NEW YORK STATE | Department of Health

Enrolling as a Billing Provider in eMedNY

Application review for Local Departments of Social Services to bill eMedNY for Community First Choice Option services

August 2019

Purpose

- Provide Local Departments of Social Services (LDSS) with the training necessary to successfully complete the New York State (NYS) Medicaid Provider Enrollment application.
- Ongoing discussions will continue with the LDSS and the Department until the implementation date of January 1, 2020.

Background

- On July 29, 2019, a letter was mailed to LDSS commissioners, notifying them of an additional, optional mechanism for payment; the county can use for certain CFCO services. (e.g., Assistive Technology, Environmental Modification, Vehicle Modification)
- The Direct Billing option is an optional payment mechanism that will allow the LDSS to bill the Medicaid program directly for such services.
- Under this option, the LDSS will enroll to be a Provider of Services for the NYS Medicaid Program.
- To help facilitate the provider enrollment process, the Department will waive the provider application fee.
- This payment mechanism provides a pathway to accelerate the time period for reimbursement.

How to Enroll as a Provider of Services for the NYS Medicaid Program

Steps to Submit MMIS Application

1. Go to https://www.emedny.org
2. Click on the Provider Enrollment Tab

3. The ***Provider Enrollment & Maintenance*** page will populate. This screen provides useful information and necessary links to complete the application process:
   - ***a) Provider List Filter***
   - ***b) Enrollment Guide***

Note: Materials are updated periodically. Current versions must be used directly from the website.

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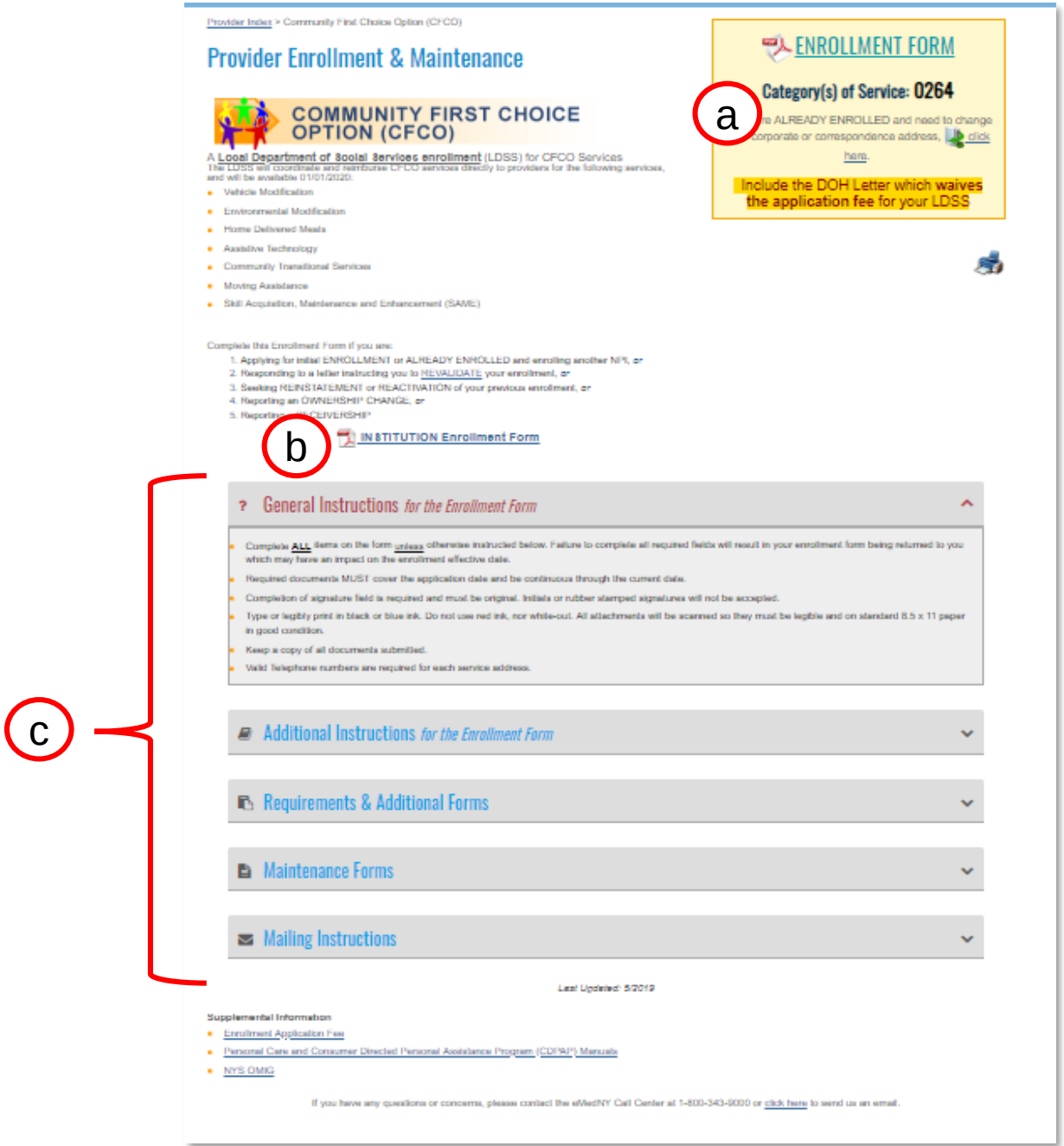
Provider List Filter

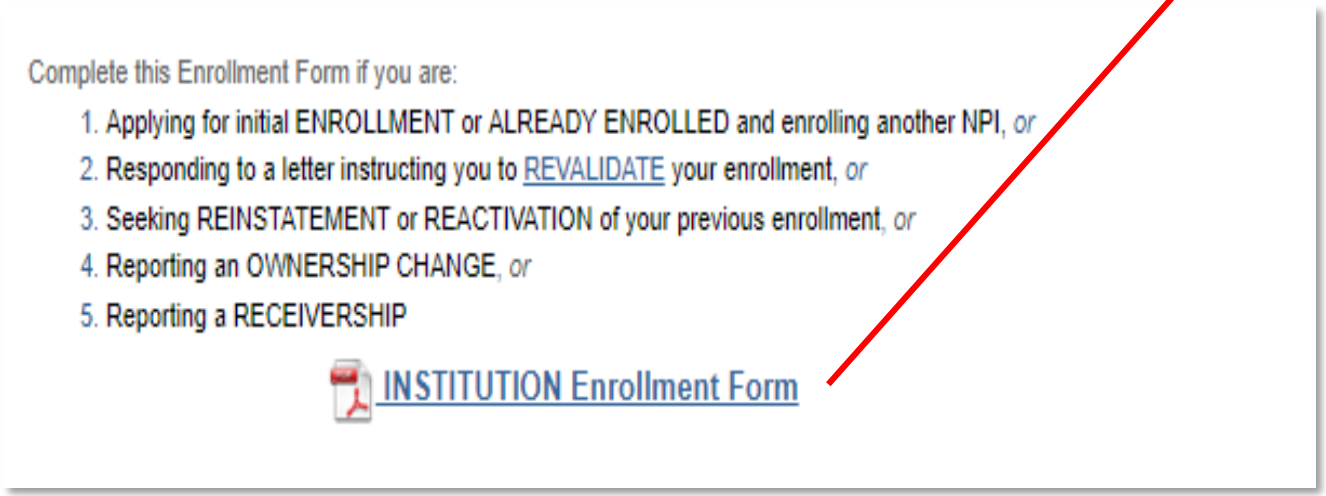
4. Select the **Institution** radio button on the right hand side under the **Provider List Filter.** This will change the **Provider index** listed below.
5. In the list below, select **Community First Choice Option (CFCO).**

