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:
Type of Material (Check one)			Check all lines of business covered by the material:
☐ ANOC / EOC / SOB		Member Incentive Program	Partial Capitation
☐ Department Template		Member Handbook Member	☐ Medicaid Advantage Plus
☐ Integrated Model Notice		Identification Cards	☐ Programs for All-
☐ Marketing Materials		Newsletter	inclusive Care for the Elderly
		Plan Letter	
		Other – See Comments.	
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 material)		_	indicated on the
SECTION B. MANAGED CARE ORGANIZATION / UR AGEN	T/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	or:		
Address:			
Phone:			
DOH Use Only			
MLTC DOC ID#:			

SECTION C. PURPOSE AND DESCRIPTION OF THE MATERIALS

1. Provide the purpose and description of the materials.

MEDIC	AID MODEL NOTICE	S:					
<u>Notic</u>	e Type:			<u>Deci</u>	sion Type:		
	Complaint Appeal		Initial Adverse Determination with Aid Continuing		Utilization [Review	_	artial oprovals
	Complaint Resolution		Initial Adverse Determination without Aid Continuing		Concurrent Review	Ot	ther*
	Extension		Final Adverse Determination without Aid Continuing		Retrospective / Claims Denials		pecific ervice*
	Approval		Final Adverse Determination with Aid Continuing		Administrative Denials		
				*Spe	cify the decision type	in the C	Comment
				Secti	on		
MEDIC	CAID ADVANTAGE	PLUS	PROGRAM INTEGRATED NOTICES:				
Notic	ce Type:			<u>Deci</u>	sion Type:		
	Appeal Decision				Utilization Review		Partial Approvals
	Appeal Extension Decision Delay	1			Concurrent Review		Other*
	Coverage Determination				Retrospective / Claims Denials		Specific Service*
	Fast Complaint Letter				Administrative Denials		
	Appeal Dismissa	I		*Spe	cify the decision type i	n the C	Comment Section
ТЕМРІ	ATE NOTICE:						
	☐ Nursing Home Intent to Disenroll Notice				Electronic Notice		
	nvoluntary Disenrol	lment ·	Intent to Disenroll Notice		Consumer Directo	ed Pers	sonal Care Assistance Notices
ANNU	AL NOTICE OF CHA	ANGE,	SUMMARY OF BENEFITS, EVIDENCE OF	of Cov	'ERAGE		
	Annual Notice of Ch	ange			Evidence of Covera	ge	
	Summary of Benefit	S					
COM	MENTS:						

Certification

MCO Unique Document ID # (required)

l 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					