ELECTRONIC OR PDF REMITTANCE ADVICE REQUEST

Prior to submitting this form, providers must:

- Have a valid and active eMedNY eXchange, Core Web Services, or VPN User ID prior to submitting this form. If you do not have an active User ID, **STOP** and contact the eMedNY Call Center at 1-800-343-9000 to start the ePACES enrollment process before completing this form.
- Be associated with the ETIN entered in the 'Provider Information' section below. If the provider is not currently associated with the ETIN entered on this form, **STOP**. You **must** complete a certification statement for the ETIN entered (EMEDNY form # 490601) and mail both forms together to the address below.

THIS FORM WILL BE REJECTED IF ANY REQUIRED FIELDS ARE NOT COMPLETED

Required Information:

(1) Provider Name: _____

Enter the name of either the individual provider or organization for which this form is being submitted.

(2) NPI (National Provider Identifier) (Required, unless exempt)**:** _____

The NPI entered must match the provider or organization name entered above in section (1).

(3) *MMIS Provider ID _____

**Required only if NPI exempt or an atypical provider.*

(4) ETIN: _____

*The 3 or 4 digit **E**lectronic **T**ransmitter **I**dentification **N**umber. Only one ETIN per form is allowed. For multiple providers, a separate form must be submitted for each provider.*

(5) Remittance Type Selection (Select One):

☐ 835/820 Electronic Remittance **OR** ☐ PDF *(can only be used with eXchange delivery method)*

- *For 835/820 electronic remittance types, software to interpret HIPAA formatted records is strongly recommended. eMedNY cannot provide remittance interpretation service.*

(6) Remittance Delivery Method (Select One): ☐ eXchange **OR** ☐ VPN **OR** ☐ Core WEB Services

(7) Current eXchange, Core WEB Services, or VPN User ID: _____

- The eXchange, Core Web Services, or VPN user ID submitted on the form must be valid and activated.
- Only one User ID is allowed per ETIN/Provider combination.

Authorized Signature

The person signing this form, even if on behalf of the Provider, warrants that s/he has the legal authority to do so.

_____ _____

Signature of Person Submitting Enrollment *Submission Date*

_____ _____

Printed Name of Person Submitting Enrollment *Email Address of Person Submitting Enrollment*

Mail or fax completed form to:

eMedNY
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, New York 12144-8614
FAX: (518) 257-4632

PLEASE ALLOW UP TO 14 BUSINESS DAYS FOR PROCESSING.