REQUEST TO DISAFFILIATE / DELETE AN ELECTRONIC TRANSMITTER IDENTIFICATION NUMBER (ETIN)

This form should be used to disaffiliate a Provider number from an ETIN with which you are no longer affiliated. Please complete and sign this form and mail or fax as indicated below.

NPI (Unless NPI exempt): _____

Provider ID (If NPI exempt): _____ Date: _____

ETIN(s) to be disaffiliated from Provider ID listed above: _____ _____ _____
_____ _____ _____ _____ _____ _____ _____

Provider/Owner Signature: _____ / Title: _____
(see note below)

Print Provider/Owner Name & Title: _____

Contact Name/Phone #: _____

NOTE: This form must be signed by the provider submitting the request. For GROUPS or BUSINESSES, an owner, as listed at the time of enrollment, must sign and declare title.

If you have any questions, please call the eMedNY Call Center at 800-343-9000. Please mail or fax the completed form to:

eMedNY
P.O. BOX 4614
RENSSELAER, NEW YORK 12144-8614
ATTN: PROVIDER ENROLLMENT SUPPORT
FAX: (518) 257-4632