actions were the Provider's own actions.

The Provider agrees to notify the Department at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Billing Agency shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

If the Provider is a legal entity other than a person, the person signing this Appointment of Billing Intermediary on behalf of the Provider warrants that he/she has actual authority to do so.

Legal name of Provider

Medicaid Provider No.

Signature

Typed or printed name

Title

Date

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.R.

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
PROVIDER APPLICATION CERTIFICATION

PLEASE READ CAREFULLY AND SIGN

This Provider Application is an application for status as a provider in the Massachusetts Medical Assistance Program administered by the Massachusetts Department of Public Welfare. This Provider Application will become part of (and is incorporated by reference into) the Provider Agreement between this applicant and the Department of Public Welfare. The applicant should make a copy of this Provider Application for his/her/its records before submitting this copy to the Department. The Department will retain this Provider Application for its records. Moreover, the applicant should understand that he/she/it has a continuing obligation to inform the Department of any change in the information submitted on or with the Provider Application within fourteen days of the date on which the applicant becomes aware of such change.

CERTIFICATION: I have carefully reviewed this Provider Application and all attachments thereto. I certify that all information contained therein in true, accurate, and complete. If the applicant is a legal entity other than a person, the person signing this Provider Application on behalf of the applicant warrants that he/she has actual authority to do so. Signed under the pains and penalties of perjury.

Legal name of Provider Applicant

Signature

Printed name of signature

Title

Date

OFFICE USE ONLY
Provider Application received by Department on

Tips for Completing the Massachusetts Substitute W-9 Form

All providers enrolled in MassHealth, including individual practitioners affiliated with group practices, must complete a Massachusetts Substitute W-9 (Request for Verification of Taxation Reporting Information) form.

You can download the Massachusetts Substitute W-9 form from the MassHealth Web site. Go to www.mass.gov/masshealth. Click on MassHealth Provider Forms in the lower-right corner of the screen. The form is listed under the list of forms for All Providers.

Below are tips for ensuring correct completion of this required form.

- You must check the appropriate box to indicate the type of entity completing the form: Individual/Sole Proprietor, Corporation, Partnership, or Other. If "Other" is checked, indicate what "Other" represents.

- Provide the applicant's legal name and address exactly as that information is known to the Internal Revenue Service (IRS). Please attach, if possible, a tax coupon or other documentation from the IRS. This address must match the legal address on the application.

- Provide the remittance address where indicated on the form, if the address differs from the legal entity address. This address must match the check mailing address on the application.

- Individuals must complete Part I with the appropriate **social security number (SSN)**. All others must use a federal employer identification number (FEIN). If an FEIN is entered, you must attach a copy of your *Notice of New Employer Identification Number Assigned* from the Department of the Treasury, IRS, or a tax coupon.

- If you entered an SSN, the form must be signed by the practitioner. If you entered an FEIN, the form must be signed by an owner, CEO, CFO, or similar official.

- **Only an original ink signature is acceptable. Photocopied or stamped signatures will not be accepted.** It is recommended that the signature be applied in an ink color other than black.

- Group practices must complete a separate Massachusetts Substitute W-9 form for the group using the appropriate tax identification number. Each individual practitioner within the group must complete a separate Massachusetts Substitute W-9 form containing the individual's SSN.

- The legal name and address on the Massachusetts Substitute W-9 form must match the legal name and address listed on the application.

- If enrolling as an individual, you must complete the Legal Address field with the individual's home address. In Part I, you must enter only the SSN of the individual.

- You must submit original Massachusetts Substitute W-9 forms. No sections may be crossed out or otherwise altered.

Please print or type

Form **W-9**
(Massachusetts Substitute W-9 Form)
Rev. April 2009

Request for Taxpayer Identification Number and Certification

Completed form should be given to the requesting department or the department you are currently doing business with.

Name (List legal name, if joint names, list first & circle the name of the person whose TIN you enter in Part I-**See Specific Instruction** on page 2)

Business name, if different from above. (**See Specific Instruction** on page 2)

Check the appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶

Legal Address: number, street, and apt. or suite no.	**Remittance Address**: if different from legal address number, street, and apt. or suite no. PO Box 416760
City, state and ZIP code	**City, state and ZIP code**

Phone # ( ) Fax # ( ) Email address: rigneyb@mail.amc.edu

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instruction on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
☐☐☐-☐☐-☐☐☐☐
OR
Employer identification number
☐☐-☐☐☐☐☐☐☐

Vendors:
Dunn and Bradstreet Universal Numbering System (DUNS)

DUNS
☐☐☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Services (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am an U.S. person (including an U.S. resident alien).
4. I am currently a Commonwealth of Massachusetts's state employee: (check one): No ☑ Yes _____ If yes, **in compliance with** the State Ethics Commission **requirements.**

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply.

Sign Here **Authorized Signature ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and , when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued).
2. Certify you are not subject to backup withholding

If you are a foreign person, use the appropriate Form W-8. See **Pub 515**, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding? Persons making certain payments to you must withhold a designated percentage, currently 28% and pay to the IRS of such payments under certain conditions. This is called "backup withholding.". Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions on page 2.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I - Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site www.irs.gov.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments.

The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.*

Part II - Certification

To establish to the paying agent that your TIN is correct or you are a U.S. person, or resident alien, sign Form W-9.

For a joint account, only the person whole TIN is shown in Part I should sign (when required).

Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold a designated percentage, currently 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number to Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]

For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4]. List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

If you have questions on completing this form, please contact the Office of the State Comptroller. (617) 973-2468.

