Request for Provider Reports

This form may be used by enrolled providers to request information on their NY Medicaid file. Please check below the report(s) you are requesting. This form must be signed by the provider, with an **original signature.** Signature stamps are not acceptable. Please provide us with **both** your email **and** your mailing address below. **Please print clearly.**

Please be advised that requests for reports will be processed no more than every six(6) months for the same provider.

- O Rate Report (Institutional Providers Only)
- O Locator Code Report
- O Specialty Code Report
- O Group Affiliation Report

Request Details:

_____

_____

_____

_____

Date of Request: _____ / _____ / _____
MM DD YYYY

Provider Name: _____

NPI:_____ (Required, unless NPI exempt)

MMIS ID: _____ (only if NPI exempt)

EMAIL Address: _____

Mailing Address:

NAME/ATTN:_____/_____

STREET:_____

CITY/STATE/ZIP_____/_____/_____

Provider Phone#: (_____) _____/_____
Area Code Phone # Extension

Provider Signature:_____/_____
Signature Title

Mail form to:

eMedNY
PO Box 4610
Rensselaer, NY 12144

EMEDNY-610901 (10/16)