



PROVIDER FAX COVER SHEET

Date: _____

TO: **1-800-210-7442** (Fax)
eMedNY Operations Claims Processing

FROM: _____ (Fax)
_____ (Phone)
_____ (Contact Name)
(Provider Name)
(Provider MA ID #)
(Address)

- Check One: Return Information Routing Sheet
 Prior Approval Change Request Form
 Electronic Transaction Attachment Scanning Sheet

Number Pages (Including this Cover Sheet and Sheet/Form checked above): _____

Message: _____

Confidentiality Notice: The documents accompanying this FACSIMILE transmission may contain confidential information which is legally privileged. The information is intended only for the use of the eMedNY contractor to the New York State Department of Health within the eMedNY system. If you are not the intended recipient or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in the transmission is hereby PROHIBITED. If you have received this transmission in error, please immediately notify us at the telephone number above, and mail the original transmission back to us. Thank you.