Upon completion of this form, please send it to the Commonwealth of Massachusetts Department you are doing business with.

Trading Partner Agreement

Commonwealth of Massachusetts
Executive Office of Health and Human Services

This Trading Partner Agreement ("Agreement") is made as of _____, 20__, between the Executive Office of Health and Human Services ("MassHealth") and

_____ _____ ("Trading Partner").
Legal Name of Trading Partner (please print) *Provider No., if applicable*

The Trading Partner intends to conduct electronic transactions with MassHealth. Both parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder. Without limiting the generality of the preceding sentence, the parties agree as follows.

1. Each party shall take reasonable care to ensure that the information submitted in each electronic transaction is timely, complete, accurate, and secure; and shall take reasonable precautions to prevent unauthorized access to (a) its own and the other party's transmission and processing systems, (b) the transmissions themselves, and (c) the control structure applied to transmissions between them.

2. Each party is responsible for all costs, charges, or fees it may incur by transmitting electronic transactions to, or receiving electronic transactions from, the other party.

3. The Trading Partner shall conform each electronic transaction submitted to MassHealth to the Specifications Addendum applicable to the transaction, and to the applicable Companion Guide. MassHealth may modify the Specifications Addendum and the Companion Guide at any time without amendment to this Trading Partner Agreement, but the Trading Partner will not be required to implement such modifications sooner than 60 days after publication of the modified Specifications Addendum or Companion Guide, unless a shorter compliance period is necessary to conform to applicable federal law or regulation. Only the last-issued Specifications Addendum of each type will be effective as of the date specified in the Specifications Addendum. MassHealth may reject any transaction that does not conform to the applicable Specifications Addendum and the Companion Guide.

4. Before initiating any transmission in HIPAA standard transaction format, and thereafter throughout the term of this Agreement, the Trading Partner shall cooperate with MassHealth and MassHealth's Business Associates (i.e., vendors who perform certain functions on MassHealth's behalf) in such testing of the transmission and processing systems used in connection with MassHealth as MassHealth deems appropriate to ensure the accuracy, timeliness, completeness, and security of each data transmission.

5. Each party is solely responsible for the preservation, privacy, and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party shall immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.

6. Termination or expiration of this Agreement or any other contract between the parties does not relieve either party of its obligations under this Agreement and under federal and state laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.

7. The Trading Partner may authorize one or more intermediaries to electronically send or receive MassHealth data on its behalf. Every such intermediary must first be bound by written agreement with the Trading Partner to comply with applicable law and regulations, with the current applicable Specifications Addenda and Companion Guides, and with the terms of this Agreement. The Trading Partner agrees and represents that it shall disclose its provider number, user ID number, password, and any other means that enable MassHealth data to be transmitted to or received from MassHealth, only to intermediaries with whom it has such agreements, or to members of its workforce, whom the Trading Partner has authorized to receive and transmit data on its behalf. The Trading Partner shall be bound by and responsible for the acts and omissions of all such persons in the exchange of electronic data with MassHealth. The Trading Partner shall notify MassHealth of any event, such as the termination of its relationship with a previously authorized employee or intermediary, that may require action to foreclose submission and receipt of transactions by persons no longer authorized by the Trading Partner to act on its behalf. Use of an intermediary will not relieve the Trading Partner of any risks or obligations assumed by it under this or any other agreement with MassHealth, or under applicable law and regulations. The Trading Partner shall bear all costs resulting from its use of intermediaries.

8. This Agreement will take effect and be binding on the Trading Partner and MassHealth when signed by the Trading Partner and received by MassHealth. In case of conflict between this Agreement and any prior contracts between the parties, including prior versions of this Agreement, this Agreement will prevail.

_____

Legal Name of Trading Partner

_____

Trading Partner Authorized Signature. Manual signature required. Facsimiles are not acceptable.

_____

Printed Name of Signer Date

_____

Telephone Number E-mail Address

Data Collection Form and Registration Instructions

NewMMIS allows providers to conduct day-to-day business with MassHealth electronically, via the Provider Online Service Center (POSC), the Eligibility Verification System software (EVSpc), and the Automated Voice Response (AVR) system. All users need a user ID and password to access these systems.

Please identify a primary user for your organization. The primary user will be the person in your organization who will be responsible for the creation and inactivation of users' accounts and password resets. MassHealth will manually create the user ID and password for the primary user.

Please complete this form to obtain a user ID and password for the primary user to access the POSC, EVSpc, and AVR. Once the primary user is registered, the primary user will need to create subordinate IDs for all other users within your organization and authorize access for your business partners, such as billing agencies.

Provider name		**Provider number or application tracking number (if applicable):**
Primary user's last name:	**Primary user's first name:**	**Middle initial:**
Month and date of birth (MMDD):	**Unique four-digit PIN number (user defined):**	**Work zip code:**
Work e-mail address:	**Existing Virtual Gateway user ID (if applicable):**	
Contact phone number:	**Check one:** ☐ **Existing provider** ☐ **Provider applicant**	

Provider type: ☐ **MCO** ☐ **Nursing facility** ☐ **PACE** ☐ **SCO** ☐ **Billing agency** ☐ **All others**

I certify that the information on this form, and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable):

_____ **Date:** _____

Please use this form to submit your request for a primary user ID and password. The data can be sent by e-mail to MassHealth Customer Service at PINregistrationsupport@mahealth.net. You can also fax or mail this form to the following address and fax number.

