NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Managed Long Term Care

MEMBER MATERIAL SUBMISSION FORM

Please read the instructions before submitting this form to the MLTC.Docs@health.ny.gov mailbox. Complete the form for each submitted material for which the Managed Care Organization 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.

Please note: For combined or related materials, please submit **one coversheet** and list the materials on page 3 under the *Materials Included* section.

SECTION A. SUBMISSION INCLUDES:

1. Type of Material (Check one)

- ☐ Annual Notice Of Change, Evidence of Coverage, & Summary Of Benefits
- ☐ Department Templates
- ☐ Email Communications
- ☐ Forms
- ☐ Integrated (Department / CMS) Notice
- ☐ Marketing Materials
- ☐ Medicaid Model Notice
- ☐ Member Handbook / Insert
- ☐ Member Identification Cards
- ☐ Member Incentive Program
- ☐ Newsletter
- ☐ Plan Letter
- ☐ Scripts
- ☐ Social Media
- ☐ Other Materials Not Listed

LINES OF BUSINESS

Check all lines of business covered by the material:

- ☐ Partial Capitation
- ☐ Medicaid Advantage Plus
- ☐ Programs for All-inclusive Care for the Elderly

2. Is this a new submission or a revised (previously approved) material?

☐ Revised Material– Please enter the last approval date / tracking number for the material.

Last approval date:_____

Tracking Number, if applicable:_____

☐ New Submission – What is the Anticipated Implementation Date?_____

SECTION B. MANAGED CARE ORGANIZATION / UTILIZATION REVIEW AGENT / BENEFIT MANAGER

1. Managed Care Organization Name: _____

Mailing Address:_____

Member Services Contact Number:_____

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

Utilization Review Agent / Benefit Manager: _____

Mailing Address:_____

Member Services Contact Number:_____

Department Contract Reference Number: _____

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Tracking Number#: _____

SECTION C. PURPOSE AND DESCRIPTION OF THE MATERIALS

1. Provide the purpose and description of the materials.

MEDICAID MODEL NOTICES:

Plan's Unique Identifier: _____

Notice Type:

- ☐ Approval
- ☐ Complaint Appeal
- ☐ Complaint Resolution
- ☐ Extension
- ☐ Final Adverse Determination with Aid Continuing
- ☐ Final Adverse Determination without Aid Continuing
- ☐ Initial Adverse Determination without Aid Continuing
- ☐ Initial Adverse Determination with Aid Continuing

Decision Type:

- ☐ Administrative Denials
- ☐ Concurrent Review
- ☐ Long Term Services & Supports
- ☐ Other*
- ☐ Out of Network (Not Materially Different)
- ☐ Out of Network (Training & Experience)
- ☐ Partial Approvals
- ☐ Retrospective / Claims Denials
- ☐ Specific Service*
- ☐ Substance Use Disorder Inpatient Treatment
- ☐ Utilization Review

*Specify the decision type in the Comment Section

INTEGRATED (CMS & DEPARTMENT) NOTICES:

Plan's Unique Identifier: _____

Notice Type:

- ☐ Appeal Decision
- ☐ Coverage Decision
- ☐ Fast Complaint
- ☐ Other Integrated Notice (+Details in the Comment Section)

Decision Type:

- ☐ Administrative Denials
- ☐ Concurrent Review
- ☐ Other*
- ☐ Partial Approvals
- ☐ Retrospective / Claims Denials
- ☐ Specific Service*
- ☐ Utilization Review

*Specify the decision type in the Comment Section

DEPARTMENT TEMPLATES:

- ☐ Electronic Notice
- ☐ Involuntary Disenrollment - Intent to Disenroll Notice
- ☐ Language Assistance Notice and Taglines
- ☐ Member Handbook / Insert
- ☐ Notice of Non-Discrimination
- ☐ Nursing Home Intent to Disenroll Notice
- ☐ Other Department Issued Template*

*Specify the template type in the Comment Section

ANNUAL NOTICE OF CHANGE, SUMMARY OF BENEFITS, EVIDENCE OF COVERAGE:

- ☐ Annual Notice of Change
- ☐ Evidence of Coverage
- ☐ Summary of Benefits

COMMENTS:

MATERIALS INCLUDED:

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 Managed Long Term Care Representative

Date

Print name of Managed Long Term Care Representative

Title

MLTC Representative's Telephone Number

E-mail Address