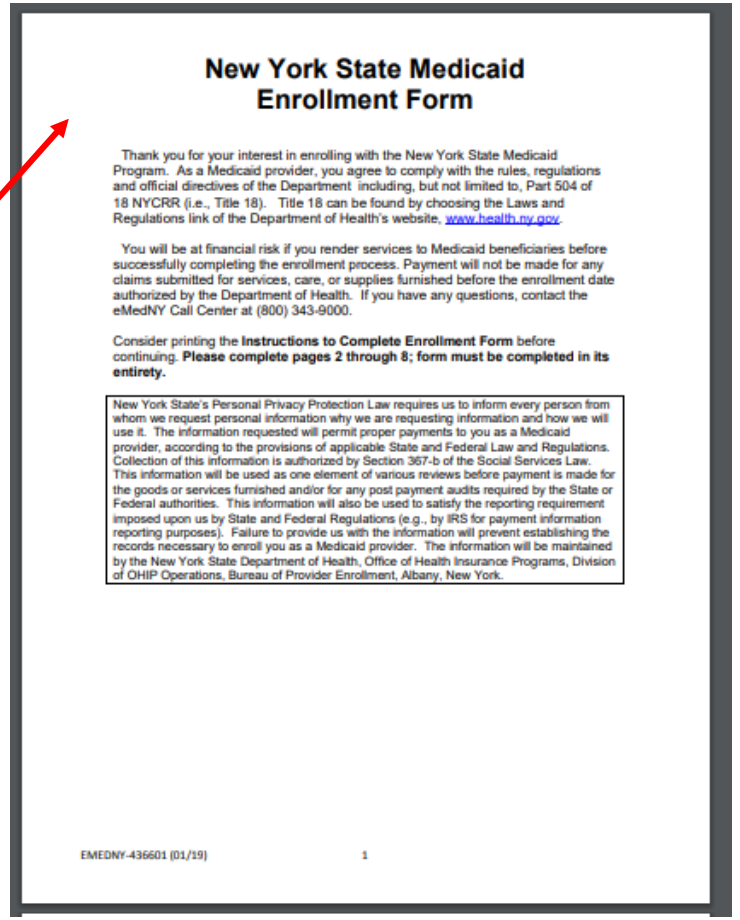
6. The ***Community First Choice Option*** page opens. This screen provides useful information and general instructions:
   - **a) The Category of Service (0264)** for all CFCO services listed.
   - **b) INSTITUTION Enrollment Form**
   - **c) General Instruction for the Enrollment Form** includes collapsible information under each heading:
     - **Additional Instructions for the Enrollment Form**
     - **Requirements & Additional Forms**
     - **Maintenance Forms**
     - **Mailing Instructions**



Enrollment Form

7. Click on the **INSTITUTION Enrollment Form.** The *New York State Medicaid Enrollment Form* will populate in a separate window. Scroll to page 2 to begin completing the form.





New York State Medicaid Enrollment Form

Thank you for your interest in enrolling with the New York State Medicaid Program. 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 (i.e., Title 18). Title 18 can be found by choosing the Laws and Regulations link of the Department of Health's website, www.health.ny.gov.

You will be at financial risk if you render services to Medicaid beneficiaries before successfully completing the enrollment process. Payment will not be made for any claims submitted for services, care, or supplies furnished before the enrollment date authorized by the Department of Health. If you have any questions, contact the eMedNY Call Center at (800) 343-9000.

Consider printing the **Instructions to Complete Enrollment Form** before continuing. **Please complete pages 2 through 8; form must be completed in its entirety.**

New York State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting 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 the New York State Department of Health, Office of Health Insurance Programs, Division of OHIP Operations, Bureau of Provider Enrollment, Albany, New York.

EMEDNY-436601 (01/19) 1

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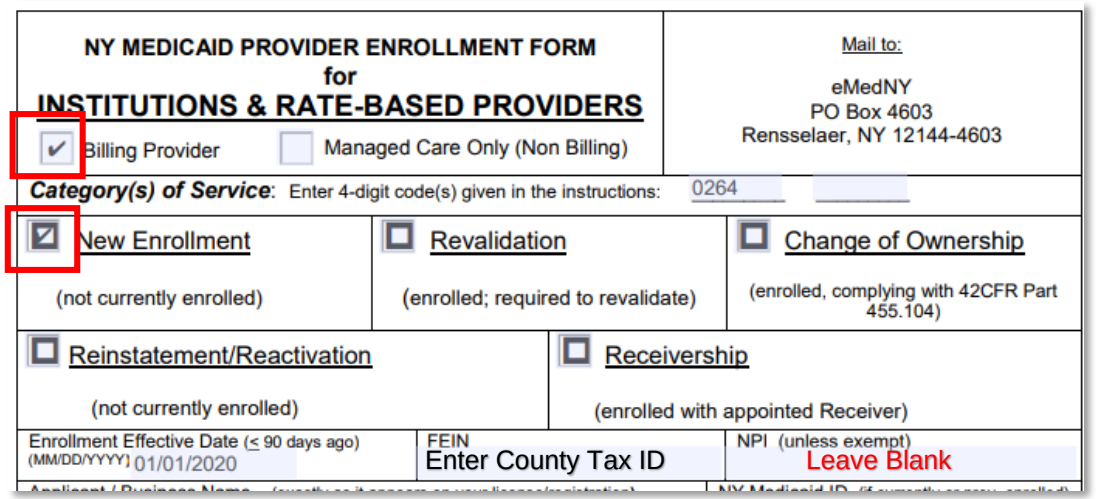
Page 2: Top Section

8. In the Top Section of page 2 complete the following fields:
   - **Billing Provider:** Select the associated check box
   - **Category(s) of Service:** Enter *0264*
   - **New Enrollment:** Select the check box
   - **Enrollment Effective Date:** Enter 01/01/2020
   - **FEIN:** Enter the district's *Federal Employer Identification Number (County's tax ID #)*
   - **NPI:** Leave blank


NY MEDICAID PROVIDER ENROLLMENT FORM
for
INSTITUTIONS & RATE-BASED PROVIDERS

Mail to:
eMedNY
PO Box 4603
Rensselaer, NY 12144-4603

☑ Billing Provider ☐ Managed Care Only (Non Billing)

Category(s) of Service: Enter 4-digit code(s) given in the instructions: 0264

☑ New Enrollment (not currently enrolled)
☐ Revalidation (enrolled; required to revalidate)
☐ Change of Ownership (enrolled, complying with 42CFR Part 455.104)
☐ Reinstatement/Reactivation (not currently enrolled)
☐ Receivership (enrolled with appointed Receiver)

Enrollment Effective Date (≤ 90 days ago) (MM/DD/YYYY) 01/01/2020
FEIN Enter County Tax ID
NPI (unless exempt) Leave Blank

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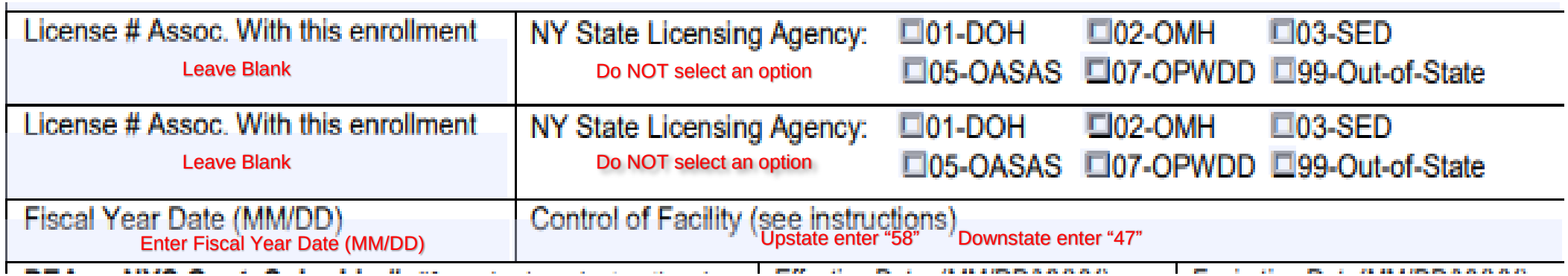
Page 2: Top Section (continued)

8. In the Top Section of page 2 complete the following fields (continued):
   - **Applicant / Business Name field:** Enter the “Name of County DSS – CFCO”
   - **NY Medicaid ID:** Leave blank
   - **Doing Business As (DBA)** Name: Leave blank

