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

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)

- ☐ ANOC / EOC / SOB
- ☐ Department Template
- ☐ Integrated Model Notice
- ☐ Marketing Materials
- ☐ Medicaid Model Notice
- ☐ Member Communication
- ☐ Member Handbook
- ☐ Member Identification Cards
- ☐ Newsletter
- ☐ Plan Letter
- ☐ Other – Specify in Section C.

Check all lines of business covered by the material:

- ☐ Partial Capitation
- ☐ Medicaid Advantage Plus
- ☐ 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 #: ___________________________
(required, must also be indicated on 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#: ____

SECTION C. PURPOSE AND DESCRIPTION OF THE MATERIALS

1. Provide the purpose and description of the materials.

MEDICAID MODEL NOTICES:

Notice Type:

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

Decision Type:

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

*Specify the decision type in the Comment Section

MEDICAID ADVANTAGE PLUS PROGRAM INTEGRATED NOTICES:

Notice Type:

- ☐ Appeal Decision
- ☐ Appeal Extension / Decision Delay
- ☐ Coverage Determination
- ☐ Fast Complaint Letter

Decision Type:

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

*Specify the decision type in the Comment Section

TEMPLATE NOTICE:

- ☐ Nursing Home Intent to Disenroll Notice
- ☐ Involuntary Disenrollment - Intent to Disenroll Notice
- ☐ Electronic Notice
- ☐ Consumer Directed Personal Care Assistance Notices

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

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

COMMENTS:

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) ______________________