



Provider Services Portal – Milestone 2

Overview

This document describes how to complete Milestone 2 of a new enrollment application in the Provider Services Portal.

Note: At this time the portal is only available to practitioners who have never been enrolled in NYS Medicaid and who do not have a paper application pending in the eMedNY system. All other provider types and transactions will be available at a later date.

Milestone 2 of an application

Milestone 2 of an application is comprised of steps 4-6. Optional steps are marked as such on the left-hand menu next to the step number. Required fields are marked with a **red asterisk**. The application will not move forward if required fields are left blank.

The screenshot shows the left-hand navigation menu with Milestone 2 expanded. Step 4 is highlighted with a red box and a red arrow points to the 'Show/Hide' button in the purple instructions banner. The right side of the screen shows the 'Add Education/Training/Work History' form, which includes sections for Education, Training, and Work History, and a Supporting Documents section.

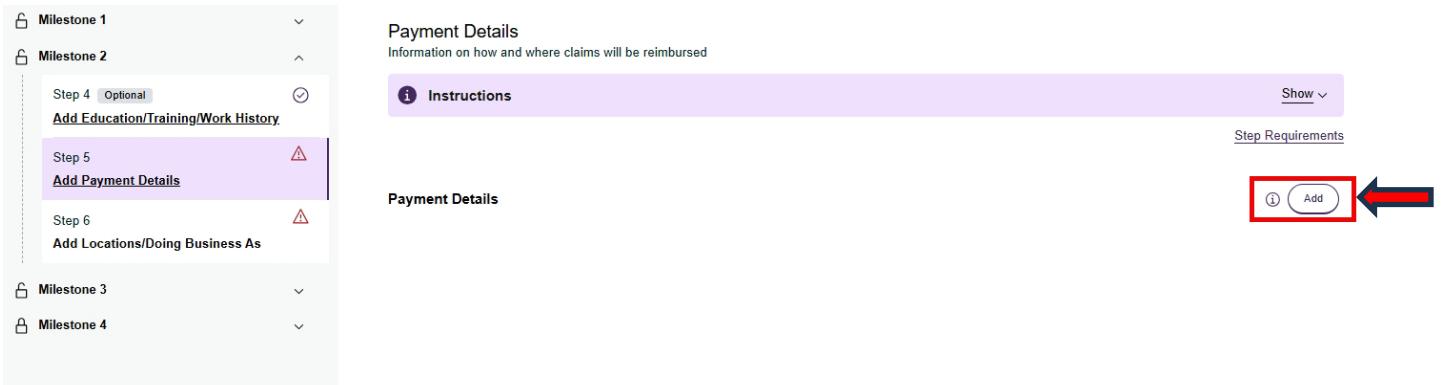
Clicking the arrow next to the Show/Hide button in the purple instructions banner of any screen will display or hide instructions for that step. See below screenshot for example.

The screenshot shows the left-hand navigation menu with Milestone 2 expanded. Step 4 is highlighted with a red box and a red arrow points to the 'Show/Hide' button in the purple instructions banner. The right side of the screen shows the 'Payment Details' section, which includes a 'Payment Details' table and an 'Add' button.

Step 4 requests Education/Training/Work History and is an optional step.

Step 5 requests Payment Details. This is required for fee-for-service/billing providers but is not available for OPRA/non-billing providers.

Click Add at the bottom right to begin this step.



Milestone 1

Milestone 2

Step 4 Optional [Add Education/Training/Work History](#)

Step 5 [Add Payment Details](#)

Step 6 [Add Locations/Doing Business As](#)

