**Durable Medical Equipment**
**Provider Information Request Form**

## Form Instructions

1. This form may be downloaded and completed electronically.
2. If additional room is needed to provide a complete response to any question, include the information on a separate page and attach it to this form. Be sure to indicate the corresponding question number on your attachment.
3. Answer every question. Any questions left blank, including failure to provide the required attachments, may result in the denial of the application pursuant to NYCRR Title 18 §504.5 (a)(1).
4. All questions related to this form must be directed to omig.enrollment@omig.ny.gov.

**If you are only seeking enrollment for Medicare crossover (co-pay and deductibles) claims, check the yes box and sign this form.**

☐ Yes, I am seeking enrollment for Medicare crossover claims only.

**If YES, you do not need to complete this form.**

**If NO, please continue, and answer the following questions:**

1. Are you an out of state provider of Durable Medical Equipment services interested in participating in the NYS Medicaid Program? ☐Yes ☐No

   *If yes, please review the New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines (including, but not limited, to pages 4 and 9) before answering the following questions as the responses may impact the enrollment determination.*

   a. Are you an out of state provider in a state that is contiguous with NY that is in a Common Medical Marketing Area? ☐Yes ☐No

      *Please see New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines, page 4 for the definition of Common Medical Marketing Area.*

   b. Are you an out of state provider that is providing standard Durable Medical Equipment and Medical Surgical Supplies that cannot be obtained from enrolled DMEPOS providers? ☐ Yes ☐No

      *If yes, provide documentation indicating the items that cannot be obtained by an enrolled DMEPOS provider and why a member cannot obtain the items dispensed from an enrolled provider.*

   c. Are you a manufacturer that also functions as a billing provider dispensing supplies directly to members? ☐Yes ☐No

d. Will your facility be able to provide direct customer service to respond to all customer concerns or complaints? ☐Yes ☐No

If yes, please explain how you will do so:

_____

e. Will the member have access to 24-hour clinical support for equipment failure troubleshooting? ☐Yes ☐No

If yes, please explain how this support will be provided:

_____

f. Will your facility be able to supply backup equipment and guidance should equipment failure occur? ☐Yes ☐No

If yes, please explain how you will do so:

_____

g. If your service address is located out of state and you do not plan on providing services to New York State Medicaid members via mail-order, please explain how services will be provided to members:

_____
_____
_____

2. Indicate the days and corresponding hours your durable medical equipment store will be open:

| | Hours of Operation | | Hours of Operation |
|---|---|---|---|
| Monday | | Friday | |
| Tuesday | | Saturday | |
| Wednesday | | Sunday | |
| Thursday | | | |

3. Do you have a walk-in storefront location in New York State or a state contiguous with New York State? ☐Yes ☐No

***A walk-in storefront location is required for enrollment.*** *See New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines, page 9.*

4. Of the Durable Medical Equipment services that you plan to provide to New York State members, what percentage of services do you expect to provide via mail-order?

_____

5. Are you presently open and conducting business? ☐Yes ☐No

   *You must be open and conducting business prior to being enrolled in NYS Medicaid. New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines, page 9.*

   If yes, when did you open? ___/___/___/___/___/___
   M M D D Y Y

   If no, when do you anticipate opening? ___/___/___/___/___/___
   M M D D Y Y

6. List the name of the owner(s) of the business and their Social Security number(s) and percentage of ownership. **The names listed must match the names given on question #5 of the Disclosure of Ownership and Control Form.** List any National Provider Identifiers (NPI) or New York State Medicaid Program provider numbers or professional licenses held by the owners. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their Social Security numbers and any National Provider Identifiers or New York State Medicaid Program provider numbers or professional licenses held.

| Last Name, First Name | Social Security Number | Percent of Ownership | NPI or NYS Medicaid number or Professional License |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

7. Leasehold arrangements:

   a. Indicate whether rent is paid in equal monthly or yearly installments. **You must attach a signed copy of the current lease.**