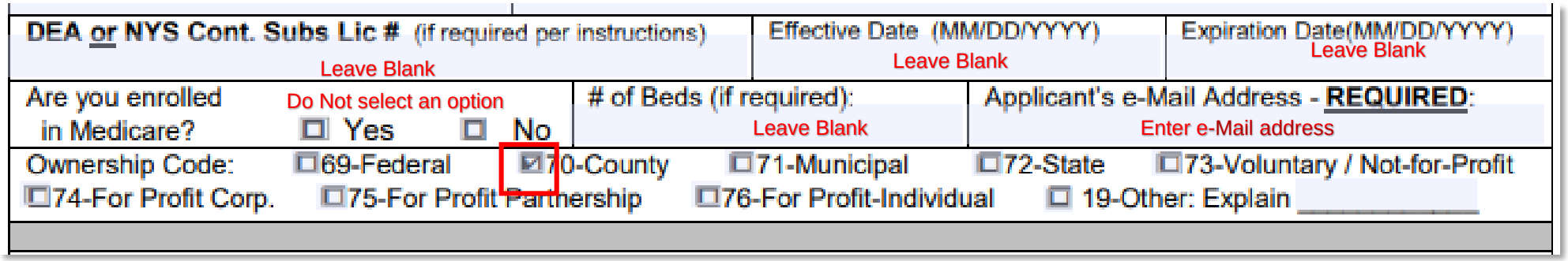
Page 2: Top Section (continued)

8. In the Top Section of page 2 complete the following fields (continued):
   - **License # Assoc** section: Leave blank
   - **Fiscal Year Date (MM/DD):** Enter your county's fiscal year
   - **Control of Facility:**
     - o Enter 58 for Upstate
     - o Enter 47 for Downstate



Page 2: Top Section (continued)

8. In the Top Section of page 2 complete the following fields (continued):
   - Leave blank the following fields:
     - **DEA or NYS Cont, Subs Lic #**
     - **Effective Date**
     - **Expiration Date**
     - **Are you enrolled in Medicare?**
     - **# of Beds**
   - **Applicant's e-Mail Address field:** Enter the e-Mail address where you would like receive notification pertaining to the MMIS number
   - **Ownership Code:** Select 70



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Page 2: CORRESPONDENCE Section

9. In the **CORRESPONDENCE** section fill in the following fields:
   - **Attention:** Enter an office or room number (Note: **Do not** enter an individual's name)
   - **Street Address, City, State and Zip Code:** Enter the street address where letters and claim forms should be sent
   - **The Suite / Department /Floor:** Enter if applicable
   - **County:** Enter your county name in the field (Boroughs)
   - **Telephone number:** Enter your 10 digit number
   - **Fax Number:** Enter your 10 digit number

CORRESPONDENCE: (indicate where letters and claims forms, if any, should be sent) – **PO Box not acceptable**		
Attention:	Street Address	Suite / Department / Floor
City	State	Zip Code (9 digits)
County (if in New York)	Telephone Number (w/ extension)	Fax Number

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Page 2: PAY TO ADDRESS Section

10. In the **PAY TO ADDRESS** section fill in the following fields:
    - **Attention:** Enter an office or room number (Note: Do not enter an individual's name)
    - **Street Address, City, State and Zip Code:** Enter the street address where checks & remittance statements should be sent until EFT and e-Remits are in place
    - **The Suite / Department /Floor:** Enter if applicable
    - **County:** Enter your county name in the field (Boroughs)
    - **Telephone number:** Enter your 10 digit number
    - **Fax Number:** Enter your 10 digit number

PAY TO ADDRESS: (indicate where checks & remittance statements should be sent until EFT and e-Remits are in place):		
Attention:	Street Address or PO Box	Suite / Department / Floor
City	State	Zip Code (9 digits)
County (if in New York)	Telephone Number (w/ extension)	Fax Number

Page 2: CORPORATE ADDRESS Section

11. In the **CORORATE ADDRESS** section fill in the following fields:
    - **Attention:** Enter an office or room number (Note: Do not enter an individual's name)
    - **Street Address, City, State and Zip Code:** Enter the street address where Annual Tax Documents should be sent

      Note: The address supplied will be ignored if Medicaid already recognizes an address for the FEIN listed above
    - **The Suite / Department /Floor:** Enter if applicable.
    - **County:** Enter your county name in the field. (Boroughs)
    - **Telephone number:** Enter your 10 digit number
    - **Fax Number:** Enter your 10 digit number

CORPORATE ADDRESS: (indicate where Annual Tax Documents (Form 1099) should be sent) **NOTE**: The address supplied will be ignored if Medicaid already recognizes an address for the FEIN listed above.		
Attention:	Street Address or PO Box	Suite / Department / Floor
City	State	Zip Code (9 digits)
County (if in New York)	Telephone Number (w/ extension)	e-Mail Address - **REQUIRED**

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Page 2: SERVICE ADDRESS Section

12. In the **SERVICE ADDRESS** section fill in the following fields.
    - **Attention:** Enter an office or room number (Note: Do not enter an individual's name)
    - **Street Address, City, State and Zip Code:** Enter the address where the approvals letters should be mailed
    - **Suite/Department/Floor:** Enter if applicable.
    - **County:** Enter your county name in the field. (Boroughs)
    - **Telephone number:** Enter your 10 digit number
    - **Fax Number:** Enter your 10 digit number

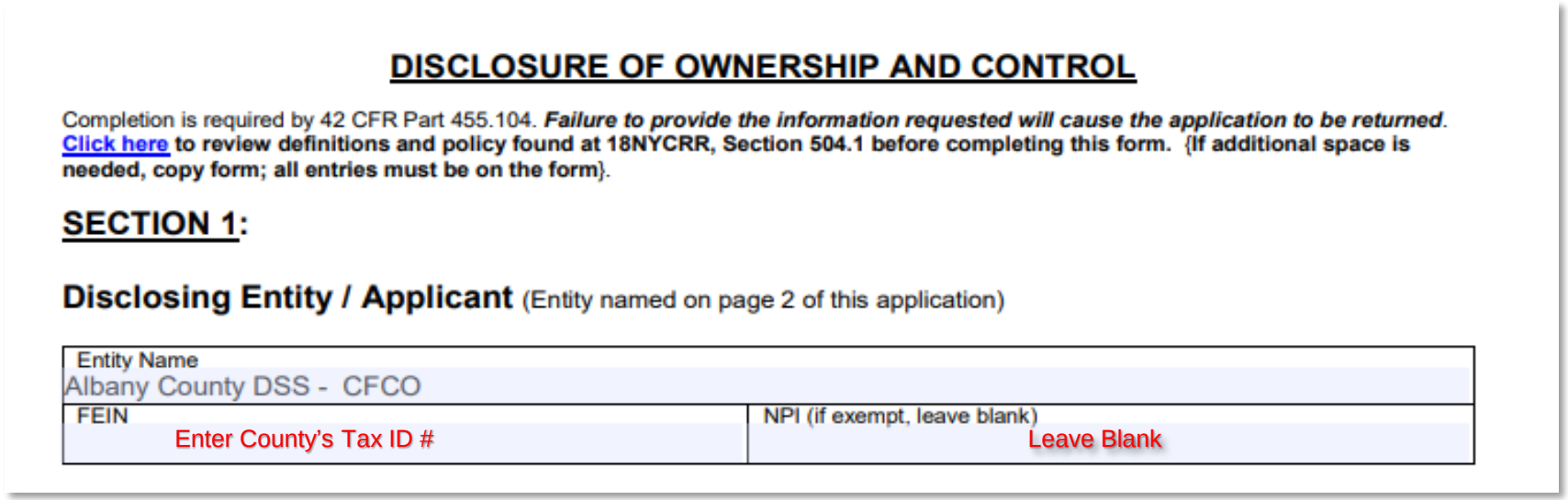
SERVICE ADDRESS: Only if listed on your license / certification
***Valid Telephone numbers are required for each service address.**

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

Page 4: Disclosing Entity / Applicant

13) In the **Disclosing Entity/Applicant** section complete the following fields:

- **Entity Name:** Enter the exact same name that was entered in step 8
- **FEIN:** Enter the district's *Federal Employer Identification Number (County's tax ID #)*
- **NPI:** Leave blank



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.*** **Click here 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 (Entity named on page 2 of this application)

Entity Name	
Albany County DSS - CFCO	
FEIN	NPI (if exempt, leave blank)
Enter County's Tax ID #	Leave Blank

