INSTRUCTIONS FOR COMPLETING THE NY MEDICAID ENROLLMENT FORM FOR those who ONLY ORDER-REFER-ATTEND-PRESCRIBE

1. General Instructions:

- Complete ALL items on the form unless otherwise instructed below**. Failure to complete all required fields will result in your enrollment form being returned to you which may have an impact on the enrollment effective date.
- Required document (see #3 below) MUST cover the application date and be continuous through the current date.
- Completion of signature field is required and must be original. Initials or rubber stamped signatures will not be accepted.
- Type or legibly print in black or blue ink. Do not use red ink, nor white-out. All attachments will be scanned so they must be legible and on standard 8 ½ x 11 paper in good condition.
- Keep a copy of all documents submitted.

2. Additional Instructions and Definitions for Form Completion:

Category(s) of Service: Enter the appropriate 4-digit code based on your Licensure (see Page 2 of these instructions)

Choose ONE and check the corresponding box on the Enrollment Form:

- ✓ *Check New Enrollment if the NPI or Provider listed is not currently enrolled in NYS Medicaid*
- ✓ *Check Revalidation if the NPI or Provider is currently enrolled and you were notified that Revalidation is required per 42 CFR, Part 455.414. The Provider ID can be found on the Revalidation Letter you received*
- ✓ *Check Reinstatement/Reactivation if the provider was previously enrolled but is not currently active. Please note: You will be at financial risk if you render services to Medicaid beneficiaries before successfully completing the enrollment process.*

**Leave the following fields blank if they do not pertain to you:

- Group NPI
- Specialty

Service Address: Do not indicate a Patient's Address. PO Box is Not Acceptable.

**Ownership in Applicant: If, after you have reviewed 18NYCRR, Section 504.1(d)(18)(iv), you determine this part of Section 1 does not pertain to you, write N/A in the box labeled, "Name of Individual or Entity"

**Section 2, 3 or 4: If one or more of these Sections do not pertain to you, write N/A in the Name box as appropriate.

Section 5: Association Type: Enter the letter (B, F, H, M, P or U) which best corresponds to the individual's role:

B: Board of Directors Member	F: Facility Administrator	H: Compliance Officer
M: Managing Employee	P: Supervising Pharmacist	U: Laboratory Director

3. ADDITIONAL REQUIREMENTS

OMIG Provider Compliance Certification – Confirmation notice for the OMIG Provider Compliance Program may be required. Visit www.omig.ny.gov to determine if the Applicant / Provider must comply. If yes, a copy of the confirmation notice (printed from the website) must be included with this application.

REQUIRED DOCUMENTS TO BE SUBMITTED WITH THIS FORM:

1. Copy of Your Current License/Registration
2. See "Additional Requirements" on Page 2 of these instructions

PRACTITIONER TYPE	CATEGORY OF SERVICE	ADDITIONAL REQUIREMENTS
Audiologist	0325	None
Certified Asthma Educator	0570	1. Copy of your National Asthma Educator Certificate 2. Form EMEDNY-431601 Employment Certification
Certified Diabetes Educator	0571	1. Copy of your National Diabetes Educator Certificate 2. Form EMEDNY-431601 Employment Certification
Chiropractor	0140	Copy of Medicare Award/ Participation letter
Clinical Psychologist	0580	None
Clinical Social Worker	0560	Copy of Medicare Award/ Participation letter
Dentist	0200	Specialty Form EMEDNY-490301, if applicable
Midwife/Nurse Midwife	0525	Copy of DEA Cert. if prescribing
Nurse – LPN	0521	None
Nurse – RN	0522	None
Nurse Practitioner	0469	1. Copy of your DEA Certificate 2. Form EMEDNY-410501 Collaborating Physician Certification
Optician (Salaried)	0403	if applicable, a copy of your Low Vision or Contact Lens Certificate(s)
Optician (Self-Employed)	0404	
Optometrist (Salaried)	0421	if applicable, a copy of your Low Vision or Contact Lens Certificate(s)
Optometrist (Self-Employed or Member of a Multi-Service Group)	0422	
Physician	0460	1. Copy of your DEA Certificate 2. Specialty Form EMEDNY-490301, if applicable
Physician Assistant (Registered)	0462	1. Form EMEDNY-412601 Supervising Physician Certification 2. Copy of DEA Cert. if prescribing
Podiatrist	0500	1. Copy of your DEA Certificate 2. Copy of Medicare Award/ Participation letter
Therapist - Occupational	0621	None
- Speech Pathology	0623	None
- Physical	0622	Copy of Medicare Award/ Participation letter