NEW YORK STATE DEPARTMENT OF HEALTH, AIDS INSTITUTE
HIV PRIMARY CARE MEDICAID PROGRAM AGREEMENT
PART 2 - Primary Care Information

Effective Date: _____(for DOH use only)

NAME OF FACILITY: _____
(As shown on operating certificate)

FEDERAL ID # _____

ADDRESS: _____

_____

FACILITY TELEPHONE # _____

MMIS PROVIDER # _____

OPERATING CERTIFICATE # _____

CONTACT PERSON: _____

TITLE: _____

CONTACT TELEPHONE # _____

EMAIL ADDRESS: _____

*HIV BILLING CODES WILL BE ISSUED ONLY FOR THE ACTIVITIES PERFORMED ON SITE AND ONLY AT THE LOCATIONS INDICATED. FOR THOSE SERVICES NOT PERFORMED ON SITE, INDICATE THE NAME AND ADDRESS OF THE REFERRAL FACILITY

ON-SITE SERVICES: AUTHORIZED LOCATOR CODES:
(For example: Main Facility locator code 03, authorized satellite clinic 04, etc.)

1) HIV Testing Visits - * _____ _____ _____ _____ _____ _____

Will the provider be conducting HIV Testing in the Emergency Department? Circle One: Yes ☐ No ☐ Not Applicable ☐

2) Initial/Annual HIV Comprehensive Evaluation - * _____ _____ _____

3) HIV Monitoring Visit - * _____ _____ _____ _____ _____

REFERRAL FACILITY:

_____

REFERRAL FACILITY ADDRESS:

_____

_____

SERVICES BEING REFERRED:

_____

Send completed agreement with a copy of the Provider's Operating Certificate to:

HIV Primary Care Medicaid Program
Division of HIV Health Care & Community Services
New York State Department of Health
AIDS Institute
Empire State Plaza
Corning Tower – Room 459
Albany, N.Y. 12237
HIVPCMP@health.state.ny.us