NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

Dear Applicant:

Thank you for your interest in enrolling in the New York State Medicaid Program.

Participation in the New York State Medicaid Program is an important undertaking. Therefore, we want to make you aware of the following factors concerning your potential enrollment as a provider.

- An enrollment application does not guarantee enrollment in the Medicaid Program.
- If your application is accepted, the effective date of your enrollment will be specified by the Department.
- **You will be at financial risk if you render services to Medicaid patients before successfully completing the enrollment process. Payment will not be made for any claims submitted for service, care or supplies furnished before the enrollment date authorized by the Department. Until the group enrollment process is completed you should continue to submit claims under the individual practitioner's Medicaid Provider ID number.**
- All of the information reported by you on the application will be verified by the Department before your acceptance into the Medicaid Program.
- Subsequent requests for information concerning your application must receive a response within the time frames specified by the Department or your application is subject to termination and/or denial.
- Enrollment may be denied for failure to accurately or completely disclose information during the application process and for any other factors the Department determines to be applicable.

Your signature on the application acknowledges that the Owner(s) or Board Member(s) of the group agree(s) that they are fully responsible for the professional services rendered by all members of the group of employees, consultants or independent contractors.

New York State Medicaid Regulations allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

When you are enrolled in the Medicaid Program, you will receive a letter informing you of your acceptance and the effective date of your enrollment. Approximately two weeks after you receive your acceptance letter, you will receive a package containing claim forms and instructions on how to obtain the appropriate Provider Manual which is available online at www.eMedNY.org. If you do not have internet access, you can obtain your provider manual by calling the eMedNY Call Center at (800) 343-9000. The Provider Manual contains New York State Medicaid policy, a list of information sources and billing instructions. The Medicaid Update may also be accessed online at www.eMedNY.org. Click Information, then DOH Medicaid Update Website.

As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, www.health.state.ny.us.

In addition, pursuant to 42 CFR §455.105, by enrolling in the Medicaid Program, you are entering into an agreement with the NYS Department of Health by which you agree to and may be requested to provide the following information within 35 days upon request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have 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 you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.

If you have any questions, please contact the eMedNY Call Center at (800) 343-9000.

Sincerely,

Bureau of Provider Enrollment
Fee for Service Operations Group
Division of OHIP Operations

Group Enrollment
EMEDNY-426101 (10/11)

New York State Medicaid
Group Enrollment Form Checklist

- The following information must be provided to process your enrollment application.
- Failure to submit any required information may result in your application being returned to you and will delay the enrollment process.

Required fields to be completed on the enrollment form

- Category of Service
- Type of Application*
- Name of Applicant
- National Provider Identifier (NPI)
- Federal Employer Identification Number (FEIN)
- Correspondence Address
- Pay to Address
- Service Address
- All Yes/No questions must be answered**
- Owner's original signature

*If reinstatement is checked, please see required documentation on page 2 of this checklist.

**If yes answered to any of the four questions, you must complete the Prior Conduct Questionnaire available at www.emedny.org. You are required to provide documentation and/or details explaining the circumstances.

Required documentation to be submitted

- Medicaid Provider Enrollment: Group Enrollment Form (requires owner's signature)
- Disclosure of Ownership and Control – Business Entity form
- Federal Employer Identification Number (FEIN):
  - Submit a copy of the Department of Treasury, Internal Revenue Service letter assigning your FEIN.
- Medicaid Provider Enrollment: Group Member List
- Submit the Office of Medicaid Inspector General (OMIG) provider compliance confirmation (if applicable). For more information go to the OMIG website, compliance section at www.omig.ny.gov.
- Request for Medicaid Participation as a Group Member (for each group member)
- Dental Group Provider Information Request Form (dental groups only COS 0020)
- If service location is not within New York State, a copy of your state's Medicaid (or equivalent) approval letter.
- If your practice location is office based surgery accredited:

Submit a copy of your certification of accreditation issued by one of the three organizations designated by the Commissioner of Health as outlined at www.nyhealth.gov.

- Medicare Award Letter:
  - Submit a copy of the group's Medicare award letter if you are enrolling as a Chiropractic, Clinical Social Worker, Podiatry or Physical Therapy group or if any member of the group is a Chiropractor, Clinical Social Worker, Physical Therapist or Podiatrist.