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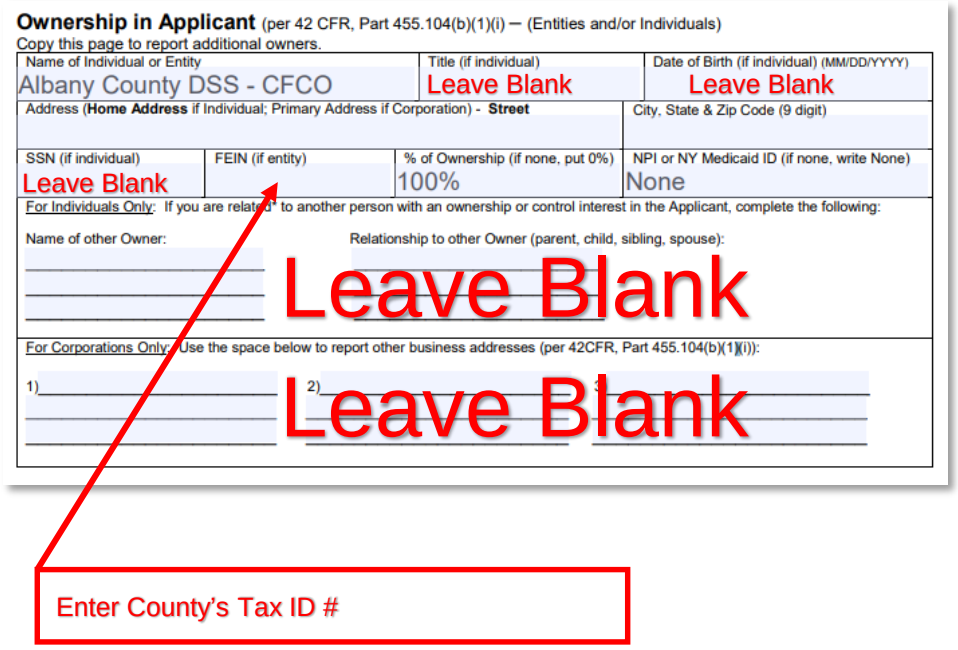
Page 4:Ownership in Applicant

14. In the **Ownership in Applicant** section complete the following fields:
    - **Entity Name**: Enter the exact same name that was entered in step 8.
    - **Title** and **Date of Birth:** Leave blank
    - **Address** and **City State** & **Zip Code:** Use the same address located on the LCM letter
    - **SSN:** Leave blank
    - **FEIN:** Enter County Tax ID #
    - **% of Ownership field**: Enter 100%
    - **NPI or NY Medicaid ID:** Enter None
    - **For Individuals Only** and **For Corporations Only** sections: Leave blank



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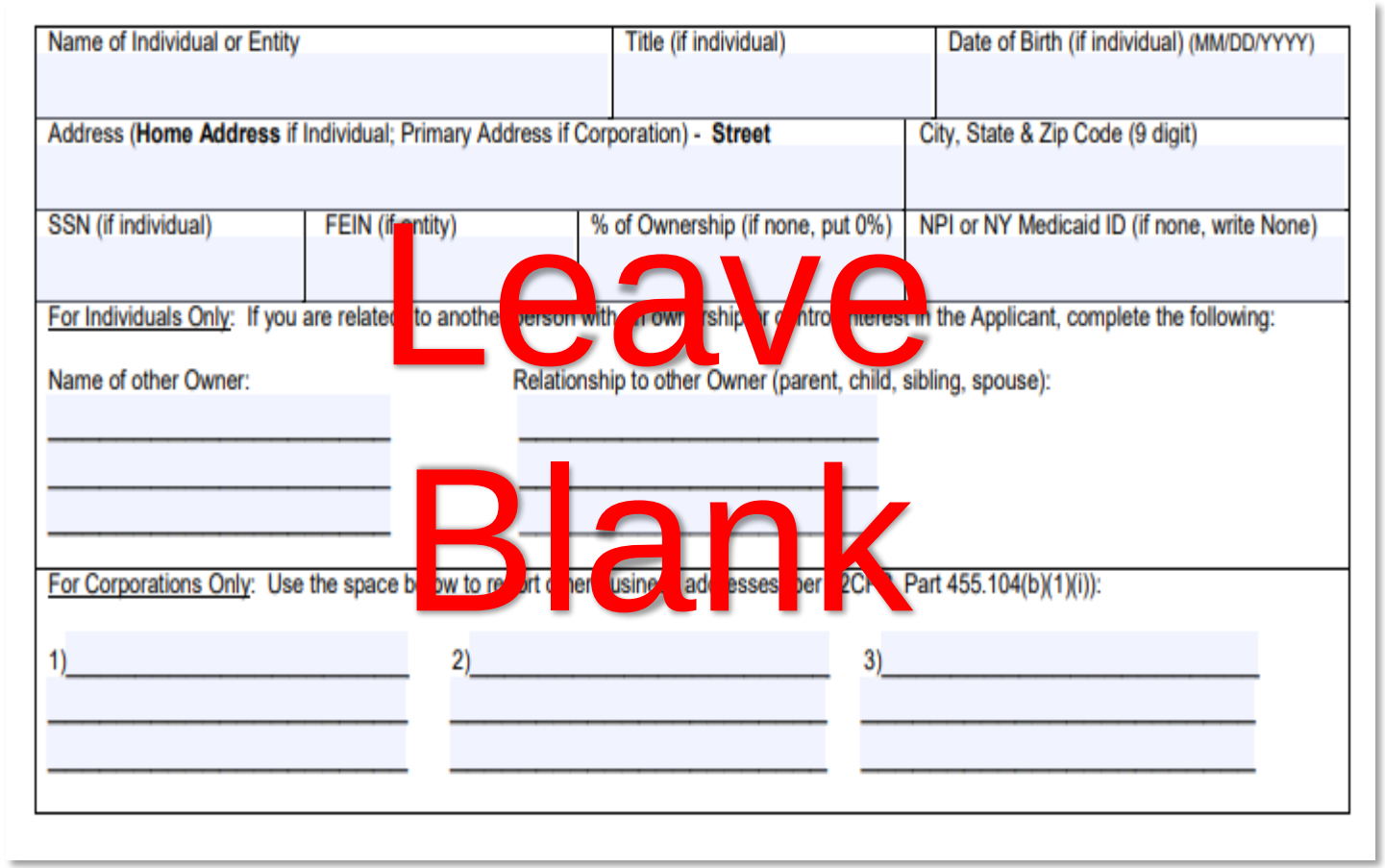
Page 4: Bottom Section

15. Leave the bottom section of page 4 blank.



Page 5: Section 2

16. In the **Ownership in Other Disclosing Entities (ODE)** complete the following fields:
    - **Name (from Section1):** Enter the exact same name that was entered in step 8
    - **NAME of ODE:** Enter Medicaid enrolled entities under your county EIN(if applicable) Make additional copies of this page if necessary.
    - **NPI or Medicaid ID of ODE: If ODE disclosed provide NPI/Medicaid ID**

SECTION 2:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104(a)(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
Albany County DSS - CFCO		
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE

Page 5: Sections 3 & 4

17. Leave **Section 3** & **Section 4** blank.

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

Leave Blank

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	Subcontractor's Name	Name & Familial Relationship
Owner's Name	Subcontractor's Name	Name & Familial Relationship

