DEA FORM

MEDICAID PROVIDER MAINTENANCE

MAIL TO: eMedNY
P.O. Box 4610
Rensselaer, NY 12144

Who: This form to be completed by any provider who is authorized to prescribe.

Instructions: Providers must complete Section A and sign Section B or complete Section A and sign Section C adding *all* (submit multiple pages if necessary) active DEA numbers associated with their professional practice to this form.

Section A:

PROVIDER NUMBERS: _____ 8-digit Medicaid Number (Required IF Available) _____ 10-digit NPI (Required)

NAME: _____
NAME EXACTLY AS IT APPEARS ON YOUR LICENSE/REGISTRATION

PROVIDER CORRESPONDENCE ADDRESS

Street Address 1 _____

Street Address 2 _____

City (**Do NOT** use abbreviations) _____

STATE _____ ZIP CODE _____ COUNTY (if within NYS) _____

Section B:

I do not have a DEA registration number because I do not prescribe, administer, or dispense controlled substances. I will update NY Medicaid Provider Enrollment if I later obtain a DEA registration.

_____
PROVIDER'S SIGNATURE (Original Signature REQUIRED.)

_____ _____
AUTHORIZED REPRESENTATIVE FOR BUSINESSES/ENTITIES SIGNATURE (Original Signature REQUIRED) AUTHORIZED REPRESENTATIVE'S TITLE

_____
DATE SIGNED

Section C:

1. DEA NUMBER: _____ BEGIN DATE: _____ END DATE: _____
2. DEA NUMBER: _____ BEGIN DATE: _____ END DATE: _____
3. DEA NUMBER: _____ BEGIN DATE: _____ END DATE: _____
4. DEA NUMBER: _____ BEGIN DATE: _____ END DATE: _____

I hereby request that the DEA information provided above be updated or entered for my NY Medicaid Enrollment file.
All corresponding DEA registration certificate copy(ies) are attached.

_____
PROVIDER'S SIGNATURE (Original Signature REQUIRED.)

_____ _____
AUTHORIZED REPRESENTATIVE FOR BUSINESSES/ENTITIES SIGNATURE (Original Signature REQUIRED) AUTHORIZED REPRESENTATIVE'S TITLE

_____
DATE SIGNED