# CONSENT FORM

**eMedNY Remittance Retrieval**
**PO Box 4605**
**Rensselaer, NY 12144**

**Expedited / Priority Shipping:**
eMedNY
327 Columbia Turnpike
ATTN: Box 4605
Rensselaer, NY 12144

Date: ___________________

Due to the Privacy rule mandated by HIPAA, we are unable to release records to anyone without written authorization. To give authorization for the release of **Remittance** records, please complete this form and mail to the address listed above. All information below is **required**.

Provider/Group Name:_________________________________________________________________

Address: ___________________________________________________________________________

City, State, Zip Code:_________________________________________________________________

Provider Number:_________________________ NPI: ____________________________________

I give eMedNY authorization to release information regarding my Remittance records to the individual(s) within my organization as listed below:

**Please Print:**

Name: ______________________________
Address: ____________________________
______________________________
Phone:______________________________

Name: ______________________________
Address: ____________________________
______________________________
Phone: ______________________________

(For more than two names, please attach additional sheet)

If you intend this statement to provide authorization for future requests, one of the individuals listed above must initiate the request by completing and signing the form on page 2 of this document, (Remittance Copy Request Form). This signed statement will remain valid until you inform us otherwise, in writing.

**For an individual provider, this form must be signed by the provider him/herself. If you are a group or business, this Consent form must be signed by an owner listed on file with NY Medicaid.**

Provider/Owner Name: ___________________________________________________________________
**Please Print**

Provider/Owner Signature: _________________________________________ Date: ___________________
**Original signature required**

If you have any questions regarding this form, please contact eMedNY's Provider Services Call Center at, (800)343-9000.

**Date:____________**

## Remittance Copy Request Form

Please complete this form if you wish to request a copy of a paper remittance that was never received or, if you need a duplicate remittance to replace a lost statement. You can also use this form to request a paper copy of an electronic remittance that is older than four (4) cycles and can, therefore, only be reproduced on paper.
If within 4 cycles of the original issuance date, an electronic remittance can be resent to you by calling Provider Services at (800) 343-9000.

There will be no charge if the requested remittance was originally received on paper and is less than 60 days old, OR, if the check associated with the remittance was reissued. Otherwise, requests for replacement remittances are subject to a 25 cent per page fee, with a $5.00 minimum charge. **DO NOT send payment until you receive an invoice from eMedNY for the replacement remittance.** The remittance will be mailed to you upon receipt of a check or money order for the exact amount due on the invoice.

You must have a **Consent Form** on file in order for eMedNY to release remittance information. The person signing this Request Form **must** be listed on the Consent Form. If you have not previously sent a Consent Form, or you wish to add additional signatures, for your convenience, there is a Consent Form on page 1 of this document. Please complete, sign, and send it along with this Request Form. Original signatures are required on both forms. Please complete all items below and mail to:

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**PO Box 4605**
**Rensselaer, New York 12144**

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ATTN: Box 4605
Rensselaer, NY 12144

✓ Provider/Group Name/Address:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

✓ Contact Name/Phone #: ________________________________/_______________________
**Please Print**

✓ Medicaid Provider Number: ________________________ NPI: __________________________

Please check as applicable:
✓ Original Remittance was: Paper ____ Electronic ____ PDF ____
✓ Original Remittance was: Not Received ____ For a reissued check ____

Please provide as much of the following identifying information as possible. For multiple requests, please complete separate forms.

✓ Remittance # / Cycle #: ________________________________/___________________________
✓ Check Date/ Dollar Amount: _____________________________/____________________________

✓ Requestor Name: __________________________________________
**Please Print**

✓ Requestor Signature: __________________________________________(signee must be listed on Consent Form)
**Original signature required**

If you have any questions regarding this form, please contact eMedNY's Provider Services Call Center at: (800)343-9000