MassHealth
P.O. Box 9118
Hingham, MA 02043
Fax: 617-988-8904

Upon receipt of this completed form, MassHealth will manually create a user ID and a password. You will then receive an e-mail from the Virtual Gateway that will display your primary user ID and password. The e-mail will be sent to the e-mail address you have provided on this form.

(over ▸)

When you receive the primary user ID and password, the primary user must take the following steps.

- **Change the password.** Once the primary user has registered, he or she must go to the Virtual Gateway at https://gateway.hhs.state.ma.us/authn/index.jsp to change his or her password. A series of "I forgot my password" questions under the "Manage My Profile - Authentication Questions" tab must be answered before the password can be changed.
- **Assign Subordinate IDs.** Once registered, the primary user must create a user account for each individual user in the organization needing access to the POSC, and give permission to share data with other entities who conduct business on their behalf. Select the "Administer Account" link to begin this process.

Your user ID and password will give you access to the POSC. You will also need your user ID and password to access the AVR and to use the EVSpc software to verify member eligibility.

When using the POSC, you will also need your NewMMIS provider ID and service location number (PID/SL) to view reports, remittance advices, letters, direct data entry (DDE), and HIPAA transactions. MassHealth will mail the NewMMIS PID/SL to you separately.

Please remember that you must submit your national provider identifier (NPI) on the HIPAA batch transactions. If you are an atypical provider (that is, not required to have an NPI), please include your NewMMIS PID/SL on your batch transactions.

If you have any questions about this registration process, please contact MassHealth Customer Service at 1-800-841-2900, or by e-mail at providersupport@mahealth.net.

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MassHealth Provider Contract for Individuals

Provider Contract between the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (hereinafter MassHealth), and

_____

(Legal Name of Provider, hereinafter the "Provider")

doing business as

Albany Medical College

(Doing Business As (DBA) Name of Provider)

In consideration of the mutual promises contained herein, the parties agree as follows.

I. The Provider agrees:

A. to comply with all state and federal statutes, rules, and regulations applicable to the Provider's participation in MassHealth.

B. to provide services to eligible members without regard to religion, race, color, or national origin in compliance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq. and its implementing regulations at 45 CFR Part 80), and without regard to handicap in compliance with Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794 and its implementing regulations at 45 CFR Part 84).

C. to keep such records as are necessary to disclose fully the extent and medical necessity of the services provided to, or prescribed for, members and to preserve these records for at least six years, or for such a length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer.

D. to furnish MassHealth and any other state and federal officials and agencies or their designees, upon request, with such information, including copies of medical records, about any services for which payment was claimed from MassHealth, to the extent permitted or authorized by law.

E. to comply with 42 CFR § 455.105 by submitting, within 35 days after the date of a request by the federal Secretary of Health and Human Services or MassHealth, full and complete information about

1. 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 five-year period ending on the date of the request.

F. to furnish to MassHealth its national provider identifier (NPI) if eligible for an NPI; and include its NPI on all claims.

II. MassHealth agrees:

to pay the Provider at rates set by the Massachusetts Division of Health Care Finance and Policy or contained in the applicable MassHealth fee schedules for all payable services and goods actually and properly delivered

to eligible members and properly billed to MassHealth both in accordance with the terms of this Provider Contract and in accordance with all applicable federal and state laws, regulations, rules, and fee schedules.

III. The Provider and MassHealth mutually agree:

A. that any Special Conditions that indicate they are to be incorporated into this Provider Contract and that are signed by both parties to this Contract will be deemed to be part of this Contract and that in the event of any inconsistency between the Special Conditions and this Contract, the former shall control.

B. that this Contract shall take effect upon notification of acceptance by MassHealth and shall continue in effect until terminated by either party upon written notice to the other party; and that MassHealth may not terminate this Contract without affording to the Provider any applicable right to contest such termination available under federal and state law and regulation that has been properly requested by the Provider.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he or she has actual authority to bind the Provider.

PROVIDER	EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
_____ (Legal Name of Provider)	
By: _____ (Signature)	By: _____ (Signature)
Name: _____ (Printed Name)	Name: _____ (Printed Name)
Title: _____	Title: _____
Date: _____	Date: _____

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

For internal use only

MassHealth provider number: _____

MassHealth provider type: _____

MassHealth Provider Application National Provider Identifier (NPI) Supplement

This supplement to this application is for the collection of national provider identifier (NPI) data. The NPI number is required for all health-care providers under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). In addition, federal regulations at 42 CFR 431.107(b)(5) require that all providers eligible for an NPI number furnish it to MassHealth and include it on all claims. If you are eligible for an NPI number, failure to provide it may result in a delay in processing your application.

Please list your name, address, Tax ID, and NPI number applicable to this enrollment.

SECTION 11. NATIONAL PROVIDER IDENTIFIER

Provider's legal name		
Street address line1		
Street address line 2		
City	State	Zip
Tax ID	NPI number	Check if not eligible for NPI Number ☐

► Is this NPI associated with another MassHealth Provider ID you currently have on file? . . . . . ☐ yes ☐ no

If yes, please indicate the other provider ID(s): _____

APPLICANT'S ATTESTATION, SIGNATURE, AND DATE

I certify under the pains and penalties of perjury that the information on this form has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the applicant or, in the case of a legal entity, duly authorized to act on behalf of the applicant. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Applicant's signature: _____
(Signature and date stamps, or the signature of anyone other than the applicant or person legally authorized to sign on behalf of a legal entity, are not acceptable).