Reinstatements

- An application is considered to be a reinstatement if the applicant was previously excluded/terminated from the Medicaid program as a result of committing an unacceptable practice, discipline action taken against their license, indictment, conviction or Medicare exclusion.

- If yes answered to any of the four questions, you must complete the Prior Conduct Questionnaire available at www.emedny.org. You are required to provide documentation and/or details explaining the circumstances. If you answer yes to the first of the yes/no questions because you were excluded, terminated, sanctioned, or restricted by an agreement from any Medicaid program and/or Medicare program; you may be requested to supply information and/or documentation detailing all corrective steps taken demonstrating that the violations leading to your exclusion/termination shall not be repeated.

- Examples:
  - Re-education courses;
  - Attestations from third party payers;
  - Reports from quality assurance committees regarding review of records;
  - Medicare Reinstatements.

- Please note:
  - If an applicant is denied reinstatement, the applicant cannot re-apply for reinstatement for two (2) years from the date of the denial.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THE MEDICAID PROVIDER ENROLLMENT APPLICATION

GENERAL INSTRUCTIONS

- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- Forms containing white out will be rejected.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not use staples.
- When including attachments less than 8 ½ " x 11" in size, affix the attachment (using transparent single-sided tape) to an 8 ½" x 11" sheet of paper. When required attachments are greater than 8 ½ " x 11" in size, make a reduced copy of the attachment using an 8 ½ " x 11" sheet of paper.
- Double-sided forms will be rejected.

MEDICAID PROVIDER ENROLLMENT GROUP ENROLLMENT FORM INSTRUCTIONS

PROVIDER NUMBER:	Leave blank.
CATEGORY OF SERVICE:	Check the category that applies. **Please note: A Multi-Service Group is defined as a group whose members consist of more than one provider type. For example: if 2 physicians and 1 nurse-midwife are in the group, the group must enroll as a Multi-Service Group.**
APPLICATION TYPE:	This field must be completed. (See Required Documentation on page 2 of the Checklist.)
APPLICANT NAME:	Enter the name exactly as it appears on your letter from the Department of Treasury, Internal Revenue Service.
DOING BUSINESS AS (DBA) NAME:	If applicable.
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter your NPI.
FEDERAL EMPLOYER ID NUMBER:	Enter the Department of Treasury, Internal Revenue Service Federal Employer Identification Number (FEIN) issued for the group. Attach a copy of the Department of Treasury, Internal Revenue Service letter assigning the FEIN.

CORRESPONDENCE ADDRESS:

Enter the address where all correspondence and claim forms will be sent. A street address is required to accommodate shipment of bulk material.

Attention Line: Use this only if the name or person who will receive the mail is different than the business or for an apartment/suite number or building location.

Street: Cannot be a P.O. Box unless accompanied by an actual street address.

PAY TO ADDRESS:

If you request that your checks be sent to an addressother than the correspondence address, complete this section. If you want your Medicaid checks to be sent to your correspondence address, write "SAME".

SERVICE ADDRESS:

This address must be the physical location of your group. If services are provided at more than one location, complete the **Additional Service Addresses form EMEDNY-490101**. If the service address is an accredited Office Based Surgery site, please check the box marked Office Based Surgery.

CORPORATE ADDRESS INFORMATION

Supply this information if this NPI is associated with a corporate entity which sponsors other Medicaid services enrolled under other NPI(s). **NOTE:** Annual tax documents will be sent to this address. If you previously enrolled an NPI with this FEIN, the address on file for the FEIN will be duplicated here. If this is the first NPI you are reporting for this FEIN and this field is left blank, the address you supplied as the Pay-To address will be duplicated here.

OWNERSHIP CODE:

Enter the number that is applicable.

MEDICARE INFORMATION

Indicate whether you are enrolled in Medicare.

TYPE OF PRACTICE:

For each service address, check the box from the list which describes your type of practice at that address.

1. Individual (Sole Proprietor)
2. Group

PLACE OF SERVICE:

For each service address, check the box from the list which describes the site.

1. Private Office
2. Hospital/Nursing Home
3. Free Standing Clinic
4. Health Maintenance Organization
5. Shared Health Facility

YES/NO QUESTIONS:

It is **mandatory** that all four questions be answered.

If yes answered to any of the four questions, you must complete the Prior Conduct Questionnaire available at www.eMedNY.org. You are required to provide documentation and/or details explaining the circumstances.

OWNER'S NAME:

Print the owner's name.

