eMedNY   **Stop Payment and Reissue Request Form**

Stop and Reissues cannot be processed UNTIL 15 business days AFTER the check was released. If it has not been 15 business days since a check was released, STOP and please allow additional time. Reissued checks will be mailed to the providers Pay-to-Address on file; if incorrect, you **MUST** send in a Change of Address form (COA). If you have any questions concerning your pay-to-address or COA, please contact the eMedNY Call Center. While the Pay-to-address is being updated, if the check needs to be sent to another address, please indicate below.

<p style="color:red; text-align:center">THIS FORM WILL BE REJECTED IF ANY REQUIRED FIELDS ARE NOT COMPLETED</p>

Required Information:

(1) Provider Name: _____
   Enter the name of either the individual provider or organization for which this form is being submitted.

(2) NPI (National Provider Identifier) (Required, unless exempt)**:** _____
   The NPI entered must match the provider or organization name entered above in section (1).

(3) *MMIS Provider ID _____
   **Required <u>only</u> if NPI exempt or an atypical provider, MMIS and NPI must match the same Provider.*

(4) Check Number: _____

(5) Check Amount: _____

(6) Date Issued: _____

(7) Remittance Number: _____

(8) Reason for Request: _____

(9) Address (Optional): Street _____

   City _____   **State** _____   **Zip** _____

<u>**Authorized Signature**</u>

If the request is for an individual provider, the individual provider must sign the form. If the request is for a facility, agency or pharmacy, an authorized person for that entity must sign the form.

The person signing this form warrants that s/he has the legal authority to do so.

_____   _____
Original Signature of Practitioner/Authorized Representative   *Submission Date*

_____   _____
Printed Name of Practitioner/Authorized Representative   *Title of Practitioner/Authorized Representative*

Mail completed form to: **eMedNY**
                     Attn: Stop and Reissue
                        P.O. Box 4611
                  Rensselaer, New York 12144

FOR EMEDNY USE ONLY – DO NOT WRITE

Processed by:_____   Date:_____

Stop Payment Transaction Accepted by Bank on: _____

Stop Payment Transaction Accepted by eMedNY on: _____   Cycle #: _____

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