

WHICH FORMS SHOULD I COMPLETE?

Provider must be enrolled with Office Ally for the 837 Claims transaction prior to enrolling for 835 (ERA) Electronic Remittance Advice.

If you are already enrolled for 837 Claims, complete the **Electronic or PDF Remittance Advice Request** (Page 2)

WHERE SHOULD I SEND THE FORM(S)?

- Fax to **(518) 257-4632**
OR
- Mail to:
eMedNY
Attn: Provider Enrollment Support
PO Box 4614
Rensselaer, NY, 12144-8614

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is 7-14 business days

HOW DO I CHECK STATUS?

- You can call Medicaid NY at (800) 343-9000 opt. 2 to verify if your Medicaid Provider ID is linked to Office Ally's ETIN, 00A0 for ERAs after the 14 business days.



ELECTRONIC OR PDF REMITTANCE ADVICE REQUEST

Prior to submitting this form, providers must:

- Have a valid and active eMedNY eXchange, Core Web Services, or VPN User ID prior to submitting this form. If you do not have an active User ID, **STOP** and contact the eMedNY Call Center at 1-800-343-9000 to start the ePACES enrollment process before completing this form.
- Be associated with the ETIN entered in the 'Provider Information' section below. If the provider is not currently associated with the ETIN entered on this form, **STOP**. You **must** complete a certification statement for the ETIN entered (EMEDNY form # 490601) and mail both forms together to the address below.

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) ETIN: _____
*The 3 or 4 digit **Electronic Transmitter Identification Number**. Only one ETIN per form is allowed. For multiple providers, a separate form must be submitted for each provider.*

(5) Remittance Type Selection (Select One):
 835/820 Electronic Remittance **OR** PDF *(can only be used with eXchange delivery method)*
 For 835/820 electronic remittance types, software to interpret HIPAA formatted records is strongly recommended. eMedNY cannot provide remittance interpretation service.

(6) Remittance Delivery Method (Select One): eXchange **OR** VPN **OR** Core WEB Services

(7) Current eXchange, Core WEB Services, or VPN User ID: _____
 The eXchange, Core Web Services, or VPN user ID submitted on the form must be valid and activated.
 Only one User ID is allowed per ETIN/Provider combination.

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 Enrollment

Submission Date

Printed Name of Person Submitting Enrollment

Email Address of Person Submitting Enrollment

Mail or fax completed form to:

eMedNY
Attn: Provider Enrollment Support
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Rensselaer, New York 12144-8614
FAX: (518) 257-4632

PLEASE ALLOW UP TO 14 BUSINESS DAYS FOR PROCESSING.