Request to Submit Electronic Claims

Initial Request ☐ Add ETIN(s) ☐

Indicate which services you will electronically claim for:

Service Coordination ☐ All Other Services ☐

Agency/Provider completes this information. Please Type Answers. This is a fillable pdf.

Type in the requested information, print the form, sign, date it below, scan, and email the form to **NYEIS@health.ny.gov**
(Include in the subject line:' *Provider Name'* Provider Request to Submit Electronic Claims to NYEIS)

All fields are required. For phone #s, please use numbers only, no spaces or hyphens.

Municipality Name(s): _____

_____

Agency/Provider Name: _____ NYS State Provider ID:_____

Street Address: _____

City: _____ State: _____ Zip+4: _____-_____

Contact name: _____

Telephone Number: _____ Fax Number: _____

E-mail address: _____

Tester's information:
(Enter the HCS NYEIS User ID, Telephone number, Name and E-mail address of the person that will **test** the Electronic Claim Submissions to NYEIS)

NYSDOH HCS (NYEIS) User ID: _____ Telephone Number: _____

Tester's Name: _____

Tester's e-mail address: _____

Agency/Provider NPI: _____

Name of the Software used to create the 837P file, if applicable _____

Does your agency submit multiple service lines on claims? Y/N _____

Signature: _____ Date: _____/_ ____/_____