Mail To: eMedNY
P.O. Box 4610
Rensselaer, NY 12144 – 4610

New York State Medicaid Affiliation/Disaffiliation Request

- This form is for Nurse Practitioners, Supervising Pharmacists, Laboratory Directors, and Physician Assistants
- Please check the appropriate box:

☐ Request for Affiliation with another provider – can only be requested by the original provider. Please enter effective date, complete **Identifying Information** and **Service Address Information** sections below, and sign form. Affiliated provider signature is required.

Effective Date _____/_____/_____
MM / DD / YY

- I agree to participate in the Medicaid Program affiliated with the affiliated provider listed below. I realize I remain personally responsible for all claims billed to Medicaid using both the below provider's Medicaid Provider Number and my individual Medicaid Provider Number. Upon completion of this form, my name may be withdrawn from the linked provider listed below.

☐ Request to Disaffiliate with another provider – may be requested by either the individual provider or the affiliated provider. Please enter effective date, complete only the **Identifying Information** section below, and sign form. A representative's signature is required, as applicable.

Effective Date _____/_____/_____
MM / DD / YY

Identifying Information – Affiliated Provider/ Original Provider

Provider Name _____
Last First MI

National Provider Identifier (NPI) _____

Medicaid Provider # _____

Affiliated Provider Name _____

Affiliated National Provider Identifier (NPI) _____

Affiliated Medicaid Provider # _____

Service Address Information (for affiliation with a provider)

- List the Service address(es) where you will work with the affiliated provider listed above. If more than two, please attach a separate sheet.
- **Do not** list private practice service addresses.

Service Address _____

Suite, Department, etc. _____

City _____ State _____ Zip _____

Service Address _____

Suite, Department, etc. _____

City _____ State _____ Zip _____

Signature

_____
Provider or Representative Signature Date