OWNER'S SIGNATURE:

The owner must **personally sign** and **date** the enrollment form acknowledging the attestation statement. If the group is owned by a medical corporation or hospital, a member of the Board of Directors must sign the application. **Signature stamps, photocopies, etc. are not acceptable.**

EMAIL ADDRESS:

Enter your email address if applicable.

PERSONAL PRIVACY LAW:

The State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting the information and how we will use it.

The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities.

This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider.

The information will be maintained by:

New York State Department of Health
Office of Health Insurance Programs
Division of Provider Relations and Utilization Management
Fee for Service Provider Enrollment Bureau
150 Broadway, Suite 6E
Albany, NY 12204

GROUP ENROLLMENT

MEDICAID PROVIDER ENROLLMENT

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

PROVIDER NUMBER (LEAVE BLANK)

CATEGORY
- ☐ 0020 - Dental Group (Office)
- ☐ 0020 - Dental Group (Mobile Van)
- ☐ 0046 - Physician Group
- ☐ 0050 - Podiatric Group
- ☐ 0090 - Multi-Service Group
- ☐ 0052 - Nurse Midwife Group
- ☐ 0058 - Clinical Psychologist Group
- ☐ 0062 - Therapy Group

APPLICATION TYPE
- ☐ New Enrollment/Reactivation
- ☐ Reinstatement (See definition on pg 2 of checklist)

APPLICANT NAME

DBA NAME

YOUR D/B/A NAME OR ANY OTHER NAME THAT THE COMPANY IS KNOWN BY

NATIONAL PROVIDER IDENTIFIER (NPI)

FEDERAL EMPLOYER ID NO.

CORRESPONDENCE ADDRESS (Claim forms and mail)

ATTENTION
Enter the NAME of the person/department/apartment number where the mail should be sent

STREET - LINE 1
Cannot be a Post Office Box UNLESS accompanied by an actual street address

- LINE 2

CITY
Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE ( ) - EXT.

PAY TO ADDRESS (Checks and Remittance Statements)

ATTENTION

STREET - LINE 1

- LINE 2

CITY
Do NOT use abbreviations

STATE ZIP CODE - COUNTY

SERVICE ADDRESS INFORMATION ☐ Office Based Surgery

ATTENTION

STREET - LINE 1
(This MUST be a physical location, NOT a P.O. Box)

- LINE 2

CITY
Do NOT use abbreviations

STATE ZIP CODE - COUNTY

TELEPHONE ( ) - EXT.

CORPORATE ADDRESS INFORMATION

Supply this information if this NPI is associated with a corporate entity which sponsors other Medicaid services enrolled under other NPI(s). Note: Annual tax documents will be sent to this address. If you previously enrolled an NPI with this FEIN, the address on file for the FEIN will be duplicated here. If this is the first NPI you are reporting for this FEIN and this field is left blank, the address you supplied as the Pay TO address will be duplicated here.

ENTER THE NAME EXACTLY AS IT APPEARS ON THE FEIN DOCUMENTATION

ATTENTION LINE (TITLE OR DEPARTMENT NAME ONLY – EXAMPLE "CFO" OR "ACCOUNTING OFFICE")

STREET ADDRESS – LINE 1

STREET ADDRESS – LINE 2

CITY – DO NOT USE ABBREVIATIONS COUNTY

STATE ZIP CODE - TELEPHONE ( ) - EXT.

OWNERSHIP CODE

16- SOLE PROPRIETORSHIP

17- PARTNERSHIP

18- PROFESSIONAL CORPORATION

19- OTHER/NOT-FOR-PROFIT

MEDICARE INFORMATION

Are you enrolled in Medicare? ☐ Yes ☐ No

TYPE OF PRACTICE (Check ONE)

☐ Individual / Sole Proprietorship (1) ☐ Group (2)

PLACE OF SERVICE (Check ONE)

- ☐ Private Office (1)
- ☐ Hospital, Nursing Home (2)
- ☐ Free Standing Clinic (3)
- ☐ Health Maintenance Organization (4)
- ☐ Shared Health Facility (5)

QUESTIONS

YES	NO	
☐	☐	Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?
☐	☐	Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?
☐	☐	Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any State?
☐	☐	Is there currently pending any proceedings that could result in the above stated sanctions?

ATTESTATION: The signature of the Owner or Board Member acknowledges that the group agrees that it is fully responsible for the professional services rendered by members of the group as employees, consultants or independent contractors.