Printed legal name of applicant: Albany Medical College Date: _____

Email: _____ Phone: _____

Printed legal name of individual signing: Albany Medical College
(if the applicant is a legal entity)

ALBANY MEDICAL CENTER EMPLOYEE DATA SHEET

(PLEASE PRINT LEGIBLY)

( ) New Record (Complete all information) ( ) Corrected Record (Complete changed/new information only)

PART A – EMPLOYEE INFORMATION **PLEASE SUBMIT TO HUMAN RESOURCES (MC-56)**

Today's Date: _____

Name: _____ (Last First MI)

Department: _____

If name change, provide former name: _____ (see additional instructions on back of this form)

Entity: ( ) Hospital ( ) SCC ( ) College ( ) Center

Address: _____

Gender: ( ) Male ( ) Female

_____

Home Phone Number: _____ _____

_____

Date of Birth: _____ (month day year)

Marital Status: ( ) S - Single ( ) M - Married ( ) D - Divorced ( ) A - Separated ( ) W - Widowed

PART B – SPOUSE INFORMATION

Spouse Name: _____ (Last First MI)

Address of Spouse: _____ (if different from employee)

Spouse Date of Birth: _____ (month day year)

_____

Spouse Gender: ( ) Male ( ) Female

_____

PART C – EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____ (Last First MI)

Relationship: _____

Emergency Contact Daytime Phone Number: _____

Extension: _____

Emergency Contact Evening Phone Number: _____

Extension: _____

PART D –ETHNICITY, RACE AND GENDER (VOLUNTARY INFORMATION)

PLEASE COMPLETE SECTION 1 OR SECTION 2 AS IT BEST APPLIES TO YOU.
(Please see reverse side for definitions)

SECTION 1	OR	SECTION 2
I wish to indicate myself as a member of the following ETHNIC group: ( ) S – Hispanic or Latino		I wish to indicate myself as a member of ONE of the following RACIAL groups: ( ) B – Black or African American (non-Hispanic or Latino) ( ) A – American Indian or Alaskan Native (non-Hispanic or Latino) ( ) E – Native Hawaiian or other Pacific Islander (non-Hispanic or Latino) ( ) O – Asian (non-Hispanic or Latino) ( ) C – White (non-Hispanic or Latino) ( ) T – Two or more races (non-Hispanic or Latino)

PART E – DISABILITY/VETERAN STATUS (VOLUNTARY INFORMATION)

Disabled: ( ) Yes ( ) No **(Please refer to reverse side for definition)**

Please indicate if you are Veteran as defined in the following categories (Please refer to reverse side for definitions)

Armed Forces Services Medal Veteran: ( ) Yes ( ) No **Disabled Veteran:** ( ) Yes ( ) No **Other Veteran:** ( ) Yes ( ) No

If you are a Recently Separated Veteran, please indicate your effective discharge date: _____/_____/_____ (month day year)

PART F – EMPLOYEE SIGNATURE

Employee Signature: _____

(OVER)

ALBANY MEDICAL CENTER IDENTIFICATION BADGE REQUEST FORM

(__) TO ISSUE FIRST BADGE (__) TO CHANGE CURRENT BADGE

PLEASE PRINT ALL INFORMATION

(Article 23-A of New York Correction Law on reverse)

To Issue First Badge: Badge applicant completes sections 1 & 2. Section 3 completed by Human Resources for employees, by Security Services for all other badge applicants. Badge applicant brings completed form to Security Services, 22 New Scotland Ave, 1st floor, Monday -Friday, 8:00 am – 4:30 pm for photo.

To Change Current Badge: Badge applicant completes sections 1 and 2**.** Section 3 completed by badge applicant's manager. When complete, fax form to Security Services at 262-3770, mail to Security Services at Mail Code 30, or bring to Security Services, 22 New Scotland Ave, 1st floor, Monday -Friday, 8:00 am – 4:30 pm.

SECTION #1 BADGE APPLICANT INFORMATION

_____ _____

Date of Hire Manager's Name **(Required for Employees Only)**

_____ / _____ / _____

Your Last Name First Name Middle Initial

_____

Your Street Address: (Home or Office)

_____ / _____ / _____

City State Zip Code

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Vehicle Make & Model: _____ Vehicle License Plate #:_____ State _____

SECTION #2 BADGE APPLICANT EMERGENCY CONTACT INFORMATION

_____

Your Emergency Contact's Name

_____

Address (City, State, Zip Code)

