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

New York State Medicaid Program
Group Affiliation/Disaffiliation Request

- Practitioners should complete this form to affiliate or disaffiliate from a group practice.
- Group practices may complete this form to disaffiliate a practitioner from their group.
- If enrolling, mail this form with your enrollment to the address **on the enrollment form**.
- If you are already enrolled and are updating the files, mail this form to address listed above.

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CHOOSE ONE:

☐ **Request to Affiliate to a Group Practice** (Complete Sections **A and B**)

☐ **Request to Disaffiliate** (Complete Sections **A and C**)

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SECTION A:

Practitioner's Information:

Name: _____ (required)
NPI: _____ (required)
Medicaid ID: _____ (optional)

Group's Information:

Name: _____ (required)
NPI: _____ (required)
Medicaid ID: _____ (optional)

Affiliation Effective Date: _____ (required)
*(NOTE: The affiliation effective date can be a future date. If the affiliation effective date is in the past and is **greater than 90 days** from the date this form was **received** by the Medicaid Program, the listed date cannot be used. The effective date will be set at the 90-day limit).*

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SECTION B:

I agree to participate in the Medicaid Program as a Member of the group listed above. I realize I am personally responsible for all claims billed to Medicaid using both the group and my personal identification numbers. I will notify the Medicaid Program if I am not longer affiliated with this group.

Practitioner's Signature: _____ Date Signed: _____

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SECTION C:

Disaffiliation Effective Date: _____ (required)

The individual and group identified in Section A are no longer affiliated with the other. This change is confirmed by the individual whose signature is provided below (a signature is required from **at least** one of parties identified below).

Practitioner's Signature: _____ Date Signed: _____

Signature of Group Practice Representative: _____ Date Signed: _____