

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:

Computer Sciences Corporation
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 eMedNY Provider Services 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 MAKE SURE ALL INFORMATION ENTERED ON THIS FORM IS LEGIBLE.

1. PROVIDER Medicaid ID: _____ (Required)
NPI: _____ (Required, unless 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.