Copy of Cleared Check Request Form

A Copy of a Cleared Check may be requested using this form. These requests are mailed to the providers Pay-to-Address on file. If the address on file is incorrect, **STOP: do not complete this form.** You will need to update your address by filling out a Change of Address (COA) Form. Contact the eMedNY Call Center at 1-800-343-9000 for assistance.

THIS FORM WILL BE REJECTED IF ANY REQUIRED FIELDS ARE NOT COMPLETED

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 only if NPI exempt or an atypical provider.*

(4) Check Number: _____

(5) Check Amount: _____

(6) Date Issued: _____

(7) Remittance Number: _____

Authorized Signature
The person signing this form, even if on behalf of the Provider, warrants that s/he has the legal authority to do so.

_____ _____
Signature of Person Submitting Form *Submission Date*

_____ _____
Printed Name of Person Submitting Form *Email Address of Person Submitting Form*

Mail or fax completed form to:

eMedNY
Attn: Financial Support Unit
P.O. Box 4611
Rensselaer, New York 12144-8614
Fax Number: 518-960-9998

PLEASE ALLOW UP TO 10 BUSINESS DAYS FOR PROCESSING.