New York State Medicaid Prescription Footwear

- Use this form for a new request to provide prescription footwear, to notify the Department of Health of a change of employment for a certified employee, or when your certification or that of your employee is renewed.
- Please submit, with this form, a copy of your certification for each orthotist, pedorthist or prosthetist to the address above.
- If you have any questions, call the eMedNY Call Center at 1-800-343-9000.

	☐ New Certification	☐ Renewal	☐ Change of Employment		
Medica	id Provider Name				
Medica	id Provider #				
	National Provider Identifier (NPI)				
Owner					
Relationship of Certified Individual to Your Company (Check one):					
	☐ Owner		☐ Employee		
If neithe	er owner or employee is check	ed, please explain:_			
Please indicate all other locations where the certified individual(s) are currently employed and					
uisperis	se snoes				
Attach a	. •	y one of the followir	ng for at least one employee or owner		
	American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc.				
	Board for Certification / Accred	itation, International			

If you have certified fitters in addition to the certified staff listed above, please submit a copy of				
those licenses as well with this form, and list those names:				
Please indicate all other locations where the certified fitters are currently employed and	d			
dispense shoes:				
For a Change in Employment:				
☐ For a new employee with new certification:				
Orthotist, Prosthetist, or Pedorthist joined employment on / / MM / DD / YY				
☐ For an employee who has left your employment:				
Orthotist, Prosthetist, or Pedorthist left employment on/ MM / DD / YY				
Name (print) of Employee Original Signature	Date			
Name (print) of Owner Original Signature	Date			