NAME _____

PROVIDER ID _____

This form is used to request a copy of a Prior Approval Roster or Missing Information Letter. Please select only one of the following:

☐ ***Prior Approval Roster***

☐ ***Missing Information Letter***

PRIOR APPROVAL TYPE *(Please Check One)*

Transportation / PCA (must indicate specific Date of Roster. Date ranges are unacceptable.)

Transportation ☐ PCA ☐ Date of Roster ____/____/____
Month Day Year

PRIOR APPROVAL TYPE *(Please Check One)*

Physician ☐ Out of State Hospital ☐ Nursing ☐ DME ☐

Residential Health Care ☐ Hearing Aid ☐ EyeCare ☐ Dental ☐

Routing Sheet required? YES ☐ NO ☐ Pharmacy ☐

PRIOR APPROVAL NUMBER _____

DATE OF ROSTER/MISSING INFORMATION LETTER (OPTIONAL) ____/____/____
If the date field is left blank, the most recent PA Roster/Missing Information Letter will be sent Month Day Year

Please send to:

Attention: _____

Address: _____

City, State, Zip Code: _____

Phone: ____ / _____ / _____

I give eMedNY authorization to release information regarding my Prior Approval Roster or Missing Information Letter.

Signature of Provider _____

Date _____

eMedNY Roster Retrieval
PO Box 4605
Rensselaer, NY 12144