



**PROVIDER FAX COVER SHEET**

Date: \_\_\_\_\_

TO: **1-800-210-7442** (Fax)  
eMedNY Operations Claims Processing

FROM: \_\_\_\_\_ (Fax)  
\_\_\_\_\_ (Phone)  
\_\_\_\_\_ (Contact Name)  
**(Provider Name)**  
**(Provider MA ID #)**  
**(Address)**  
\_\_\_\_\_  
\_\_\_\_\_

- Check One:  Return Information Routing Sheet  
 Prior Approval Change Request Form  
 Electronic Transaction Attachment Scanning Sheet

Number Pages (Including this Cover Sheet and Sheet/Form checked above): \_\_\_\_\_

Message: \_\_\_\_\_  
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