NAME _____

PROVIDER ID _____

I hereby request a copy of the following Prior Approval Roster / Missing Information Letter for my records:

PRIOR APPROVAL TYPE ***(Please Check One)***

Transportation / PCA (must indicate specific Date of Roster. Date ranges are unacceptable.)

Transportation ☐ PCA ☐ Date of Roster ____/____/____
Month Day Year

All other PA Types (must indicate Prior Approval Number)

Pharmacy ☐ DME ☐ Nursing ☐ EyeCare ☐

Physician ☐ Dental ☐ Hearing Aid ☐ Residential Health Care ☐

Routing Sheet required? YES ☐ NO ☐ Out of State Hospital ☐

PRIOR APPROVAL NUMBER _____

Please send to:

Address: _____

City, State, Zip Code: _____

Phone: __ __ __ / __ __ __ / __ __ __ __

I give eMedNY authorization to release information regarding my Prior Approval Roster or Missing Information Letter.

Signature of Provider _____

Date _____

eMedNY Roster Retrieval
PO Box 4605
Rensselaer, NY 12144