

NEW YORK STATE MEDICAID PROGRAM- ENTERAL FORMULA PRIOR AUTHORIZATION CANCELLATION REQUEST FORM

This form is to be completed by prescribing or dispensing providers to request cancellation of activated Interactive Voice Response (IVR) and Enteral Web Portal prior authorizations only. Once the prior authorization is cancelled, the prescribing provider can obtain a new automated prior authorization.

Prior authorizations that have been rendered or billed on cannot be cancelled and require submission of a prior approval request via ePACES or paper form.

Completed cancellation request forms may be submitted via fax to (518) 474-4137

Date:

Requester Name:

Requester Phone Number:

Prior Authorization Number:

Date Submitted:

Member's Medicaid ID (2 alpha/5 numeric/1 alpha):

Member's Date of Birth (MM/DD/YYYY):

Prescriber's 10-digit National Provider ID # (NPI):

Dispenser's 10-digit National Provider ID # (NPI):

Reason for Cancellation: