

## Prescription Footwear Form

**EFFECTIVE APRIL 1, 2009, THE NEW YORK STATE MEDICAID PROGRAM WILL REIMBURSE PROVIDERS FOR PRESCRIPTION FOOTWEAR ONLY IF THEY HOLD A CURRENT CERTIFICATION BY ONE OF THE CERTIFICATION BOARDS LISTED BELOW.**

Provider Name: \_\_\_\_\_

Medicaid Provider Identification Number: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

I have attached a copy of my current certification by one of the following:

\_\_\_\_\_ American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.

\_\_\_\_\_ Board for Certification/Accreditation, International

Print Owner's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Owner's Signature: \_\_\_\_\_

The owner must sign and date this form. Signature stamps, photocopies, etc. are not acceptable.

Submit this completed form and required documentation to:

Computer Sciences Corporation  
PO Box 4610  
Rensselaer, New York 12144

PLEASE NOTE: When your certification expires, please submit a copy of your current certification to the address above.

If you have any questions, please contact the eMedNY Call Center at 1-800-343-9000.