



Request for Provider Reports

This form may be used by enrolled providers to request information on their NY Medicaid file. Please check below the report(s) you are requesting. This form must be signed by the provider, with an **original signature**. Signature stamps are not acceptable. Please provide us with **either** your email **OR** mailing address below. If Email address is provided, you will only receive the soft copy of the requested report(s). Otherwise, the hard (paper) copy will be mailed to the mailing address entered below. **Please print clearly.**

Please be advised that requests for reports will be processed no more than every six (6) months for the same provider.

- Rate Report (Institutional Providers Only)
- Locator Code Report
- Specialty Code Report
- Group Affiliation Report

Request Details:

Date of Request: ___ / ___ / _____

NPI: _____ (Required, unless NPI exempt)

MMIS ID: _____ (only if NPI exempt)

EMAIL Address: _____ **Provide ONLY if report is to be Emailed**

Mailing Address:

NAME/ATTN: _____ / _____

STREET: _____

CITY/STATE/ZIP _____ / _____ / _____

Provider Phone#: (_____) _____ / _____
Area Code Phone # Extension

Provider Signature: _____ / _____
Signature Title

Mail form to:

Computer Sciences Corporation
PO Box 4610
Rensselaer, NY 12144