

MEMBER MATERIALS SUBMISSION FORM

Please read the instructions before completing this form. Complete the form for each member facing material for which the MCO is seeking approval. If additional space is needed, attach a continuation page. If all applicable questions are not answered, if the provided answers are determined to be incomplete or inaccurate, or required supporting documentation is not attached, the material will not be accepted for review.

SECTION A. SUBMISSION INCLUDES:

DATE:

1. Type of Material (Check one)

Check all lines of business covered by the material:

- | | |
|--|---|
| <input type="checkbox"/> ANOC / EOC / SOB | <input type="checkbox"/> Member Incentive Program |
| <input type="checkbox"/> Department Template | <input type="checkbox"/> Member Handbook Member |
| <input type="checkbox"/> Integrated Model Notice | <input type="checkbox"/> Identification Cards |
| <input type="checkbox"/> Marketing Materials | <input type="checkbox"/> Newsletter |
| <input type="checkbox"/> Medicaid Model Notice | <input type="checkbox"/> Plan Letter |
| | <input type="checkbox"/> Other – See Comments. |

- | |
|--|
| <input type="checkbox"/> Partial Capitation |
| <input type="checkbox"/> Medicaid Advantage Plus |
| <input type="checkbox"/> Programs for All-inclusive Care for the Elderly |

For previously approved materials indicate:

MCO Unique Identifier#: _____

Original approval date: _____

Tracking Number, if applicable: _____

2. Anticipated Implementation Date: _____

3. MCO Unique Document ID #: _____

(The MCO Unique Identifier is required on Medicaid Model and Integrated Notices and must also be indicated on the material)

SECTION B. MANAGED CARE ORGANIZATION / UR AGENT / BENEFIT MANAGER

1. MCO Name: _____

City/State/Zip: _____

Phone: _____

2. Contact Information of UR Agent/Benefit Manager (If none, leave blank):

Corporate Relationship to MCO/Management Contractor: _____

Address: _____

Phone: _____

DOH Use Only

MLTC DOC ID#: _____

Certification

I affirm that the attached material will be utilized as indicated above and that all information is true and accurate to the best of my knowledge. I understand that the New York State Department of Health is relying upon this attestation as part of its review and approval process, and that should it be determined that this attestation is materially false or incomplete or incorrect or includes incorrect, false, or misleading, information, appropriate regulatory action will be taken.

Signature of MCO Representative

Date

Print name of MCO Representative

Title

Direct Telephone Number

E-mail Address

MCO Unique Document ID # (required)