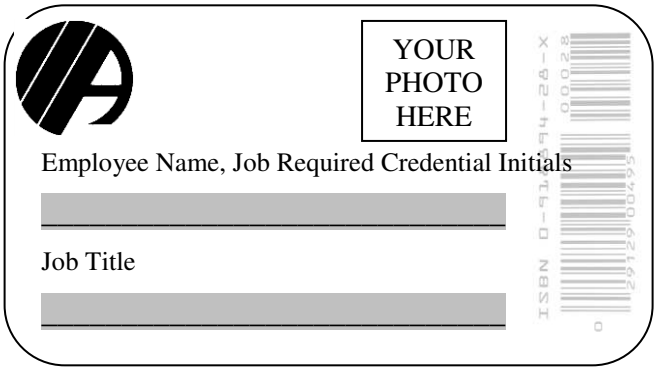
_____ / _____ _____

Emergency Contact Home Phone Emergency Contact Cell Phone Relationship to You

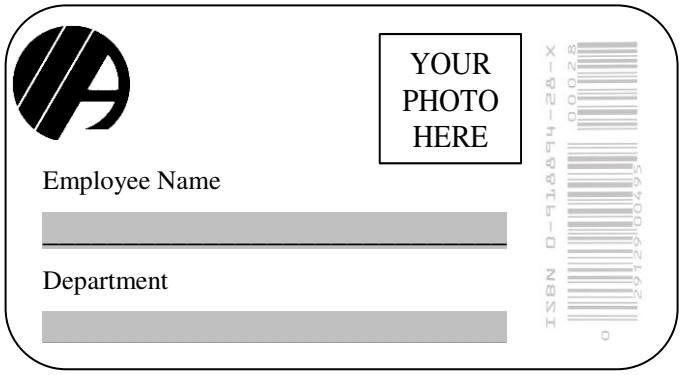
SECTION #3 ID BADGE INFORMATION

(To Be Completed By Human Resources, Security Services or Applicant's Manager)

PATIENT CARE DEPARTMENT BADGE
Check here if *NURSING* degrees are held
BS ( ) or MS ( ) [*VERIFIED BY* _____]



NON - PATIENT CARE DEPARTMENT BADGE



Approved By: _____ **Badge No:** _____ **Last 4 SS#:** _____

(Human Resources, Security Services, Manager) **(Security Dept.)** **(Security Dept.)**

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details . . . . 1 $

2 Enter: { $12,400 if married filing jointly or qualifying widow(er) / $9,100 if head of household / $6,200 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2014 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $3,950 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

ALBANY MEDICAL CENTER

ACKNOWLEDGMENTS

NAME (Print Name Legibly):_____
Last *First* *Middle Initial*

DATE OF HIRE: ___/____/___ **ENTITY:** (__) **HOSPITAL** (__) **SCC** (__) **COLLEGE** (__) **CENTER OPERATIONS**

JOB TITLE: _____ **DEPARTMENT:** _____

When used below unless the context indicates otherwise, "Albany Medical Center" (Albany Med) means the Albany Medical Center and each of its constituent corporations, such as Albany Medical College, Albany Medical Center Hospital, and the South Clinical Campus.

I. EMPLOYEE MANUAL:

- I have received a copy of Albany Med's Employee Manual and will read and familiarize myself with its terms.
- I understand that the manual is not a binding contract, but a set of guidelines for the implementation of human resource policies.
- I understand that Albany Med may modify any of the provisions of the Employee Manual at any time, and it is my responsibility to remain familiar with any modifications. An updated version of the manual can be found on Albany Med's intranet or by asking my manager or Human Resources to provide to me a copy.
- If I fail to abide by the policies, procedures and practices outlined in the Employee Manual, I understand that I may be subject to Albany Med's Corrective Action Policy that could lead to termination of my employment from Albany Med.
- I have been informed and understand that Albany Med considers me to be an "at-will" employee. This means that my employment has been voluntarily entered into and I may end my employment at any time, for any reason, as can Albany Med. As an at-will employee, no contract governs my employment with Albany Med.

II. CONFIDENTIAL INFORMATION AND PRIVACY:

- I understand that all confidential information regarding patients, employees, visitors and institutional finances (e.g. personnel records, patient health information, budgets) may not be disclosed unless specifically authorized and the rights of these parities must be rigidly respected. Confidential medical information, personal information, private matters, etc. are to be treated as private and should never be discussed with those not concerned, particularly as matters of gossip.
- I have received a copy of Albany Med's Notice of Privacy Practices, which provides a summary of the rights and responsibilities governing protected health information, and understand that it is to be followed by all members of Albany Med's workforce.
- I understand that Albany Med is required by Federal and State Laws to protect the privacy of health information and personally identifying information (e.g. social security number, date birth, account numbers) of its patients. I understand that protected health information and personally identifying information are strictly confidential and should never be given to anyone who is not authorized under Albany Med's policies by job responsibility or applicable law to receive this information. This includes law enforcement or District Attorney's Office inquires seeking disclosure of protected health information.
- I understand that accessing records or any information for purposes other than to perform my job is forbidden and that improper accessing of records and/or use or disclosure of information is cause for corrective action up to and including termination of my employment from Albany Med.
- I have been informed and understand that violation of confidential information and privacy statutes and rules can also lead to civil or criminal procedures or penalties.

- OVER -

III. ALCOHOL AND DRUG FREE WORKPLACE:

- I have received a copy of Albany Med's Drug and Alcohol Policy and understand that I am responsible for reading this information as alcohol and drug abuse (including prescription abuse) has negative effects on performance and increases the risk of injury to myself and others.
- I will notify my manager in writing within 5 days if I have been convicted of any criminal drug or alcohol offense.
- I understand that unlawful or unauthorized manufacture, distribution, sale, dispensation, possession or use of any drug, or alcoholic beverage, is prohibited in the workplace and that faculty and staff must not report for duty under the influence or in withdrawal from alcohol or drugs.
- I understand that violations of the Drug and Alcohol Policy will result in corrective action up to and including termination of my employment from Albany Med.

IV. DISCRIMINATION AND HARASSMENT:

- I understand that discrimination of patients, discrimination in the workplace and unlawful harassment is prohibited.
- I understand that violations of Albany Med's policies on discrimination and harassment could lead to corrective action up to and including termination of my employment from Albany Med, and, that I may also be held liable for acts of discrimination and harassment under anti-discrimination and harassment laws.
- I understand that I have a responsibility to report harassment to my manager, acting manager or the Human Resources Department and that reports will be investigated without fear of retaliation according to Albany Med's Harassment Complaint procedure.

