



*Formerly Known As  
Monroe Plan for Medical Care*



## **Provider Bulletin**

---

TO: Participating Primary Care Monroe Plan IPA and YourCare Primary Care IPA  
Network Providers (dba Elm and Oak Health)

FROM: Monroe Plan for Medical Care and YourCare IPA (dba Elm and Oak Health)  
Provider Relations Department

DATE: 04/08/2026

SUBJECT: Molina Provider Exclusion Monitoring Attestation

Molina Healthcare of New York, Inc. is required to confirm our network providers have procedures in place to identify and determine the exclusion status of your managing employees through routine checks of Federal databases. These include the Social Security Administration's Death Master file, the National Plan and Provider Enumeration System (NPPES), the SAM, the List of Excluded Individuals and Entities (LEIE), and any such other databases as the Secretary may prescribe; and ii) check the LEIE, the SAM, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists and the NYS OMIG Exclusion List no less frequently than monthly.

For us to determine your compliance, the following documents must be submitted to our Provider Network Department, [providerrealitions@elmandoakhealth.com](mailto:providerrealitions@elmandoakhealth.com) by **5/31/2026**. Please complete page 2 and provide the following:

- Point of Contact
  - First and Last Name, Job Title
- Contact Information
  - Phone Number
  - Email
- Managing Employee Exclusion Check Policies and Procedures
- List of all Managing Employees for 2025
- Three (3) months of routine checks, conducted in 2025, covering all required databases
  - Clearly indicating month and year of check

Upon completion of our review the results will be communicated to your Point of Contact. If you are determined to be compliant this review is complete. If you are deemed non-compliant, a corrective action plan will be required to come into compliance with your requirement to monitor managing employees against routine checks of Federal databases. In addition, you will need to provide us with three (3) months of consecutive checks for the CAP to be validated and closed.

Failure to comply with this request or corrective action may result in termination from the network. Questions can be directed to Molina's Healthcare of New York's Provider Relations Department email, [mhnyproviderservices@molinahealthcare.com](mailto:mhnyproviderservices@molinahealthcare.com).

Thank you for your attention,  
Provider Network Management

## **ATTESTATION FORM**

1. Provider Name:

TIN: \_\_\_\_\_

Point of Contact: \_\_\_\_\_

Contact Information

1. Name:

1. Email:

2. Procedures in Place

1. Provider Procedures inclusive of all required database checks and are those checks being completed Monthly. **Yes or No?**

3. Exclusion Database

1. Are the providers procedures inclusive of all required database checks and are those checks being completed (**Routine/ Monthly**).

Select **Yes or No?**

1. Social Security Administration's Death Master file (**Routine**)

Select **Yes or No?**

1. National Plan and Provider Enumeration System (NPPES) (**Routine**)

Select **Yes or No?**

1. SAM **(Monthly)**

Select **Yes or No?**

1. List of Excluded Individuals and Entities (LEIE) **(Monthly)**

Select **Yes or No?**

1. S. Department of the Treasury's Office of Foreign Assets Control (OFAC)  
**(Monthly)**

Select **Yes or No?**

1. NYS OMIG Exclusion List **(Monthly)**

Select **Yes or No?**

4. Evidence of the Exclusion Monitoring (Above Items) **Yes or No?**

5. Please provide description of how evidence was provided:

---

---

---

---

---

I attest to the best of my knowledge that the above information is true, accurate and complete

Signed by:

Name (Print):

Name (Signature):

Title:

Elm & Oak Health, 1120 Pittsford Victor Road, Pittsford, NY 14564, United States, 585-244-5550

[Unsubscribe](#) [Manage preferences](#)