Milestone 3

Milestone 4

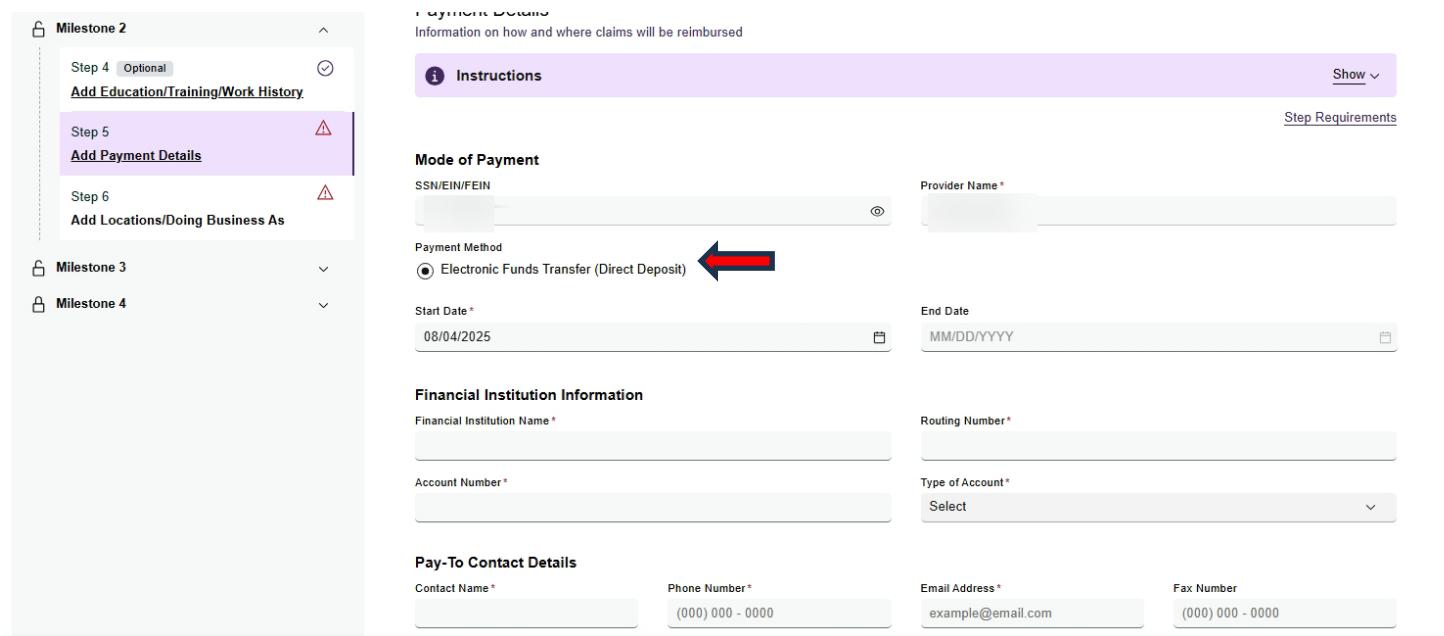
Payment Details
Information on how and where claims will be reimbursed

Instructions [Show](#)

Payment Details

Add 

Information such as Social Security Number/EIN/FEIN and Provider Name will pre-populate based on information entered in Milestone 1. Payment Method defaults to Electronic Funds Transfer (Direct Deposit).



Milestone 2

Step 4 Optional [Add Education/Training/Work History](#)

Step 5 [Add Payment Details](#)

Step 6 [Add Locations/Doing Business As](#)

Milestone 3

Milestone 4

Payment Details
Information on how and where claims will be reimbursed

Instructions [Show](#)

Mode of Payment

SSN/EIN/FEIN Provider Name*

Payment Method **Electronic Funds Transfer (Direct Deposit)** 

Start Date* End Date

Financial Institution Information

Financial Institution Name* Routing Number*

Account Number* Type of Account*

Select 

Pay-To Contact Details

Contact Name* Phone Number* Email Address* Fax Number

The EFT Agreement must be read in full and signed. The signature box will remain greyed out until the entire EFT Agreement has been read (scroll down to read in entirety). Click the box that acknowledges the EFT Agreement has been read and agreed to.

EFT Agreement

The Electronic Fund Transfer form will be pre-filled with the information provided on this page. But it must still be signed to signify the agreement with the terms on page 2 of the EFT form. Both pages must then be sent in along with any additionally required documentation. This information will appear on the form that gets created. However, the signature field will be empty in the form and must therefore be signed before sending in the EFT Agreement.