Leave Blank

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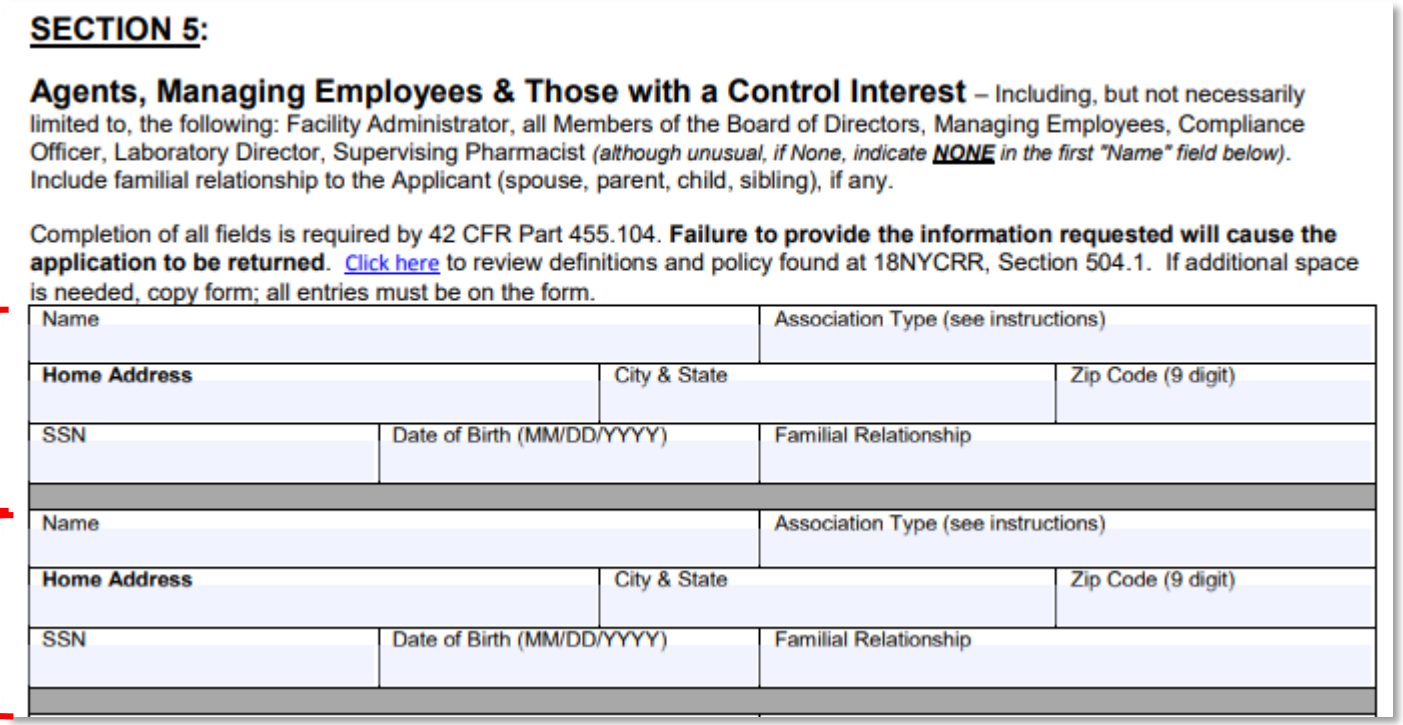
Page 5 & 6: Section 5

There must be at least one agent, managing employee or those with a control interest entered. NYSDOH is recommending that the first individual entered would be the Local District Commissioner. If applicable the second individual should be the Compliance Officer.

LDSS Commissioner

LDSS Compliance Officer



SECTION 5:

Agents, Managing Employees & Those with a Control Interest – Including, but not necessarily limited to, the following: Facility Administrator, all Members of the Board of Directors, Managing Employees, Compliance Officer, Laboratory Director, Supervising Pharmacist *(although unusual, if None, indicate **NONE** in the first "Name" field below)*. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any.

Completion of all fields is required by 42 CFR Part 455.104. **Failure to provide the information requested will cause the application to be returned**. Click here to review definitions and policy found at 18NYCRR, Section 504.1. 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

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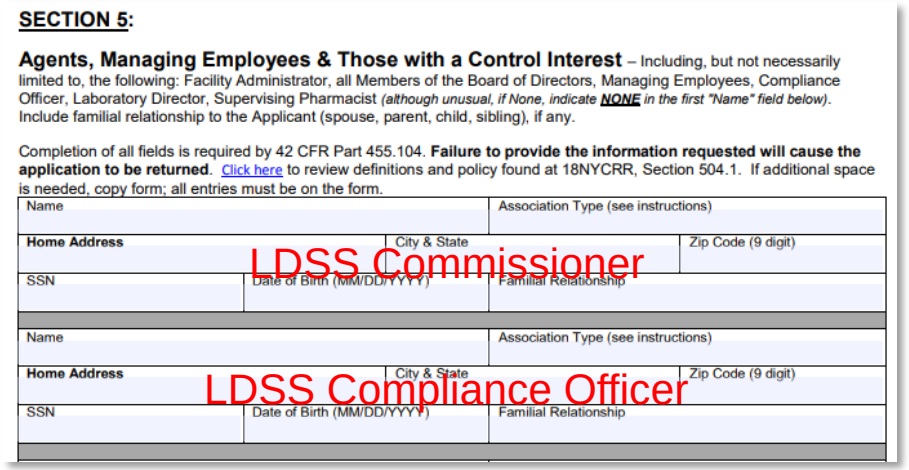
Page 5 & 6: Section 5

17. In the **Agents, Managing Employees & Those with a Control Interest** complete the following fields:
    - **Name:** Enter Full Legal Name
    - **Association Type:** See next slide for instructions
    - **Home Address, City, State, Zip Code:** Use home address of the Managing Employee
    - **SSN:** Enter Social Security Number
    - **DOB:** Enter Date of Birth
    - **Familial Relationship:** Leave Blank



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Completion of all fields is required by 42 CFR Part 455.104. **Failure to provide the information requested will cause the application to be returned**. Click here to review definitions and policy found at 18NYCRR, Section 504.1. 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

LDSS Commissioner

LDSS Compliance Officer

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO, Governor | HOWARD A. ZUCKER, M.D., J.D., Commissioner | SALLY DRESLIN, M.S., R.N., Executive Deputy Commissioner

July 29, 2019

Albany County
162 Washington Avenue
Albany, NY 12210

Dear Commissioner:

The purpose of this letter is to inform Local Departments of Social Services (LDSSs) of an additional, optional mechanism for payment they may use for certain Community First Choice Option (CFCO) services (e.g., Environmental Modification, Vehicle Modification, Assistive Technology) that are provided by entities that are non-Medicaid enrolled providers.

Repeat the steps above for all individual's identified as defined in https://regs.health.ny.gov/content/section-5041-policy-and-scope

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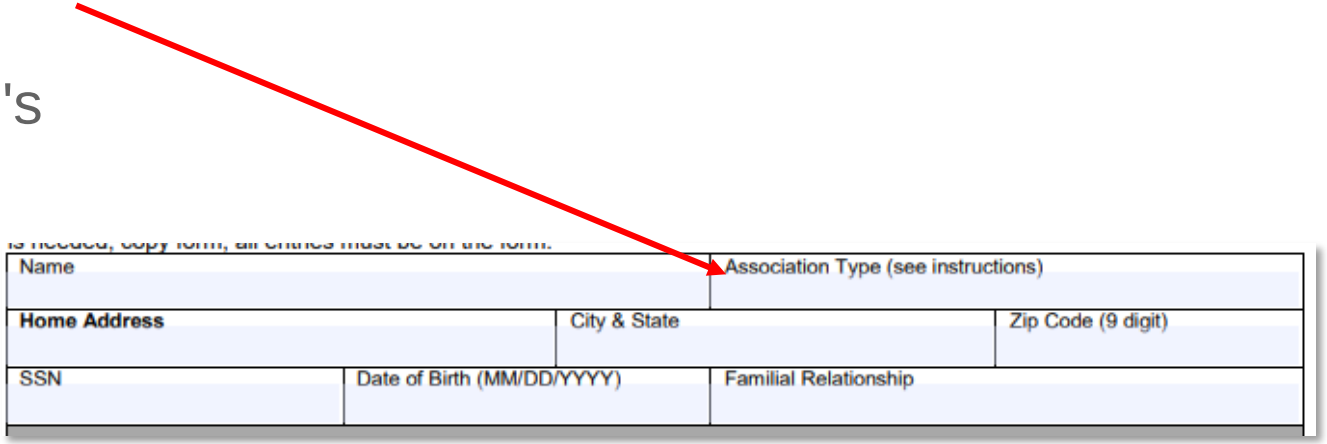
Page 5 & 6: Section 5 – Association Type