OWNER OR BOARD MEMBER NAME (PRINT) | EMAIL ADDRESS

I swear that the information that I have provided is true and accurate to the best of my knowledge

OWNER OR BOARD MEMBER SIGNATURE (ORIGINAL SIGNATURE REQUIRED) | DATE SIGNED | PREPARER NAME (PRINT) | TELEPHONE #

MAIL TO:

MEDICAID PROVIDER ENROLLMENT
ADDITIONAL SERVICE ADDRESS

COMPUTER SCIENCES CORPORATION
P.O. BOX 4603
RENSSELAER, NY 12144

PROVIDER ID# [_____]
NATIONAL PROVIDER IDENTIFIER [_____]
APPLICATION DATE MM/DD/YY [/ /]
CATEGORY OF SERVICE [_____]

APPLICANT NAME [_____]

SERVICE ADDRESS INFORMATION

ATTENTION [_____]
ADDRESS-1 [_____]
ADDRESS-2 [_____]
This MUST be a physical location, NOT a P.O. Box
CITY [_____]
Do NOT use abbreviations
STATE [ ] ZIP CODE [-] COUNTY
TELEPHONE [( ) - EXT]

OFFICE BASED SURGERY ☐
TYPE OF PRACTICE (Check ONE)
☐ Individual (1) ☐ Salaried (3)
☐ Group (2) ☐ Contract (4)

PLACE OF SERVICE (Check ONE)
☐ Private Office (1)
☐ Hospital/Nursing Home (2)
☐ Free Standing Clinic (3)
☐ Health Maintenance Org. (4)
☐ Shared Health Facility (5)

SERVICE ADDRESS INFORMATION

ATTENTION [_____]
ADDRESS-1 [_____]
ADDRESS-2 [_____]
This MUST be a physical location, NOT a P.O. Box
CITY [_____]
Do NOT use abbreviations
STATE [ ] ZIP CODE [-] COUNTY
TELEPHONE [( ) - EXT]

OFFICE BASED SURGERY ☐
TYPE OF PRACTICE (Check ONE)
☐ Individual (1) ☐ Salaried (3)
☐ Group (2) ☐ Contract (4

PLACE OF SERVICE (Check ONE)
☐ Private Office (1)
☐ Hospital/Nursing Home (2)
☐ Free Standing Clinic (3)
☐ Health Maintenance Org. (4)
☐ Shared Health Facility (5)

SERVICE ADDRESS INFORMATION

ATTENTION [_____]
ADDRESS-1 [_____]
ADDRESS-2 [_____]
This MUST be a physical location, NOT a P.O. Box
CITY [_____]
Do NOT use abbreviations
STATE [ ] ZIP CODE [-] COUNTY
TELEPHONE [( ) - EXT]

OFFICE BASED SURGERY ☐
TYPE OF PRACTICE (Check ONE)
☐ Individual (1) ☐ Salaried (3)
☐ Group (2) ☐ Contract (4)

PLACE OF SERVICE (Check ONE)
☐ Private Office (1)
☐ Hospital/Nursing Home (2)
☐ Free Standing Clinic (3)
☐ Health Maintenance Org. (4)
☐ Shared Health Facility (5)

MEDICAID PROVIDER ENROLLMENT

GROUP MEMBER LIST

APPLICANT NAME

CATEGORY OF SERVICE

This form MUST be completed with each group member's name, license number, Medicaid Provider Identification Number and National Provider Identifier (NPI). If the member is not yet enrolled but has submitted an enrollment application, write *pending* after the name of the group member.

NAME OF GROUP MEMBER	LICENSE NUMBER	MEDICAID PROVIDER IDENTIFICATION NUMBER	NATIONAL PROVIDER IDENTIFIER (NPI)

REQUEST FOR MEDICAID PARTICIPATION AS A GROUP MEMBER

NOTE:
Each member MUST complete and sign this form. This form may be photocopied.

1. Group Member's Name: _____

2. Member's National Provider Identifier (NPI): _____ Medicaid # _____
   (You must enroll to participate.)

3. Name of Group: _____

4. List the Service Address(es) where you work as a group member. Do not list private practice service addresses.

(a) _____
_____
_____

(b) _____
_____
_____

(c) _____
_____
_____

(d) _____
_____
_____

I agree to participate in the Medicaid Program as a member of the above named group. I realize that I continue to remain personally responsible for all claims billed to NYS Medicaid using both the Group National Provider Identifier (NPI)/Medicaid # and my Individual National Provider Identifier (NPI)/Medicaid #. I may have my name withdrawn from the above named group upon written request to the Office of Health Insurance Programs.