Agreement

Providers who receive payment of claims under the Title XIX (Medicaid) program in New York State Department of Health must agree to the following terms and conditions:

1. Legal Compliance: Provider shall abide by all federal and state laws governing the Medicaid program.
2. EFT information: Provider will submit the EFT information that includes the Payee, name of the bank, address of bank, transit number, account number, and a bank letter or voided check on the account to which funds will be transferred.
3. Acceptance of Funds: Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the New York State Medicaid program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. The provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.
4. Notice of Change: Provider will notify the Department of any changes in Payee, Payee's name or address, or bank account details. This notification must be supported in writing on company letterhead and include the provider's number(s) (MMIS ID or NPI), new account number, routing number, and a brief explanation for the change. The letter must also be signed by the provider and their title must be indicated.
5. Alternate Payment Methods: For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the

First Name * ⓘ

Last Name * ⓘ

Date * 

I hereby acknowledge that I have read and agreed to the terms and conditions stated in the EFT Agreement. (Authorization Agreement - By Selecting the Check Box)*

Click on Save Details after checking the box to agree.

First Name * ⓘ

Last Name * ⓘ

Date * 

I hereby acknowledge that I have read and agreed to the terms and conditions stated in the EFT Agreement. (Authorization Agreement - By Selecting the Check Box)*

 **Save Details**

Click on Add under Address Details to enter the Pay-To Address, which is where paper checks (if necessary) and remittances will be sent until electronic or PDF remits are set up.

Address Details

 **Add**

Delete

Click on Validate Address.

Click on Save after the address has been validated.

Address Details

Type of Address *

Pay-To Address

Address

Address Line 1 *

Enter Street Address or PO Box Only

Address Line 2

Address Line 3

City/Town *

Other City *

State/Province *

OTHER

NEW YORK

▼

County

Other County

Country *

OTHER

UNITED STATES

▼

Zip Code *

00000

0000



Validate Address

Back

Save



Once Saved you will be redirected to the previous screen. Scroll back down to the **Address Details** section. Here you will see the “Pay-to Address” just saved.

Click on Add under Address Details again to enter the Financial Institution address details.

Address Details

Add

Delete

<input type="checkbox"/> Address Type ↑↓	Address ↑↓	Actions
<input type="checkbox"/> Pay-To Address		

Click on Validate Address and then Save under the Validate Address button.

Address Details

Type of Address *

Financial Institution Address

Address

Address Line 1 *

1

Enter Street Address or PO Box Only

Address Line 2

Address Line 3

City/Town *

Select

State/Province *

Select

County

Select

Country *

UNITED STATES

Zip Code *

0000

**Back****Save**

Again, once Saved you will be redirected to the previous screen. If you scroll back down to the Address Details section, you can review the Pay-to and Financial Institution just saved.

Scroll up to the EFT Agreement and click on Download in the upper right corner. **Note:** This download button will not be available until both addresses have been entered.

EFT Agreement

The Electronic Fund Transfer form will be pre-filled with the information provided on this page. But it must still be signed to signify the agreement with the terms on page 2 of the EFT form. Both pages must then be sent in along with any additionally required documentation. This information will appear on the form that gets created. However, the signature field will be empty in the form and must therefore be signed before sending in the EFT Agreement.

 Agreement	 Download
<p>Providers who receive payment of claims under the Title XIX (Medicaid) program in New York State Department of Health must agree to the following terms and conditions:</p> <ol style="list-style-type: none">1. Legal Compliance: Provider shall abide by all federal and state laws governing the Medicaid program.2. EFT information: Provider will submit the EFT information that includes the Payee, name of the bank, address of bank, transit number, account number, and a bank letter or voided check on the account to which funds will be transferred.3. Acceptance of Funds: Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the New York State Medicaid program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. The provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.4. Notice of Change: Provider will notify the Department of any changes in Payee, Payee's name or address, or bank account details. This notification must be supported in writing on company letterhead and include the provider's number(s) (MMIS ID or NPI), new account number, routing number, and a brief explanation for the change. The letter must also be signed by the provider and their title must be indicated. <p><small>E - Alternate Payment Methods: For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the</small></p>	
<small>First Name * (A)</small>	<small>Last Name * (C)</small>

Once the EFT Agreement has been downloaded, it must be **printed, physically signed by provider, saved to computer, and uploaded** under the Supporting Documents section of this step.

MODE OF PAYMENT

Payment Method

Electronic Funds Transfer(EFT)

AUTHORIZED SIGNATURE

Original Signature of Practitioner/Authorized Representative

Click on Add under Supporting Documents.

Supporting Documents **Add**

A new screen will pop up that allows upload of supporting documents for this step.

