eMedNY

PROVIDER FAX COVER SHEET

Date: _____

TO: **1-800-210-7442 _____(Fax)**
eMedNY Operations Claims Processing

FROM: _____(Fax)
_____(Phone)
_____(Contact Name)
(Provider Name)_____
(Provider MA ID #)_____
(Address)_____
_____
_____

Check One:
- ❒ **Return Information Routing Sheet**
- ❒ **Prior Approval Change Request Form**
- ❒ **Electronic Transaction Attachment Scanning Sheet**

Number Pages (Including this Cover Sheet and Sheet/Form checked above): _____

Message: _____
_____
_____
_____
_____
_____