ALL FIELDS REQUIRED FOR COMPLIANCE

Confirmation of Return or Destruction of Misdirected Paper Correspondence **Form Required for Completion**

By completing this form, you are acknowledging that you have received and viewed correspondence or accessed data from eMedNY for a provider who is not at the address listed or with whom you have no current affiliation. If you have questions, please contact the eMedNY Call Center at 1-800-343-9000.

Section A: Who was the receiver of this information?

Name : _____

Section B: Check all that apply and complete indicated information (Required)

☐ I am **returning by mail** a remittance statement meant for

_____ that was issued for _____
Provider Name *Remittance Number*

☐ I am **returning by mail** other misdirected correspondence
- ☐ I am **returning by mail** a Letter or written correspondence
- ☐ I am **returning by mail** a Transportation Roster
- ☐ I am **returning by mail** a Recertification Application

the correspondence was ***meant*** for:

_____
Provider Name

☐ I am **faxing a copy of and destroying******* the misdirected correspondence meant for

_____ with _____
Provider Name *Provider Number*

****** Prior to destruction, the misdirected correspondence and this form should be faxed to (518) 257-4653. Commence destroying the documents only after a confirmed receipt is received on your fax machine. Use an approved technology or methodology in accordance with the federal Department of Health and Human Services (DHHS) guidelines (burning, shredding or pulverizing) when destroying correspondence.

*****Please describe how you determined the correspondence was misdirected and why it is being returned*****:

Section C: Confirmation Statement (Required)

I,_____, _____at _____
Print Name *Print Title* *Phone Number*

Confirm that the misdirected correspondence has been returned or destroyed and no copies or information were retained or forwarded to any unauthorized persons.

_____ _____
Signature of Provider/Authorized Representative *Date*

If Document was destroyed; shredded, it was witnessed by: _____
Print Name of Witness that observed destruction

Mail or fax the completed form with all misdirected correspondence to:

eMedNY
Attn: HIPAA System Analyst Lead
P.O. Box 811
Rensselaer, New York 12144
FAX: (518) 257-4653

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