V. ALBANY MED'S CORPORATE COMPLIANCE PROGRAM:

- I understand that Albany Med has adopted a Corporate Compliance Plan that is outlined in the employee manual and that it is my responsibility to adhere to the standards listed.
- I also understand that Albany Med maintains a confidential, anonymous Compliance Hotline at (518) 262-HELP, that I may use to report concerns regarding possible fraudulent or abusive billing practices, business ethics issues, potentially illegal or inappropriate financial transactions, questionable research billing practices, possible research misconduct, and patient safety, quality of care or EMTALA-related patient transfer issues.
- I understand that a full review of concerns raised will be conducted and that I may report these concerns without fear of retaliation.
- I have been informed that failure to report knowledge of wrongdoing may result in corrective action, up to and including termination.

VI. PERSONNEL RECORDS:

- I understand that Albany Med maintains an official personnel record for each of its employees, consisting of information provided by or in connection with former or current employment, such as resumes, application forms, evaluations, recommendations, immigration records, attendance records, corrective action records and other types of employment-related documentation.
- I understand that all documents which become part of Albany Med's personnel record after being acquired from any source, whether provided by me or provided by others (such as my previous employer) become Albany Med's property and I acknowledge and consent to the fact that the information contained in the personnel record may be used by Albany Med for any reasonable purpose related to or concerning my employment, subject to all applicable laws and regulations.
- I further understand that Albany Med treats these records as confidential and that I may not have a copy, although with permission of my manager I may be permitted to view Albany Med's record which pertains to me.

_____ ____/____/_____

Employee Signature Date

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write In This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write In This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority		5. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**For persons under age 18 who are unable to present a document listed above:** 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record		8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

ALBANY MEDICAL COLLEGE

APPOINTMENTS, PROMOTION AND TENURE APPLICATION

The following form must be completed for any appointment or promotion to the level of Instructor and above and for all tenure awards. To initiate the review of the application by the Appointments, Promotion and Tenure Committee (APTC), the following should be submitted to the Office of the Secretary of the APTC (Vice Dean):

1. Completed, typewritten application form and **up-to-date** CV (see page 2). **NOTE**: Application will be rejected if CV is not up-to-date.
2. Supporting letters from appropriate individuals who are able to evaluate the candidate's credentials, if required (see pages 3-4)
3. Supporting letter from the Department Chair/IRC Director (see page 3)
4. Demographic Data Form for all new appointments.

The IRC Director/Chair's letter should clearly define the current or proposed effort in research, teaching and professional service (clinical and administrative). Secondary appointments are documented on applications submitted by the Chair/IRC Director (Chairperson) of the secondary Department. Applicants and their supporting Chairpersons should be thoroughly familiar with the relevant portions of the Policies and Procedures for Appointments, Promotions and Tenure. Incomplete, handwritten, or inappropriately documented applications will be returned without action by the APTC. For advice or questions regarding the application process or appropriate documentation, contact the Office of the Secretary of the APTC (Ext. 2-5919).

STEPS IN APPLICATION PROCESS

Letters required (See page 3-4)	Letters not required
1. Chairperson and candidate develop a list of individuals from whom letters of evaluation may be solicited. Letters are solicited by the Departmental APTC.	N/A
2. Chairperson submits letter of support with the application (see pages 3-4) to the Departmental APTC. (In exceptional cases, the candidate may submit all necessary documentation directly.)	Same
3. Once evaluation letters are received, the Departmental APTC evaluates the application materials and meets with the department Chairperson to discuss and suggest revisions to the application. Chair may terminate the application process at this point.	N/A
4. Chairperson submits 14 copies (plus original) of the completed application materials (and 1 copy of the Demographic Data Form for new appointments) to the Office of the Secretary of the APTC. All members of the APT Committee review the application to make appointment, promotion or tenure recommendation to the Dean.	Same

APPLICATION FOR APPOINTMENT, PROMOTION OR TENURE

Name (last, first, middle):_____

Proposed Title:_____ **Department:**_____

Full Professional Address: _____

Highest Degree: _____ **Institution:** _____ **Date Achieved:** _____

Instructions: Please refer to the APT policies and procedures regarding applicant eligibility for appointment, promotion or tenure. ***The tenure track is only available to full time faculty. Any faculty member not on the tenure track is a member of the non-tenure track***. The total effort contributed must equal 100% regardless of the full or part time status of the faculty member. Provide hrs/month for secondary appointment or non-full time faculty. Attach Candidate qualifications to this document (see page 2).

Check ALL that apply:

☐ New Appointment ☐ Promotion in Rank ☐ Secondary Appointment

☐ Tenure Award (Associate or Professor on tenure track) ☐ Visiting Appointment (Dates: From _____ to _____)

Check Employment Status:

☐ Full Time Faculty ☐ Part Time Paid Faculty: _____Hours/Mo ☐ Volunteer Faculty

Check Present AMC Rank: Date Achieved:_____	**Proposed Rank:**	**% Total Contribution to AMC**
☐ None of the following	☐ Instructor	Full Time: % of total effort
☐ Instructor	☐ Assistant Professor	Part Time: % of number of hours per month
☐ Assistant Professor	☐ Associate Professor	_____ Teaching
☐ Associate Professor	☐ Professor	_____ Research
☐ Professor	☐ Distinguished Professor	_____Service (clinical/administrative)
☐ Distinguished Professor	☐ Professor Emeritus	**100%** **Total Contributed Effort**

