ELECTRONIC PRIOR APPROVAL REQUEST FORM

In order to receive the New York Medicaid Prior Approval determinations in a printable PDF format, through eMedNY eXchange, please complete **all** of the following information and either mail or fax the completed form to:

eMedNY
Attn: Provider Enrollment
P.O. Box 4614
Rensselaer, New York 12144
FAX: (518) 257-4632

If you have not already enrolled for eXchange, please visit the eMedNY website at **www.emedny.org** for details or call the eMedNY Call Center at (800) 343-9000.

NOTE: YOU MUST BE ENROLLED IN EMEDNY EXCHANGE PRIOR TO REQUESTING THE ELECTRONIC PRIOR APPROVAL ADVICE. PLEASE ENTER YOUR ASSIGNED EXCHANGE USER ID BELOW. PLEASE LOG INTO ePACES TO ACTIVATE YOUR USER ID.

PLEASE MAKE SURE ALL INFORMATION ENTERED ON THIS FORM IS LEGIBLE.

1. NPI: _____ **(Required, unless NPI exempt)**

PROVIDER Medicaid ID: _____ **(If NPI exempt)**

(For multiple provider IDs, please submit a separate list attached to this form)

2. ORGANIZATION NAME: _____

3. ADDRESS:

_____

_____

_____

4. CONTACT NAME: _____

5. CONTACT PHONE #: _____

6. EMAIL ADDRESS: _____

7. FAX #: _____

8. ☐ **CHECK HERE TO REVERT BACK TO PAPER PRIOR APPROVAL DETERMINATIONS**

PLEASE ENTER YOUR ASSIGNED EMEDNY EXCHANGE USER ID BELOW:

USER ID: _____

SIGNATURE: _____ **DATE SIGNED:** _____

SIGNED BY (PRINT NAME): _____ **TITLE:** _____

Please note: This form will be returned if it contains incomplete or illegible information.