eMedNY PRACTITIONER ENROLLMENT APPLICATION SCREENING CHECKLIST	
Provider Name:	**Correspondence Address:**
SS#	
License #	
COS	
	Phone:

MANDATORY FIELDS TO BE COMPLETED ON THE ENROLLMENT FORM	COMPLETED	
	Yes	No
Category of Service		
Application Type		
Applicant Name		
NPI #		
Social Security #		
License Number		
Limited License Question (Yes or No)		
Applicant's Email		
Enrolled in Medicaid (Yes or No)		
DEA Number, Effective Date and Expiration Date		
If affiliated with Group, Private Practice Questions (Yes, No or N/A)		
Correspondence Address		
Pay to Address		
Corporate Address		
Service Address		
Disclosure of Ownership Section		
Signature and Affirmation		

REQUIRED DOCUMENTATION TO BE SUBMITTED	ATTACHED TO APPLICATION		
	N/A	Yes	No
License			