   _____

   b. Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

   _____
   _____
   _____
   _____

   c. Provide the name and address of the owner(s) of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their Social Security numbers.

| Last Name, First Name | Address | Social Security Number |
|---|---|---|
| | | |
| | | |

   d. Provide the name and address to whom the rent is paid. Attach a copy (front and back) of the most recent canceled rent check or receipt.

| Last Name, First Name | Address |
|---|---|
| | |

e. If rent is paid to a corporation or partnership, list the names of the officers, directors, principal stockholders, partners and their Social Security numbers and any National Provider Identifier (NPI) or NYS Medicaid Program provider numbers or professional licenses held.

| Last Name, First Name | Social Security Number | NPI or NYS Medicaid number or Professional License |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

8. How does your establishment provide access to persons with disabilities (ramps, parking, adequate passage)? *New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines, page 9*.

_____

_____

9. Was the business location previously a place at which NYS Medicaid services were rendered? ☐Yes ☐No

   If yes, list the National Provider Identifier (NPI) or NYS Medicaid Number of the prior owner(s):

   _____

   Enclose copies of any promissory notes, sales agreements and any other relevant documents pertaining to the sale, if applicable.
   Documents attached: ☐Yes ☐N/A

10.

a. List the top 10 items you supply:

| | | | |
|---|---|---|---|
| 1. | | 6. | |
| 2. | | 7. | |
| 3. | | 8. | |
| 4. | | 9. | |
| 5. | | 10. | |

b. Will the same Durable Medical Equipment items be provided to all clients including Medicaid members? ☐Yes ☐No

   If no, list what items you plan to provide to Medicaid members that differ from those provided to other clients.

   _____

   _____

c. Estimate the dollar value of the stock and medical supplies currently on hand.

   _____

   _____

d. List the name and address of all suppliers of your stock:

| Name | Address |
|---|---|
| | |
| | |
| | |
| | |

11. Do you provide complex Durable Medical Equipment? ☐Yes ☐No

*New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines, page 11.*

If yes, answer the following:

a. Does your facility employ at least one full-time Assistive Technology Professional (ATP), certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA), who specializes in wheelchairs, participates in the selection of appropriate equipment in consultation with a qualified practitioner, and who has specific training and/or experience in wheelchair evaluation and making recommendations for complex Durable Medical Equipment? ☐Yes ☐No

*Provide a copy of the ATP's RESNA certification and the ATP's proof of employment.*

b. Do you have the capability to provide service and repair by qualified technicians to the Durable Medical Equipment dispensed? ☐Yes ☐No

c. Can your facility provide suitable loaner equipment while the primary device is under repair? ☐Yes ☐No

12. If you are a provider of orthopedic footwear, provide a copy of your certification as listed on the Durable Medical Equipment Form Checklist. (EMEDNY-4272, page 3)

Certification attached: ☐Yes ☐N/A

a. If you are not certified, do you employ others who are certified? ☐Yes ☐No ☐N/A

13. List all orthotists and prosthetists in your service and attach a copy of their certification as listed on the Durable Medical Equipment Form Checklist. (EMEDNY-4272, Page 3)

| Last Name, First Name | Title | Social Security Number | Hours/Week |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

14.

a. List all managerial and technical employees.

| Last Name, First Name | Title | Social Security Number | Hours/Week |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

b. List all Durable Medical Equipment training programs completed by the above individuals and attach a copy of their certification.

| Last Name, First Name | Training Course |
|---|---|
| | |
| | |
| | |
| | |

15.

a. Identify the name, address and account number(s) of the bank(s) to be used by the business.

| Name of Bank | Address | Account Number |
|---|---|---|
| | | |
| | | |

b. Provide the names and Social Security numbers of all personnel authorized to sign corporate checks against those accounts.

| Person(s) Authorized to Sign Checks | Social Security Number |
|---|---|
| | |
| | |

16. Attach a statement signed by the owner or manager identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signatures. Signature stamps, photocopies, etc., are not acceptable. Signed statement attached:

