

REQUEST FOR ELECTRONIC REMITTANCE ADVICE

In order to receive the New York Medicaid remittance advice in the electronic HIPAA-compliant 835 or 820 format, through eMedNY eXchange or FTP, please complete **all** of the following information and either mail or fax the completed form to:

Computer Sciences Corporation
Attn: Provider Enrollment Support
1 CSC Way
East Greenbush, New York 12144
FAX: (518) 447-9037

NOTE: YOU MUST BE ENROLLED IN EITHER EMEDNY EXCHANGE OR FTP PRIOR TO REQUESTING THE ELECTRONIC REMITTANCE ADVICE. PLEASE ENTER YOUR ASSIGNED eXchange or FTP USER ID BELOW.

1. ETIN (formerly TSN): _____

2. PROVIDER ID(S): _____
(For multiple provider IDs, please submit a separate list attached to this form)

3. GROUP ID: _____
(Only if billing with a Group ID. If this request is for a Group remittance, no Provider ID should be entered)

4. ORGANIZATION NAME: _____

5. ADDRESS:

6. CONTACT NAME: _____

7. CONTACT PHONE #: _____

8. EMAIL: _____

9. FAX #: _____

PLEASE ENTER YOUR ASSIGNED USER ID BELOW AND CHECK YOUR CHOSEN METHOD OF REMITTANCE RETRIEVAL (eXchange or FTP):

USER ID: _____ eXchange _____ FTP _____

SIGNATURE: _____ DATE SIGNED: _____

SIGNED BY (PRINT NAME): _____ TITLE: _____