



## Payment Listing Request Form

The purpose of this Payment Listing Request Form is to receive a record of payments made to an individual provider or organization. Completed requests will be mailed to the 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. If you have questions about the COA form, please 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 Date(s) Range** \_\_\_\_\_

*Form will be rejected if the check date(s) provided are not valid check dates.*

**(5) Two delivery options are available for this Payment Listing. Please select one of the following:**

Paper/Mail

PDF/Email

(Email listed below will be used.)

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### **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.**