Check Track Designation	**Current**	**Proposed**
Tenure Track		
Without Tenure	☐	☐
Tenure	☐	☐

**To progress through the academic ranks on this track will require demonstration of professional growth, continuing potential, excellence of performance, and leadership in at least two of the three elements of professional achievement, i.e., education, research and professional service.*

Non-Tenure Track	☐	☐

**To maintain faculty status and to progress through the academic ranks on this track will require demonstration of professional growth, continuing potential, and excellence of performance in one of the three elements of professional achievement.*

No Track (i.e., Instructor)	☐	☐

Approval by Dept. APTC Chairperson:

_____ _____
Signature Date

_____
Name of Department

Approval by Dept. Chair:

_____ _____
Signature Date

Approval of Dean (for tenure):

_____ _____
Signature Date

FORMAT FOR DOCUMENTATION OF CANDIDATE QUALIFICATIONS

This information must accompany all appointment, promotion and tenure applications.

Education:

Years Attended	Undergraduate College, Degree Obtained
Years Attended	Graduate and/or Medical College, Degree Obtained
Years Attended	Institution of Residency and/or Post-doctoral Experience
Year Obtained	Other Professional Certifications

Honors and Awards:

List academic and professional achievements, scholarships, and awards pertinent to career goals and accomplishments with year of receipt.

Research and Professional Appointments:

List academic and professional appointments by year and institution.

Professional Associations:

List national and regional organizations in which you are currently a member. Identify any leadership positions you hold at this time or have held in the past.

Grants and Awards:

List grants and awards obtained to support educational, research and/or clinical initiatives. For each list: 1) Funding agencies by name; 2) Identification number of the grant or award assigned by the granting agency; 3) Time course of study; and 4) Total direct and indirect costs.

Teaching:

List present and past teaching responsibilities. Include and identify specifically: 1) name of the course and institution [if other than AMC]; 2) Identification number of the course; 3) Number of hours of lectures or clinical instruction with titles or content descriptors; 4) Number of students; and 5) Instructional materials developed. Written evaluations by course directors should be added as an appendix to this document

Academic Services and Committees:

List present and past academic administrative responsibilities. Identify, for example: Directorship held for any course or clerkship; participation in curriculum committee; the faculty senate; departmental or interdisciplinary committees; thesis committees; quality management committees and College-wide services (i.e. admissions committee; institutional review boards)

Clinical Services:

Describe unique clinical skills and experiences, the size and scope of the practice, and your specific contribution to the practice

Publications:

List publications according to the following categories: 1)Peer-reviewed basic or clinical research articles; 2) Non-peer reviewed articles, and 3) Review articles and book chapters

Extramural Lectures and Seminars:

List (no more than ten of the most recent) professional lectures and seminars presented outside of Albany Medical College.

LETTERS OF SUPPORT/EVALUATION

Letters of support/evaluation are an essential part of the documentation materials included in an application for appointment, promotion and/or tenure at Albany Medical College. The candidate's CV and the Guidelines for Letters of Support/Evaluation (page 4) will be forwarded to all individuals being asked to provide a letter. All letters received will be included in the application package when it is forwarded to the Committee on Appointments, Promotion and Tenure.

1. **Who needs letters**:

   - Letters are required for all new primary appointments at, or promotion to, the rank of Associate Professor and above, ***regardless*** of track.
   - Letters are optional for the rank of Assistant Professor and are not required for Instructor level candidates.
   - Adjunct appointments require only a letter from the Chair/IRC Director.
   - Secondary appointments require a letter from both the primary and secondary Department Chair/IRC Director.

2. **How many letters are needed**:

   - A letter from the Department Chair/IRC Director is required for **every** application. This letter is **in addition** to any other required letters.
   - For appointment or promotion **with tenure**, six (6) letters will be the minimum number required for review of an application.
   - For all other faculty appointments, three (3) letters will be the minimum number required for review of an application.

3. **Source of letters**:

   In consultation with the department Chairperson/IRC Director, the candidate should provide a list of individuals to be asked to provide letters of evaluation. (Occasionally, the candidate may feel compelled to recommend that certain individuals not be contacted for letters of support/evaluation. These individuals may also be listed.)

   - Letters will be solicited by the Departmental APTC.
   - Letters are to be solicited from individuals with an equal or higher rank compared with the candidate's proposed rank.
   - Evaluation letters must be from faculty of national or international stature. One letter may be from a regional individual but not an individual with a primary AMC appointment. (The Chair/IRC Director's letter is not considered in this category.) The Departmental APT Committee may solicit letters from the list developed by the Chair/IRC Director and the candidate for appointment or promotion. The candidate's CV and the APT requirements should be sent to the solicited letter-writer so that the reference can comment on how the candidate fulfills the APT requirements. The relationship, professional and personal, of the candidate to the suggested reviewer **should be** clearly and explicitly detailed by the reviewer.
   - Letters of support for voluntary faculty may be solicited from full time AMC faculty or from external faculty of prominent stature who are asked to comment on the candidate's qualifications as they relate to the APT requirements.

GUIDELINES FOR LETTERS OF SUPPORT/EVALUATION
for Appointment, Promotion, and/or Tenure

Your confidential letter of support and evaluation is requested to assist the Albany Medical College Appointments, Promotion and Tenure Committee. Please address the issues listed below for the candidate. Each reviewer is asked to describe the nature of previous personal and professional interactions with the candidate.

