CONSENT FORM

eMedNY Remittance Retrieval
PO Box 4605
Rensselaer, NY 12144

Date: _____

Due to the Privacy rule mandated by HIPAA, we are unable to release records to anyone without written authorization. To give authorization for the release of **Remittance** records, please complete this form and mail to the address listed above. All information below is **required**.

Provider/Group Name:_____

Address: _____

City, State, Zip Code:_____

Provider Number:_____ NPI: _____

I give eMedNY authorization to release information regarding my Remittance records to the individual(s) within my organization as listed below:

Please Print:

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone:_____ Phone: _____

(For more than two names, please attach additional sheet)

If you intend this statement to provide authorization for future requests, one of the individuals listed above must initiate the request by completing and signing the form on page 2 of this document, (Remittance Copy Request Form). This signed statement will remain valid until you inform us otherwise, in writing.

For an individual provider, this form must be signed by the provider him/herself. If you are a group or business, this Consent form must be signed by an owner listed on file with NY Medicaid.

Provider/Owner Name: _____
Please Print

Provider/Owner Signature: _____ Date: _____
Original signature required

If you have any questions regarding this form, please contact eMedNY's Provider Services Call Center at, (800)343-9000.

Date:_____

Remittance Copy Request Form

Please complete this form if you wish to request a copy of a paper remittance that was never received or, if you need a duplicate remittance to replace a lost statement. You can also use this form to request a paper copy of an electronic remittance that is older than four (4) cycles.
If within 4 cycles of the original issuance date, an electronic remittance can be resent to you by calling Provider Services at (800) 343-9000.

There will be no charge if the requested remittance was originally received on paper and is less than 60 days old, OR, if the check associated with the remittance was reissued. Otherwise, requests for replacement remittances are subject to a 25 cent per page fee, with a $5.00 minimum charge. **DO NOT send payment until you receive an invoice from eMedNY for the replacement remittance.** The remittance will be mailed to you upon receipt of a check or money order for the exact amount due on the invoice.

You must have a **Consent Form** on file in order for eMedNY to release remittance information. The person signing this Request Form **must** be listed on the Consent Form. If you have not previously sent a Consent Form, or you wish to add additional signatures, for your convenience, there is a Consent Form on page 1 of this document. Please complete, sign, and send it along with this Request Form. Original signatures are required on both forms. Please complete all items below and mail to:

eMedNY Remittance Retrieval
PO Box 4605
Rensselaer, New York 12144

- ✓ Provider/Group Name/Address:
  _____
  _____ _____
  _____
- ✓ Contact Name/Phone #: _____/_____
  Please Print
- ✓ Medicaid Provider Number: _____ NPI: _____

Please check as applicable:
- ✓ Original Remittance was: Paper ☐ Electronic ☐ PDF ☐
- ✓ Original Remittance was: Not Received ☐ For a reissued check ☐

Please provide as much of the following identifying information as possible. For multiple requests, please complete separate forms.

- ✓ Remittance # / Cycle #: _____/_____
- ✓ Check Date/ Dollar Amount: _____/_____

- ✓ Requestor Name: _____
  Please Print

- ✓ Requestor Signature: _____(signee must be listed on Consent Form)
  Original signature required

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