Print full name.

NAME _____
FIRST **MIDDLE** **LAST**

SIGNATURE _____ **DATE** _____

Mail To: Computer Sciences Corporation
P.O. Box 4603
Rensselaer, NY 12144 – 4603

New York State Medicaid
Disclosure of Ownership and Control – Business Entity

Name of Business Entity_____

Note

- The following questions do NOT only pertain to this provider application but include any and all past activity.
- Respond to these questions on behalf of yourself and any individuals or organizations having a direct or indirect ownership or control interest of 5% or more, and any partners, directors, officers, agents or managing employees of the provider completing this form.

Questions

1. Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?
   ☐ Yes ☐ No
2. Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?
   ☐ Yes ☐ No
3. Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or 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?
   ☐ Yes ☐ No
5. Type of entity
   ☐ Sole Proprietorship ☐ Unincorporated Association
   ☐ Corporation ☐ Governmental
   ☐ Partnership ☐ Other (Specify)_____
6. Has there been a change of ownership or control within the last 12 months?
   ☐ Yes ☐ No
   If "Yes," provide both: _____/_____/_____
   MM / DD / YY
   Medicaid # or National Provider Identifier (NPI)_____
7. Do you anticipate a change of ownership within the next 12 months?
   ☐ Yes ☐ No
   If "Yes," give date _____/_____/_____
   MM / DD / YY

8. Ownership Information:

Who Must Disclose

- Individual or **corporation** with an ownership control interest (direct or indirect of 5% or more), managing employees of the disclosing entity, subcontractor with 5% or more interest in the disclosing entity, other disclosing entities in which an owner of the disclosing entity has an ownership or control interest.

What to Disclose

- Name, address of any person (individual or **corporation**) with an ownership or control interest in the disclosing entity.
- Date of birth (DOB) and Social Security Number (SSN) for individuals and tax identification number (EIN) for **corporations**. Include familial relationship (spouse, parent, child, sibling) to other persons with ownership and control interest in the disclosing entity and subcontractors with 5% or more interest in the disclosing entity.
- Corporate entities must attach a separate list of every business location and PO Box address.
- For definitions of ownership, indirect ownership, managing employee refer to Part 504 of 18 NYCRR.
- For complete set of rules and regulations refer to Federal Register Vol. 76 No 22 §455.104.
- Failure to provide the required information may result in denial of enrollment.
- This page may be photocopied for additional listings.

Name		Title
Address		
SSN/EIN	DOB	% Ownership
Title: ☐Owner ☐Board Director ☐Managing Employee		Familial Relationship
Name		Title
Address		
SSN/EIN	DOB	% Ownership
Title: ☐Owner ☐Board Director ☐Managing Employee		Familial Relationship
Name		Title
Address		
SSN/EIN	DOB	% Ownership
Title: ☐Owner ☐Board Director ☐Managing Employee		Familial Relationship
Name		Title
Address		
SSN/EIN	DOB	% Ownership
Title: ☐Owner ☐Board Director ☐Managing Employee		Familial Relationship

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

☐ Yes ☐ No

If "Yes," give date _____/_____/_____
MM / DD / YY

10. Has there been a change in your laboratory director/supervising pharmacist within the last 12 months?

☐ Yes ☐ No ☐ Not Applicable

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

☐ Yes ☐ No

If "Yes," indicate amount $_____

- Has payment been arranged?

☐ Yes ☐ No

If "Yes," please attach verification of this.

12. If this application is for a change of ownership or an impending change of ownership, are you assuming all current or future liabilities owed by the seller to the Medicaid program for the entity that you have purchased or are purchasing?

☐ Yes ☐ No ☐ Not Applicable

Unannounced site visits by Medicaid, CMS or their agents/designated contractors may be a condition of initial and continued enrollment. In addition, the provider and/or owners (defined as at least a 5 percent interest) may be required to consent to criminal background checks including fingerprinting.

As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, http://health.ny.gov.

In addition, pursuant to 42 CFR §455.105, by enrolling in the Medicaid Program, you are entering into an agreement with the NYS Department of Health by which you agree to and may be requested to provide the following information within 35 days upon request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have 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 you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.