To document excellence in teaching, reviewers should comment on:

a. the specific strengths of the candidate as a teacher
b. evidence of lasting contributions to students' intellectual growth
c. the impact of scholarly publications and/or value of teaching materials developed by the candidate
d. the candidate's reputation and impact nationally and regionally on educational issues

To document excellence in research, please comment on the candidate's scholarly attainments as specifically as possible concerning the following:

a. the quality and quantity of peer-reviewed published and submitted work in comparison to other individuals at a similar career level in the candidate's discipline
b. the quality or standing of the journals in which the work has been published
c. the candidate's area or areas of specialization and the significance of his/her contributions to the field
d. the candidate's reputation nationally and the impact of specific aspects of the candidate's work on others

To document excellence in clinical practice, reviewers should be familiar with the candidate's field of clinical practice. Please describe evidence that the candidate:

a. participates in the scholarly dissemination of knowledge regarding enhanced patient care, surgical or diagnostic procedures, original clinical observations, or improved practice outcomes
b. provides current, competent, ethical, and humanistic patient care
c. possesses unique clinical skills essential to the mission of Albany Medical College
d. is recognized and held in high regard by other health care providers, including other physicians, nationally and regionally;
e. adequately maintains his/her professional credentials

To demonstrate leadership skills and service to the College and other professional organizations, please comment on:

a. the participation and achievements of the candidate with regard to service on College administrative committees
b. the participation and achievements of the candidate with regard to service within nationally and regionally recognized professional organizations

ALBANY MEDICAL COLLEGE
New Faculty: Demographic Data Form

PLEASE TYPE ALL INFORMATION

Name: _____
Last, First, Middle, Degree

Social Security #: _____/_____/_____
Date of Birth: ____/____/____
Gender: ___Male ___Female
Ethnic Identity: _____
Citizenship: ___United States ___Other (specify:_____)

Proposed Appointment Information

This is a ___primary or ___secondary appointment
Department: _____
Division: _____
Academic Rank: _____
Requested Appt. Date: _____ (effective upon approval by Board of Trustees)
Tenure Status: ___Tenure track, with tenure
___Tenure track, non-tenured
___Non-tenure track
___No track (i.e., Instructor)
Time Allocation: ____% Teaching
____% Research
____% Patient Care
____% Administration
____% Other
Status: ____Full-time, paid
____Part-time, paid
____Part-time, non-paid
Note: AMC, VAMC, or CDPC are all considered "paid"

Administrative Appointment, if any (e.g., Department Chair, Division Head, Section Chief):
Division/Section: _____
Title: _____
Date Obtained: ____/____/____

If not full-time employee of Albany Medical Center, indicate affiliated hospital/clinical facility:
_____

Mailing Address
(please provide **only** the **preferred** mailing address)

Internal:		External:	
Department:	_____	Department:	_____
Bldg./Rm.:	_____	Institution:	_____
Mail Code:	_____	Street:	_____
Telephone:	_____	City/State/Zip:	_____
E-mail:	_____	Telephone:	_____
		E-mail:	_____

Professional Employment History

From/To 20___-______
Status ___Full-time ___Part-time
Institution ____
Department ____
Academic Rank ____
Time Allocation ____% Teaching ____% Research ____% Patient Care
____% Administration ____% Other

From/To 20___-______
Status ___Full-time ___Part-time
Institution ____
Department ____
Academic Rank ____
Time Allocation ____% Teaching ____% Research ____% Patient Care
____% Administration ____% Other

From/To 20___-______
Status ___Full-time ___Part-time
Institution ____
Department ____
Academic Rank ____
Time Allocation ____% Teaching ____% Research ____% Patient Care
____% Administration ____% Other

From/To 20___-______
Status ___Full-time ___Part-time
Institution ____
Department ____
Academic Rank ____
Time Allocation ____% Teaching ____% Research ____% Patient Care
____% Administration ____% Other

From/To 20___-______
Status ___Full-time ___Part-time
Institution ____
Department ____
Academic Rank ____
Time Allocation ____% Teaching ____% Research ____% Patient Care
____% Administration ____% Other

Year of first salaried appointment at a U.S. medical school:
Part-time: 20_____ Full-time: 20_____

Year of first salaried faculty appointment for the following ranks:
Professor: 20_____ Associate Professor: 20_____ Assistant Professor: 20_____ Instructor: 20_____

(Revised 10/14/09)

Education and Training

	Degree	Field of Study	Institution	Year
MD/DO/MBBS or equiv.	_____	_____	_____	
PhD or equiv.	_____	_____	_____	
Health related doctorate	_____	_____	_____	20___
MS public health	_____	_____	_____	20___
Other	_____	_____	_____	20___

Have you had post-doctoral research training of six months or more? ___Yes ___No

Graduate Medical Education

From/To	Institution	Specialty	Requirements Complete?
20___-_____	_____	_____	___Yes ___No
20___-_____	_____	_____	___Yes ___No
20___-_____	_____	_____	___Yes ___No
20___-_____	_____	_____	___Yes ___No

Board Certification

Year	Specialty	Board Certified?
20___	_____	___Yes ___No
20___	_____	___Yes ___No
20___	_____	___Yes ___No

FOR FULL-TIME FACULTY ONLY:
A copy of this form is forwarded to the Association of American Medical Colleges' (AAMC) Faculty Roster System for inclusion in their national faculty data base. Please provide signature consent or non-consent for the AAMC to release any of the above information for medical school/federal agency recruitment purposes.

____Yes Consent _____ (signature)

--or--

____No Non-Consent_____ (signature)

(Revised 10/14/09)

w:apt/demoform