- Allowable file formats are .gif, .jpg, .jpeg, .html, .htm, .pdf, .xls, .tif, .doc, .docx, .xlsx, and .txt.
- File must be under 10 MB in size

For each Required Document to be uploaded, **click on Upload Document** and follow cues for uploading.

Click on Close when the documents have successfully uploaded.

Supporting Documents

Application ID	Enrollment Type Individual	Applicant Type Fee For Service (Billing)	Name	Application Status In Process
----------------	-------------------------------	---	------	----------------------------------

Required Documents

- Bank Letter or Cancelled Check
- EFT Agreement

Document Type *

Select

File Name *

Choose

Document Name *

Select

Remarks

File must be under 10 MB in size

Upload document

Added Documents

Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date	Actions
No records found!						

Close

Click on Save at the bottom right right once all details of this page have been completed.

Supporting Documents

Add

Document Type	Document Name	File Name	Remarks	Uploaded By	Uploaded Date	Actions
Payment	EFT Agreement	78837.jpg			09/04/2025	

Back

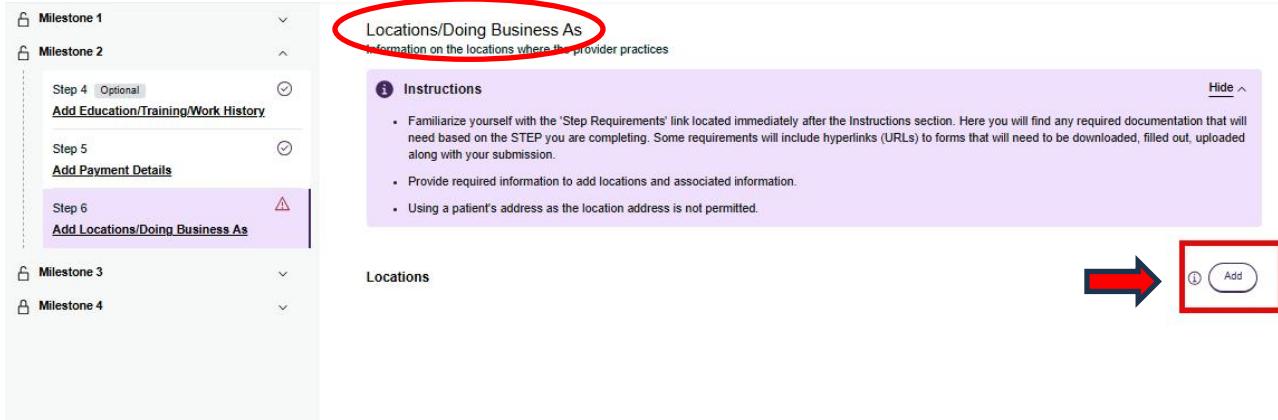
Save

Click on Next Step at the bottom right of the page.

Next Step

Step 6 requests locations and “doing business as” information.

Click Add at the bottom right.



Milestone 1

Milestone 2

Step 4 Optional
Add Education/Training/Work History

Step 5
Add Payment Details

Step 6
Add Locations/Doing Business As

Milestone 3

Milestone 4

Locations/Doing Business As
Information on the locations where the provider practices