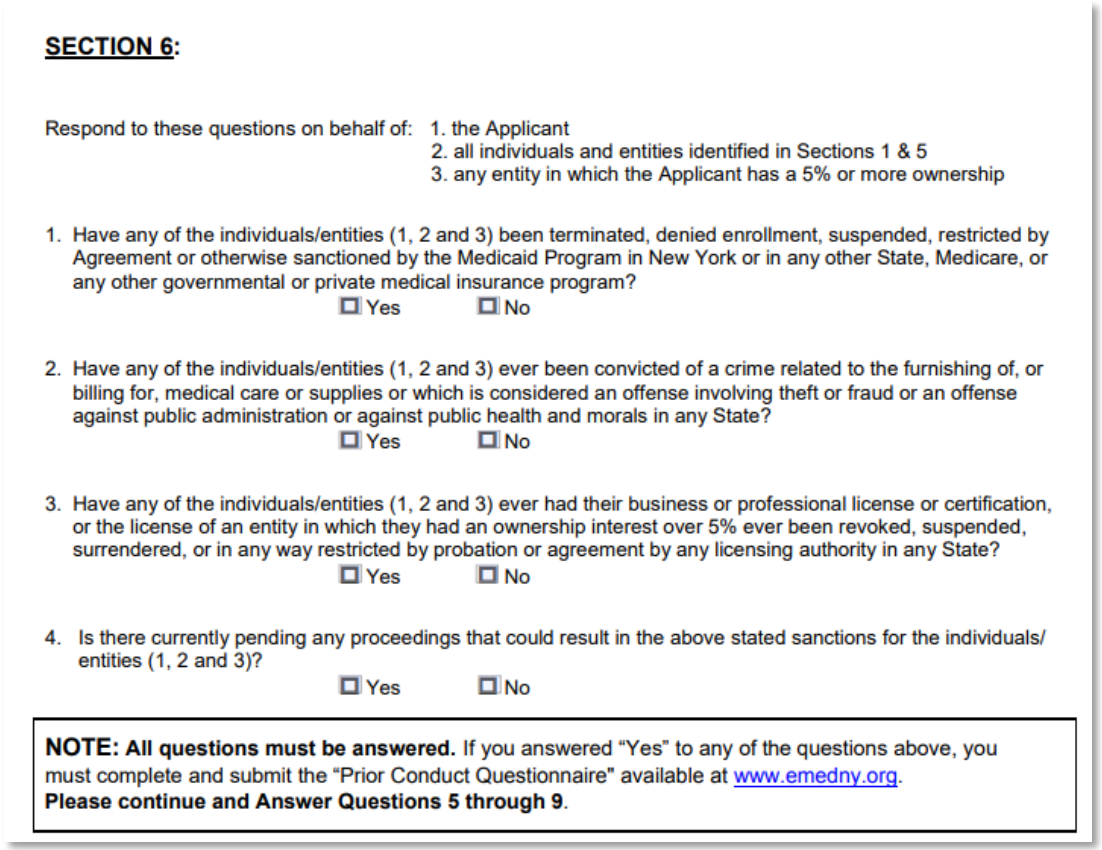
19. In the **Association Type** field enter the letter *B, F, H, M, P* or *U* which best corresponds to the individual's role:
    - B: Board of Directors Member
      - LDSS Commissioner
    - F: Facility Administrator
    - H: Compliance Officer
    - M: Managing Employee
    - P: Supervising Pharmacist
    - U: Laboratory Director



Page 7: Section 6 – Question 1 – 4

20. Complete all questions in section 6

NOTE: If you answered “Yes” to Q1 – Q4, you must submit the “Prior Conduct Questionnaire” available at www.emedny.org



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: All questions must be answered. If you answered “Yes” to any of the questions above, you must complete and submit the “Prior Conduct Questionnaire” available at www.emedny.org.
Please continue and Answer Questions 5 through 9.

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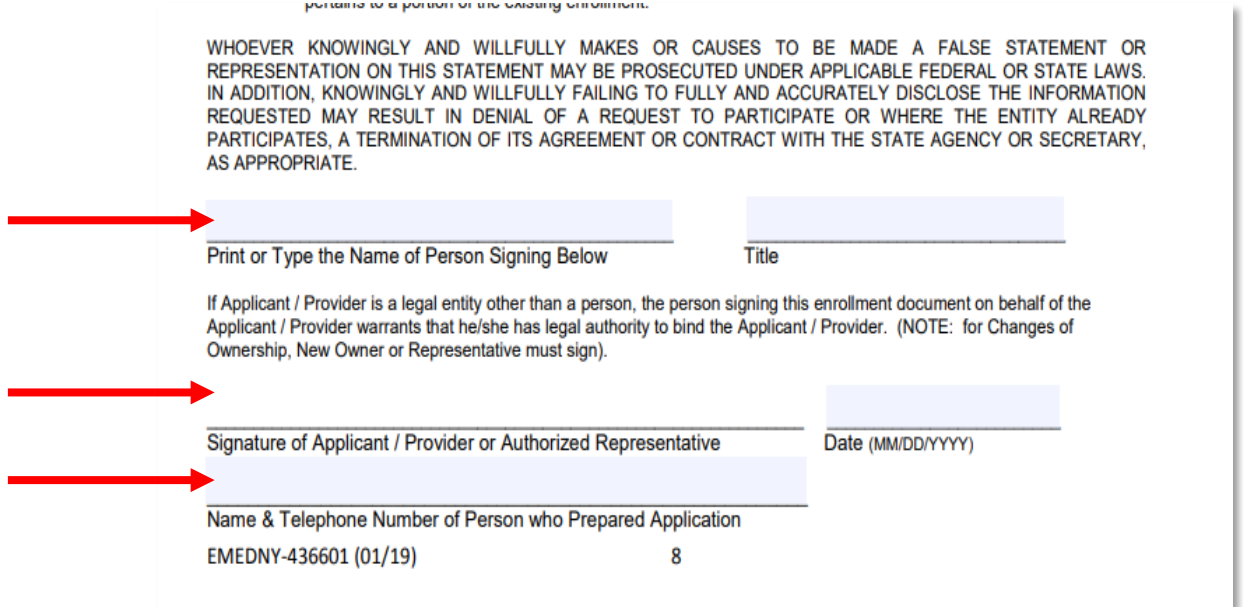
Page 8: Signature and Affirmation

21. Read the affirmation prior to signing.
22. Print or type the name of the person signing the application. Note: Must be an individual listed in Section 1 or 5.
23. Sign the form and date. Note: Must be an individual listed in Section 1 or 5.
24. Enter the telephone number of the person who prepared the application.



pertains to a portion of the existing enrollment.

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.

Print or Type the Name of Person Signing Below

Title

If Applicant / Provider is a legal entity other than a person, the person signing this enrollment document on behalf of the Applicant / Provider warrants that he/she has legal authority to bind the Applicant / Provider. (NOTE: for Changes of Ownership, New Owner or Representative must sign).

Signature of Applicant / Provider or Authorized Representative

Date (MM/DD/YYYY)

Name & Telephone Number of Person who Prepared Application

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Requirement & Additional Forms

