New York State Medicaid Provider Change Form (Practitioners in Groups)

Thank you for participation in the New York State Medicaid Program. As a Medicaid provider, you have agreed to comply with the rules, regulations and official directives of the Department including, but not limited to, Part 504 of 18NYCRR (i.e., Title 18). Title 18 can be found by choosing the Laws and Regulations link of the Department of Health's website, www.health.ny.gov.

As a member of a Group practice, the services you provide are claimed by, and paid to, the Group practice. Members of Group practices, therefore, are non-billing providers UNLESS they also have a private practice from which they provide services to Medicaid beneficiaries.

If you are a member of a Group practice and do not have a private practice as well, please complete this form. **DO NOT complete this form if you have a private practice.** The Medicaid Program will update your enrollment records. If your situation changes and you leave the Group and/or establish your own practice, please remember to notify the Medicaid Program at that time.

Mail this completed document to: eMedNY
PO Box 4610
Rensselaer, NY 12144-4610

Your Name - **Last, First, MI**		
Date of Birth (MM/DD/YY)	SSN	
Your NPI	Your Medicaid ID (if known)	Group NPI
CONTACT ADDRESS: (for questions about this Form)		
Attention:	Street Address	Suite / Department / Floor
City	State	Zip Code (9 digits)
e-Mail Address	Telephone Number (w/ extension)	Fax Number

_____ _____
Provider's Signature (original; no stamps) Date