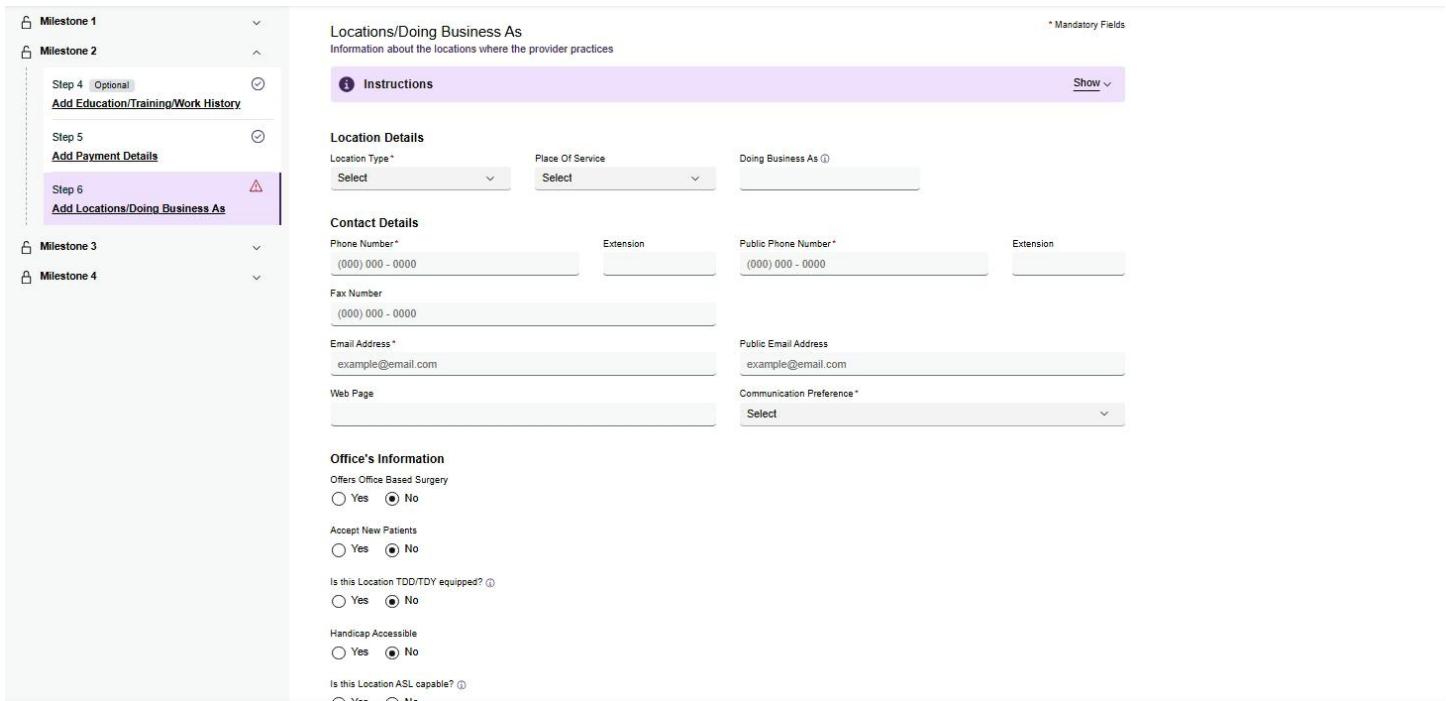
Instructions

- Familiarize yourself with the 'Step Requirements' link located immediately after the Instructions section. Here you will find any required documentation that will need based on the STEP you are completing. Some requirements will include hyperlinks (URLs) to forms that will need to be downloaded, filled out, uploaded along with your submission.
- Provide required information to add locations and associated information.
- Using a patient's address as the location address is not permitted.

Locations

Add

Enter required and optional (if desired) details for the service location.



Milestone 1

Milestone 2

Step 4 Optional
Add Education/Training/Work History

Step 5
Add Payment Details

Step 6
Add Locations/Doing Business As

Milestone 3

Milestone 4

Locations/Doing Business As
Information about the locations where the provider practices * Mandatory Fields

Instructions

Location Details

Location Type * Select

Place Of Service Select

Doing Business As

Contact Details

Phone Number * (000) 000 - 0000 Extension

Public Phone Number * (000) 000 - 0000 Extension

Fax Number (000) 000 - 0000

Email Address example@email.com

Public Email Address example@email.com

Web Page

Communication Preference * Select

Office's Information

Offers Office Based Surgery
 Yes No

Accept New Patients
 Yes No

Is this Location TDD/TDY equipped? Yes No

Handicap Accessible
 Yes No

Is this Location ASL capable? Yes No

Pediatric Services
 Yes No

Age Restrictions
 Yes No

In Person/Telehealth*
Select

Disability Accommodations
Select

Maximum Clients
Select

Offers OB-Gyn Services
Select

Languages Spoken

Selected Languages*
Select

Office Hours

24/7

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Click on Validate Address in the bottom right-hand corner.

Click on Save directly below Validate Address when all information is correct.

Address

Address Line 1*
Enter Street Address or PO Box Only

Address Line 2

Address Line 3

City/Town*
Select

State/Province*
Select

County
Select

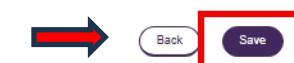
Country*
UNITED STATES

Zip Code*
Select

Latitude

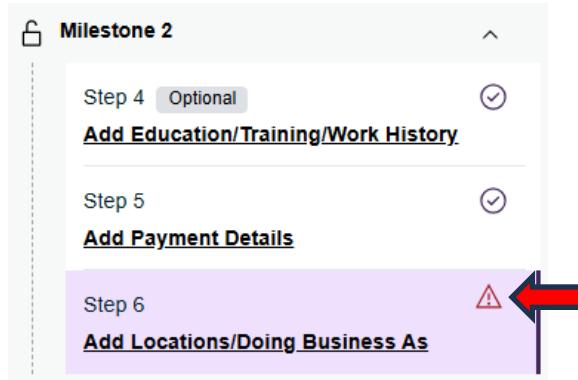
Longitude

 Validate Address

 Back Save

The main page of this step will now appear.

A red triangle on the left side of the screen will pop up if there is an error requiring correction.



To correct the errors, click on the edit button of the address. Additional information will be required to complete the step.

Locations/Doing Business As Information on the locations where the provider practices

A screenshot of the 'Locations' list page. It shows a table with one item: '01-Main Office' listed as a 'Primary Practice Location'. The 'Actions' column for this item has a red arrow pointing to the edit icon (pencil symbol). The page also includes a 'Show Filter' button and a '1 of 1 item' message.

The address details that were initially entered will now appear under Location Details, and a ribbon toward the top of the screen will display two sections, Address and PT/SP/SSP, each marked with a red warning triangle and requiring additional information.

NOTE: The Address Tab refers you to the area where you will enter the provider's correspondence address. The PT/SP/SSP refers to the area where you will enter the provider specialties that are associated to this location. This will be based on information provided in Milestone 1, Step 3. The remaining five tabs to the right are optional (License/Certification, Insurance, Contacts, +2).

A screenshot of the ribbon at the top of the page. It includes tabs for 'Location Details' (selected), 'Address' (with a red warning triangle), 'PT/SP/SSP' (with a red warning triangle), and other optional tabs like 'License/Certification', 'Insurance', 'Contacts', and '+2'. Two red arrows point to the 'Address' and 'PT/SP/SSP' tabs.

Click on the Address tab first.

Select the Correspondence as Type of Address. The Correspondence Address is where any paper communications will be mailed.

Once address details are entered, **click** Validate Address then **click** Save.

TIP: If the Correspondence Address is the same as the Location Address, click the circle next to “Use the same as Location Address.”

Address Details

Location: 01-Buffalo Bills LLC

Type of Address*: Correspondence

Start Date*: End Date:

Address

Address Line 1*: Enter Street Address or PO Box Only

Address Line 2

Address Line 3

City/Town*: Select

State/Province*: Select

County*: Select

Country*: UNITED STATES

Zip Code*: Latitude Longitude

Validate Address

Save

Back

Click PT/SP/SSP tab.

Select the specialty(ies) from the box on the left and **click** the arrow pointing to the right to move the specialty over to the box on the right. *This will be based on information you provided in Milestone 1, Sept 3. The remaining five tabs to the right are optional (License/Certification, Insurance, Contacts, +2).*

Click Save when all subspecialties have been moved over to the box on the right.

The screenshot shows the 'Provider Type/Specialty/ Subspecialty' section. On the left, under 'Available Subspecialty', there is a checkbox for 'Physician/Family Practice/No Subspecialty - 207Q00000X'. A red arrow points from this box to a red-bordered arrow icon with a right-pointing arrow. Another red arrow points from this icon to the 'Associated Subspecialty' list on the right. The 'Associated Subspecialty' list is empty. Below the lists are 'Add All' and 'Remove All' buttons. At the bottom right of the interface are 'Back' and 'Save' buttons, with a red arrow pointing to the 'Save' button.

Click on Next Step at the bottom right. A screen will pop up to indicate that Milestone 2 is complete.

The screenshot shows the 'Provider Type/Specialty/Subspecialty List' page. It displays a single item: 'Physician' with a start date of 09/04/2025 and an end date of 12/31/2999. The 'Actions' column for this item includes edit and delete icons. At the bottom right of the page is a large red arrow pointing to a 'Next Step' button.

Click Okay to acknowledge and move on to Milestone 3.