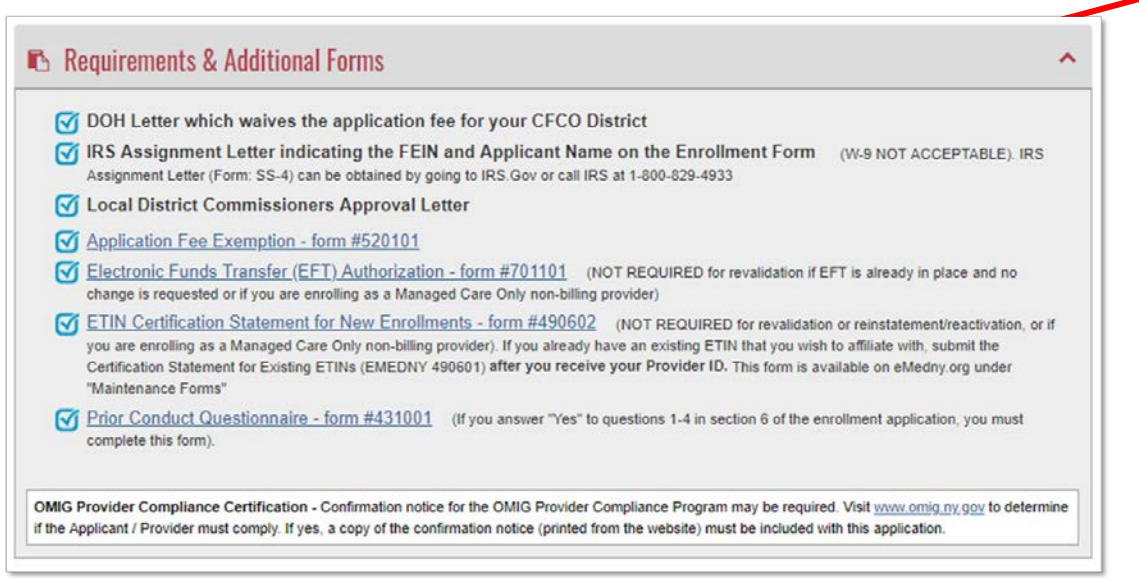
Requirements & Additional Forms

- DOH Letter which waives the application fee for your CFCO District
- IRS Assignment Letter indicating the FEIN and Applicant Name on the Enrollment Form (W-9 NOT ACCEPTABLE). IRS Assignment Letter (Form: SS-4) can be obtained by going to IRS.Gov or call IRS at 1-800-829-4933
- Local District Commissioners Approval Letter
- Application Fee Exemption - form #520101
- Electronic Funds Transfer (EFT) Authorization - form #701101 (NOT REQUIRED for revalidation if EFT is already in place and no change is requested or if you are enrolling as a Managed Care Only non-billing provider)
- ETIN Certification Statement for New Enrollments - form #490602 (NOT REQUIRED for revalidation or reinstatement/reactivation, or if you are enrolling as a Managed Care Only non-billing provider). If you already have an existing ETIN that you wish to affiliate with, submit the Certification Statement for Existing ETINs (EMEDNY 490601) **after you receive your Provider ID.** This form is available on eMedny.org under "Maintenance Forms"
- Prior Conduct Questionnaire - form #431001 (If you answer "Yes" to questions 1-4 in section 6 of the enrollment application, you must complete this form).

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.

Requirement & Additional Forms

The DOH Letter: The LCM was sent via e-Mail on 7/29/19. The LCM MUST be included with the application. This will allow the application fee to be waived.



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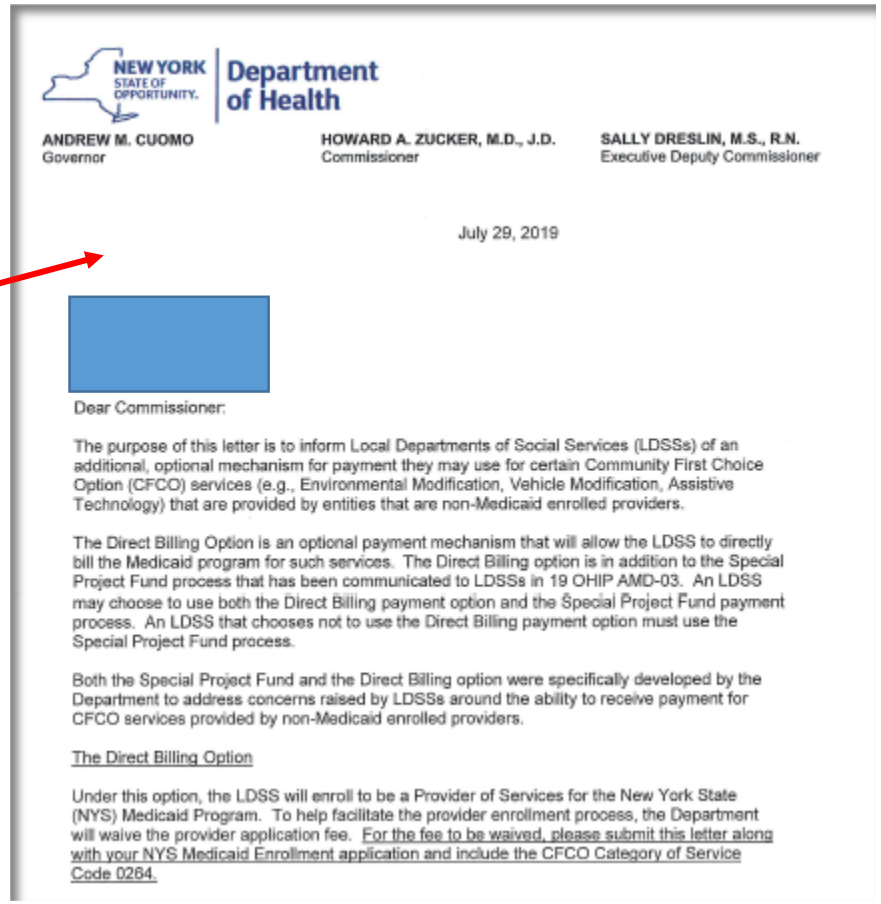
- Application Fee Exemption - form #520101
- Electronic Funds Transfer (EFT) Authorization - form #701101 (NOT REQUIRED for revalidation if EFT is already in place and no change is requested or if you are enrolling as a Managed Care Only non-billing provider)
- ETIN Certification Statement for New Enrollments - form #490602 (NOT REQUIRED for revalidation or reinstatement/reactivation, or if you are enrolling as a Managed Care Only non-billing provider). If you already have an existing ETIN that you wish to affiliate with, submit the Certification Statement for Existing ETINs (EMEDNY 490601) **after you receive your Provider ID.** This form is available on eMedny.org under "Maintenance Forms"
- Prior Conduct Questionnaire - form #431001 (If you answer "Yes" to questions 1-4 in section 6 of the enrollment application, you must complete this form).

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.



NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO, Governor
HOWARD A. ZUCKER, M.D., J.D., Commissioner
SALLY DRESLIN, M.S., R.N., Executive Deputy Commissioner

July 29, 2019

[redacted]

Dear Commissioner:

The purpose of this letter is to inform Local Departments of Social Services (LDSSs) of an additional, optional mechanism for payment they may use for certain Community First Choice Option (CFCO) services (e.g., Environmental Modification, Vehicle Modification, Assistive Technology) that are provided by entities that are non-Medicaid enrolled providers.

The Direct Billing Option is an optional payment mechanism that will allow the LDSS to directly bill the Medicaid program for such services. The Direct Billing option is in addition to the Special Project Fund process that has been communicated to LDSSs in 19 OHIP AMD-03. An LDSS may choose to use both the Direct Billing payment option and the Special Project Fund payment process. An LDSS that chooses not to use the Direct Billing payment option must use the Special Project Fund process.

Both the Special Project Fund and the Direct Billing option were specifically developed by the Department to address concerns raised by LDSSs around the ability to receive payment for CFCO services provided by non-Medicaid enrolled providers.

The Direct Billing Option

Under this option, the LDSS will enroll to be a Provider of Services for the New York State (NYS) Medicaid Program. To help facilitate the provider enrollment process, the Department will waive the provider application fee. For the fee to be waived, please submit this letter along with your NYS Medicaid Enrollment application and include the CFCO Category of Service Code 0264.

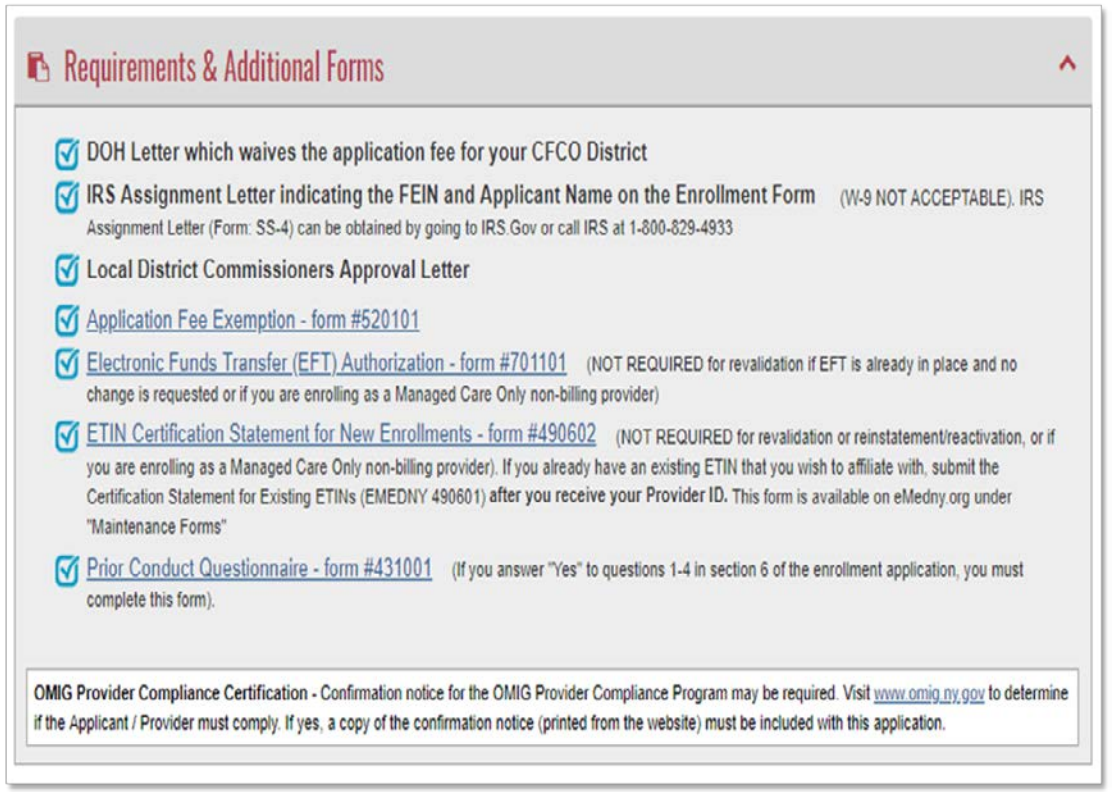
NEW YORK STATE | Department of Health

Requirement & Additional Forms

IRS Assignment Letter: IRS Assignment letter (Form: SS-4) can be obtained by going to IRS.Gov or call IRS at 1-800-829-4933

