Prior Approval Roster Request

Transportation – PCA:

PROVIDER NAME _____

PROVIDER ID _____

This form is used to request a copy of a Prior Approval Roster. The Prior Approval Roster for Transportation – PCA Providers can only be sent to an address that is on file with eMedNY. If your address needs to be updated, please fill out the Change of Address Form PRIOR to filling out this request form. If the address listed is not currently on file, then the request will be rejected.

NOTE: Date of Roster should be a Monday. If the date listed is not, then we will select the Roster closest to the date provided.

PRIOR APPROVAL TYPE *(Please Check One)*

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

Transportation ☐ **PCA** ☐ **Date of Rosters** _____/_____/_____
Month Day Year

FEIN (Tax ID) _____ **Or Last 4 of SSN** _____

Please send to:

Attention: _____

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 _____

All Other Providers:

PROVIDER NAME _____

PROVIDER ID _____

This form is used to request a copy of a Prior Approval Roster or Missing Information Letter. Please select only one of the following:

◯ **Prior Approval Roster** ◯ **Missing Information Letter**

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

Physician ☐ Out of State Hospital ☐ Nursing ☐ DME ☐

Residential Health Care ☐ Hearing Aid ☐ EyeCare ☐ Dental ☐

Routing Sheet required? YES ☐ NO ☐ Pharmacy ☐

PRIOR APPROVAL NUMBER _____

DATE OF ROSTER/MISSING INFORMATION LETTER (OPTIONAL) ___/___/___

If the date field is left blank, the most recent PA Roster/Missing Information Letter will be sent Month Day Year

Please send to:

Attention: _____

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 _____

Either mail or fax the completed form to:
eMedNY Roster Retrieval
PO Box 4605
Rensselaer, NY 12144
Fax: 518-257-4304