☐Yes ☐No

17. Indicate whether bills to Medicaid will be submitted directly by you or through a billing service. If a billing service, provide the name, address and NYS Medicaid provider number of the billing service.

| Name | Address | NYS Medicaid Provider Number |
|---|---|---|
| | | |

18. List the top six referring practitioner's names and license numbers who currently order Durable Medical Equipment through your business.

| Last Name, First Name | License Number |
|---|---|
| | |
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| | |

19. If you are located in New York City, submit a copy of your Dealer in Products for the Disabled license.

License attached: ☐Yes ☐N/A

## Certification

I certify, to the best of my knowledge and belief, that all information contained in and attached to this application for enrollment in the Medicaid program is complete and accurate. I understand that failure to provide complete and accurate information may result in denial of enrollment.

By signing below, I acknowledge that I have read the New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines (eMedNY.org), and I agree to comply with the Policy Guidelines. I understand that failure to comply with Policy Guidelines will result in denial of enrollment.

Owner's Name (Print): _____
Owner's Signature: _____ Date Signed _____
Application Prepared By (Print): _____
Telephone Number: _____

## Application Completeness Checklist

**If applicable, please make sure all the following documents are attached. Failure to do so may result in denial of the application pursuant to New York Codes, Rules, and Regulations Title 18 § 504.5 (a)(1).**

Please note that no PHI should be sent electronically. All questions related to the attachments listed below must be directed to omig.enrollment@omig.ny.gov. All photographs should be sent directly to omig.enrollment@omig.ny.gov at the time the application is submitted. Please ensure the NPI number of the applying entity is included in all emails.

**For all applicants:**

- Photograph(s) of the exterior of the DME provider location including signage of business
- Photograph(s) of the entrance of the DME location (close-up)
- Photograph(s) of the interior of the DME provider location
- Photograph(s) of the storage location for your DME supplies
- Photograph(s) of inventory
- Sample of inventory invoices from within the last 6 months
- List of other insurance plans you are contracted with
- List of top ordering physicians (name, license number, and address)
- List of employed technical personnel including name, how many years they have been with the company, and any certifications or licenses held
- Example of patient record including the order for DME received by the ordering provider (please redact PHI)
- Name on business checking account and three pages of check registry
- Signed copy of the current lease (Question 7a)
- A copy (front and back) of the most recent canceled rent check (Question 7d)
- A statement identifying the persons who will be authorized to sign NYS Medicaid Program claims and provide original examples of their signatures (Question 16) *Signature stamps, photocopies, etc., are not acceptable*

**For Out of State Applicants:**

- Documentation indicating the items that cannot be obtained by an enrolled DMEPOS provider and why a member cannot obtain the items dispensed from an enrolled provider (Question 1b)

**If you provide complex Durable Medical Equipment:**

- If you employ at least one full-time Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) submit a copy of the ATP certification and proof of employment (Question 11a)

**If located in New York City:**

- Submit a copy of your Dealer in Products for the Disabled license (Question 19)

**If applicable:**

- Copies of any promissory notes, sales agreements and any other relevant documents pertaining to the sale, if the business location was previously a place at which NYS Medicaid services were rendered (Question 9)

**If supplying shoes (please see New York State Medicaid Program Durable Medical Equipment, Prosthetic, Orthotic, And Supply Manual Policy Guidelines, Orthopedic Footwear, page 9 (specialty 711):**

- A copy of any orthotists and prosthetists certification as listed on the Durable Medical Equipment Form Checklist (Questions 12 and 13)
- A copy of your certification
- Photograph of Ritz Stick or measuring device and impression box
- Photographs of equipment used for custom shoes and fitting area/room
- Brochures and invoices within last 6 months for inventory
- If you use contractors, please list name, addresses, and provide copies of any contracts with these employees/contractors

**If supplying oxygen, ventilators, or other respiratory services/equipment:**

- Provide name and license of Respiratory Therapist. If RT is a contractor, provide copy of contract