Note: W-9 not acceptable

Local District Commissioners Approval Letter: A letter from the LDSS Commissioner must accompany the application stating that the request for a MMIS number has been approved for CFCO.

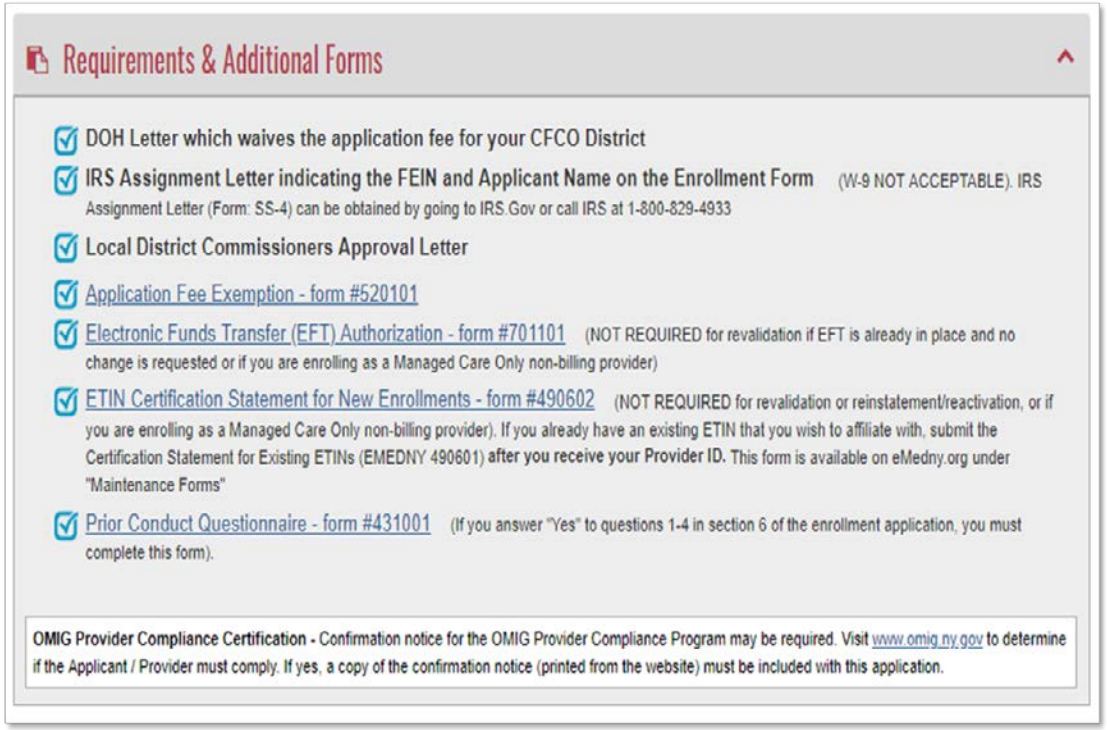


NEW YORK STATE | Department of Health

Requirement & Additional Forms

Application Fee Exemption: This form is not required. It has been replaced by the DOH letter.

Electronic Funds Transfer (EFT) Authorization – Form & ETIN Certification Statement : For both the EFT Authorization and the ETIN Certification, eMedNY recommends doing new applications for both even if there are existing ETIN numbers and EFT authorizations for your County.



Requirements & Additional Forms

- DOH Letter which waives the application fee for your CFCO District
- IRS Assignment Letter indicating the FEIN and Applicant Name on the Enrollment Form (W-9 NOT ACCEPTABLE). IRS Assignment Letter (Form: SS-4) can be obtained by going to IRS.Gov or call IRS at 1-800-829-4933
- Local District Commissioners Approval Letter
- Application Fee Exemption - form #520101
- Electronic Funds Transfer (EFT) Authorization - form #701101 (NOT REQUIRED for revalidation if EFT is already in place and no change is requested or if you are enrolling as a Managed Care Only non-billing provider)
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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.

NEW YORK STATE | Department of Health

The LDSS MMIS Application Shared Mailbox

This mailbox is on the Health Commerce System to protect personal and confidential information included in the MMIS applications. The link for the Health Commerce System is:
https://commerce.health.state.ny.us/public/hcs_login.html
You must have an active HCS account to access the system, once logged in, click All Applications from the drop-down menu and choose Secure File Transfer.

3. Once you launch the Secure File Transfer, a screen appears giving you the option of **Send Package**.
4. Click on the icon next to the "TO:" box, (that will pull up a search field box.)
5. Then type LDSS MMIS into the search box (that will pull up the icon for LDSS MMIS Application Shared Mailbox, which you then should select.)
6. You should now see "**To: LDSS MMIS Application Shared Mailbox"** at the bottom of the screen.
7. Click on OK and it will bring you to the new package screen that will allow you to send a secure e-mail and include an attachment.

For routine questions without protected information, e-mails can be sent to;
LDSS.MMIS.Applications@health.ny.gov

Submission of Application & Additional Information

- **Keep a copy of ALL documents submitted**
- Send the complete enrollment form, required documents and additional forms to https://commerce.health.state.ny.us/public/hcs_login.html
  - This mailbox is on the Health Commerce System to protect personal and confidential information included in the MMIS applications.
  - You must have an active HCS account to access the system.

Submission of Application & Additional Information

- Once logged in, click All Applications from the drop down menu and chose Secure File Transfer.
- Once you launch the Secure File Transfer, a screen appears giving you the option of Send Package (choose that option)
- In the TO: box, click on the icon next to the TO: That will pull up a search field box.
- Type LDSS MMIS into the search box. That will pull up the icon for LDSS MMIS Application Shared Mailbox.
- Click on it-you will see To: LDSS MMIS Application Shared Mailbox at the bottom of the screen.
- Click on OK and it will bring you to the new package screen that will allow you to send a secure e-mail and include an attachment.

NYSDOH Review and Submission to Provider Enrollment

August 2019

Review and Submission

- As soon as the application is received at the Bureau of Managed Long Term Care (MLTC), it will be reviewed for accuracy and completeness.
- If required application fields are incorrect or blank, a notification will be sent to the designated contact for each county to review, correct, and resubmit the application to MLTC.
- Once an application has been determined to be complete, it will be forwarded to the Bureau of Provider Enrollment for processing.
- As long as the information provided is accurate and complete, Provider Enrollment will issue a CFCO specific MMIS number to the County.
- This MMIS number should be used to submit CFCO services to eMedNY for reimbursement.

Next Steps

Additional training for claim submissions and reimbursement will be scheduled with eMedNY shortly. All claims for CFCO will be submitted as 837I (institutional) type claims.

Welcome Letters will be sent once your application has been reviewed and approved. Please be aware that your Welcome Letter will state “COS 0264 – HHAS: Vendor Personal Care Ser”. It will not state CFCO. All CFCO services will be included under Category of Service 0264. The districts should note the COS Code (number) only and the “CFCO” identification on the end of their enrolled name.

For assistance or questions, please contact:

- The eMedNY Call Center at
  1-800-343-9000 (Option 2, then Option 3)

- LDSS.MMIS.Applications@health.ny.gov

QUESTIONS