Remittance Copy Request Form

This form is used to request a copy of a paper remittance, or to request a PDF or paper copy of an electronic remittance that is older than four (4) cycles. **NOTE:** If the requested remit was issued electronically and is within 4 cycles of the check release date, **STOP: do not complete this form**. The electronic remittance can be resent to you by calling Provider Services at 1-800-343-9000.

Please note: This remittance request form is not intended to replace or change your normal remittance delivery method, and should only be used as a temporary exception to your normal remittance delivery method. You may request up to **12 cycles** using this form. Any request for greater than 12 cycles requires additional explanation and will be reviewed (see top of page 2). You may also be contacted by a member of our Provider Services team if additional information is needed.

SECTION 1:

Failure to complete any of the required fields below will result in your request being rejected.

(Required) Reason(s) for Request:

Cannot Access   Unsure of How to Access   Vendor Issue   Changing Vendor

Updating Remittance Delivery Method   Audit   Proof of Income/Income Verification

*Other   **If selecting other, please briefly describe reason (required):*

(Required) Are there any ongoing issues preventing you from Receiving Remittance   Yes   NO

(Required) Provider/Facility/Group Name (Name Associated to NPI/MMIS): ____

(Required) Medicaid Provider Number (MMIS): _________________________ or NPI: ____________________________

(Required) Provider Tax ID or Last 4 of SSN: _______________________

(Required) Requestor First and Last Name: ____

(Required) Phone # and email:
__________________________________/____

(Required) Is this request related to a Reissued Check? Yes____ No____

Please provide as much of the following identifying information as possible. **For multiple requests under the same MMIS/NPI, please attach a separate sheet with this request form.**

Remittance #   Cycle #   Check #:

___________________________________/____________________________/___________________________

If you are requesting more than 12 cycles, please use the box below to provide a detailed explanation of the reason for the request. If you are requesting more than 12 cycles and do not provide this required information, your request will be rejected.

SECTION 2:

Two delivery options are available for this remittance request. Please select **one** of the following:

☐ **PDF / Email:** A PDF copy of the requested remittance will be sent securely via email as an attachment at no charge to the email address indicated below.

(Required) Email address: ____________________________________

(Note: If no email is listed here, you are authorizing eMedNY to use the contact email listed in section 1.)

☐ **Paper / Mail:** Requests for replacement remittances by paper 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. The remittance will be mailed to you upon receipt of a check or money order for the exact amount due on the invoice. The paper remittance will be sent to the Pay-To-Address on file.

Requestor Signature: ____ **Date:** __________________

(Original signature required)

Please Allow 6-8 Weeks for Processing.

Request over 12 cycles and Paper Request may be subject to additional time.

Completed requests can be faxed or mailed to:

Fax: **518-257-4153**

(If you are faxing this form and sending request for multiple NPIs or MMIS IDs, please send separate faxes for each individual NPI or MMIS ID. If the faxes are not sent separately for multiple NPIs or MMIS IDs, the request will be rejected)

Mail: **eMedNY Remittance Retrieval**
PO Box 4605
Rensselaer, New York 12144

If you have any questions regarding this form, please contact eMedNY's Provider Services Call Center at 1-800-343-9000