MAIL TO: eMedNY
P.O. Box 4610
Rensselaer, NY 12144

DEA UPDATE FORM

MEDICAID PROVIDER MAINTENANCE

PROVIDER NUMBER _____ _____
8 digit Medicaid Number (Required) 10 digit NPI (Required)

PROVIDER NAME
NAME EXACTLY AS IT APPEARS ON YOUR LICENSE/REGISTRATION

PROVIDER CORRESPONDENCE ADDRESS

STREET
- LINE 1
- LINE 2

CITY
Do NOT use abbreviations

STATE ZIP CODE COUNTY

DEA NUMBER _____
A copy of the DEA certificate must be attached.

I hereby request that the DEA information provided above be updated in my records.

PROVIDER'S SIGNATURE (Original Signature REQUIRED.)

AUTHORIZED REPRESENTATIVE'S SIGNATURE (Original Signature REQUIRED.)

AUTHORIZED REPRESENTATIVE'S TITLE

DATE SIGNED