

Remittance Copy Request Form

This form is used to request a copy of a missing paper or PDF remittance. **NOTE:** If the requested remit was issued electronically via an 835/820 file, or was originally issued as a PDF to your exchange inbox, and you would like it to be sent electronically, **STOP: do not complete this form.** The electronic remittance can be resent without charge by calling eMedNY Provider Services at 1-800-343-9000. Mailing copies of missing remittances has been discontinued. Using this form, copies will only be sent as PDF via email.

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 require 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

**If Selecting Cannot Access, please briefly describe the reason (required):*

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: _____

A Federal Tax ID or Social Security Number is Required – This should match what is listed on file with eMedNY for the NPI/MMIS listed above.

Full Provider Tax ID Number (Groups/Businesses/Facilities): _____

Last four digits of SSN Number (Individual Providers): XXX-XX- _____

(Required) Requestor First and Last Name: _____

(Required) Requestors Phone # and email:

_____/_____

Email Requestor is Authorizing eMedNY to send Remittances: _____

(If no email is listed here, you are authorizing eMedNY to use the contact email for the requestor)

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.

Please provide as much of the following identifying information as possible. For multiple requests under the same MMIS/NPI, please write **'See Attached'** on the lines listed below and attach a separate sheet with this request form.

Remittance #

Cycle #

Check #:

_____/_____/_____

Requestor Signature: _____
(Written signatures are required. Electronic signatures are not allowed.)

Date: _____

**Please Allow 6-8 Weeks for Processing.
Request over 12 cycles 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 are mailing the form, do not send double sided or stapled, or the request will be rejected)

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