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 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 of Health and Human Services, as appropriate.

Owner/Board Member Name (printed) Signature (No stamps) Date

New York State Medicaid
Dental Group Provider Information Request Form

1. Lease agreements:

   - Please attach a signed copy of your current lease. The lease must indicate the amount of rent and to whom it is paid.

   - If you do not have a lease, please explain:
     _____
     _____

   - Please list the name and address of the owner of the building to be used by the business. If a corporation owns the building, please list the corporation name and the names of the officers and directors of the corporation:

   _____
   _____
   _____

2. Group member status:

   - Are the members of the group employees? Yes ____ No ____
   - Are the members' individual subcontractors or consultants?
     Yes _____ No ____
   - Are there any other dentists at your address that are not members of your group? Please explain.
     _____

3. Is the group operated by a management company? Yes _____ No _____

   If yes, please list the name of the company and submit a copy of the management contract with your application: _____

4. If the members of the group are employees, attach W2(s), contracts and/or employment verification between the group and individual members.

   If the members are individual subcontractors or consultants, please submit a copy of the 1099 and current contract.

5. Have any members of the group ever been excluded, terminated or denied enrollment or re-enrollment from Medicaid? Yes _____ No _____
   If Yes, please list the member's name(s) and explain:
   _____
   _____
   Do any members have license restrictions, such as probation or a monitoring requirement? Yes _____ No _____
   If Yes, please list the member's name(s) and explain:

   _____

6. List all dentists, dental assistants and hygienists that were not included as members of the group:

Name **License # and category**

_____
_____
_____

7. List all group members that provide dental specialties and provide a copy of their certification:

_____
_____

8. Identify any locations not listed on your application where you will provide services:

_____
_____

9. Do you provide services in dental vans or any other mobile vehicle?
Yes _____ No _____
If Yes, please list the vehicle type, registration number and Vehicle Identification Number (VIN) for each:

Vehicle Type **Registration #** **VIN**

_____
_____
_____

Please note that dental van services will not be reimbursed if you leave this area blank. If you do not currently use a van but add a dental van in the future, a new application must be submitted.

10. Place of service

- Do you provide services in skilled nursing facilities or group homes?
  Yes _____ No _____
  If Yes, please list and include any contracts you have with them.
  _____
  _____

- Do you provide services in patients' homes? Yes _____ No _____
  If Yes, indicate what percentage of your business is provided in this manner, and describe how you are referred to these patients and by whom.
  _____
  _____

11. Do you provide dental services to children? Yes _____ No _____

If yes, do you allow parents in the room where services are provided? _____

Do you use restraints under any circumstances? Yes _____ No _____

Please describe _____

12. Does your group utilize a billing service (service bureau)? Yes ____ No _____

If so, please provide their name and address. If enrolled in the Medicaid Program, please provide the provider number and a copy of your contract or agreement.

Name **Address** **Provider or NPI #**

_____

_____

If you do not use a billing service, please attach a statement identifying who is authorized to sign the Medicaid claim forms:

_____

_____

13. When did your group start providing services? _____

Please list your total income over the last 12 months: _____

14. Indicate the days and corresponding hours the dental office fill be open

Monday _____ Friday _____
Tuesday _____ Saturday _____
Wednesday _____ Sunday _____
Thursday _____

15. Please list all third party insurers that you currently contract with:

_____

_____

If you do not currently contract with any insurers, please list the insurers that you have submitted bills to within the last 12 months:

_____

_____

16. Estimate the percentage of your total business that will be billed to the Medicaid Program: _____%

17. Has your group recently purchased or acquired an enrolled group in the Medicaid Program? Yes _____ No_____

If yes, please name the purchased group and submit a copy of all sales documents.

18. Has your group ever gone under a different name? Yes _____ No _____

If yes, please list the name and if ever enrolled, the Medicaid Provider #:

_____

19. List any dental laboratories that your practice utilizes.

_____

If dental laboratory services are performed in-house, please supply purchasing invoices for all equipment and photos of your dental lab area, including equipment.

20. Do you routinely receive referral work from other dentists or groups?
Yes _____ No_____

If so, please name:
_____

21. Do you routinely refer work to other dentists or groups?
Yes _____ No_____

If so, please name:
_____

Form completed by: _____

Owner's Signature: _____

(form must be signed by an owner of the group)