



REQUEST FOR EXISTING PROVIDER ID

If you are currently enrolled in the New York Medicaid program, but you do not know your Medicaid Provider ID, please provide the following identifying information and mail your **signed** request to the address below:

**COMPUTER SCIENCES CORPORATION
PO BOX 4610
RENSSELAER, NEW YORK 12144**

- Provider Name: _____
- License Number: _____
- Social Security Number: _____
or
- Tax ID #: _____
- Provider Signature and Title (see note): _____
- Date Signed: _____

NOTE: Original signature is required. Photocopy or signature stamp is unacceptable. The provider for whom the number is being requested must sign this form. For **GROUPS or **BUSINESSES**, an administrator or owner, as listed at the time of enrollment, must sign and declare title.**

- Please print address where provider ID information is to be mailed:

If you have any questions, please contact CSC’s Call Center at 800-343-9000.