MAP 2166B (face)
(rev. 2/17/98)

Human Resources Administration
Medical Assistance Programs

COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) PROVIDER TRANSFER REQUEST

REQUESTING (NEW) CMCM PROVIDER AGENCY:	CURRENT (OLD) CMCM PROVIDER AGENCY:
AGENCY NAME:________	AGENCY NAME:________
ADDRESS:________	ADDRESS:________
ZIP CODE:________ TELEPHONE:(____)________	ZIP CODE:________ TELEPHONE:(____)________
CONTACT PERSON:________	FAX NUMBER: (____)________

Client Name (Last, First)	Client CIN	Case Number	Current CMCM ID	Thru Date (MM/DD/YY)
Social Security Number	Birth Date	Sex		
			New CMCM ID	From Date (MM/DD/YY)

☐ **EMEVS Tape/Verification**

REQUESTING CMCM PROVIDER CERTIFICATION: In signing this form, this agency attests to the following for each individual listed enrolling for CMCM services: Each client is part of the targete population and documentation verifying this is in the case record; each client understands the voluntary nature of CMCM and freely accepts services from this agency; and the client's signed stateme to that effect is in the case record. This agency has asked the client if he or she is currently enrolled in another CMCM, and this agency is satisfied that this agency is the sole provider of requested CMC services. This agency has notified the current CMCM provider of this transfer and the above transfer (From) date and is sending the current CMCM provider a copy of this form.

CLIENT SIGNATURE:________ DATE:________

REQUESTING PROVIDER AUTHORIZED SIGNATURE:________ DATE:________

UNABLE TO PROCESS CODES

1	CURRENT RESTRICTION ALREADY EXISTS
2	INDIVIDUAL HAS NO MA COVERAGE FOR ENROLLMENT REQUEST
3	NO DISENROLLMENT REQUIRED
4	SPECIFIED CLIENT NOT FOUND IN DATA BASE
5	OTHER (Explain)

MEDICAL ASSISTANCE PROGRAMS (MAP)

INPUT DATE ________

DISPOSITION
☐ Successful Data Entry ☐ Unable to Process, Reason: 1, 2, 3, 4, 5________

MAP Signature:________ Date:________ Telephone Number: (____)________

Human Resources Administration
Medical Assistance Programs

INSTRUCTIONS FOR FORM MAP 2166B, COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) PROVIDER TRANSFER REQUEST

CMCM Agency

Use Form **MAP 2166B** to reques **transfer** of a client from another CMCM agency to your agency. Use Form MAP 2166 to enroll clients in your agency, and Form MAP 2166A to disenroll clients.

When a client transfers from one CMCM provider to another, the requesting (new) CMCM provider must document the transfer and place the documentation in the case record. Documentation should include the client's signed and dated request for a transfer.

Prepare Form MAP 2166B in quadruplicate. Send one copy to the current CMCM provider, and two copies to the Medical Assistance Programs, Computer Systems Services, 330 West 34th Street, Room ~~803~~ 517, New York, NY 10001. A self-addressed return envelope should be included. Retain the fourth copy for your file.

Please **type or print** clearly.

Fill in the required information for the client, your agency, and the current CMCM provider, including:

PROVIDER NUMBER: If you do not know the current agency's 8-digit provider number, leave the box blank.

THRU DATE: Enter the current provider's last day of service.

FROM DATE: The "From" date is the transfer date. Enter the date that your agency will begin CMCM services. It must be a date after the "Thru" date.

REQUESTING PROVIDER AUTHORIZED SIGNATURE: Only the NYS authorized representative of your agency must sign this form. By signing, he or she certifies the validity of the data submitted.

MAP

If the information submitted was entered successfully in our computer file, MAP staff will check "Successful Data Entry."

If the information supplied could not be entered, MAP staff will check "Unable to Process" and specify the reason. Resubmit a new Form MAP 2166B.

MAP staff will mail the completed form back to your agency, and a copy to the current provider to inform them of the change.

MAP 2166 (face)
(rev. 2/19/98)

Human Resources Administration
Medical Assistance Programs

COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) ENROLLMENT REQUEST

CMCM AGENCY NAME: ______________________ PROVIDER NUMBER: ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦

ADDRESS: ______________________ ZIP CODE: __________

CONTACT PERSON: ______ ______________ TELEPHONE NUMBER: (______) __________

CASE MANAGEMENT AGENCY DATA

	CLIENT NAME (Last, First)	CLIENT ID (CIN)	CASE NUMBER	SSN	BIRTH DATE	SEX	FROM (enroll) MM/DD/YY
1							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________ ☐ EMEVS Tape/Verification							
2							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________ ☐ EMEVS Tape/Verification							
3							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________ ☐ EMEVS Tape/Verification							
4							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________ ☐ EMEVS Tape/Verification							

CMCM PROVIDER CERTIFICATION: In signing this form, this agency attests to the following for each individual listed enrolling for CMCM services: Each client is part of the targeted population and documentation verifying this is in the case record; each client understands the voluntary nature of CMCM and freely accepts services from this agency; and the client's signed statement to that effect is in the case record. This agency has asked the client if he or she is currently enrolled in another CMCM, and this agency is satisfied that this agency is the sole provider of requested CMCM services.

AUTHORIZED PROVIDER SIGNATURE: ______________________ **DATE:** __________

UNABLE TO PROCESS CODES

1	CURRENT RESTRICTION ALREADY EXISTS
2	INDIVIDUAL HAS NO MA COVERAGE FOR ENROLLMENT REQUEST
3	NO ENROLLMENT REQUIRED
4	SPECIFIED CLIENT NOT FOUND IN DATA BASE
5	OTHER (Explain)

MEDICAL ASSISTANCE PROGRAMS (MAP)

MAP SIGNATURE: ______________________ DATE: __________ TELEPHONE: (______) __________

INSTRUCTIONS FOR FORM MAP 2166, COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) ENROLLMENT REQUEST

CMCM Agency

Use Form **MAP 2166** to request **enrollment** of clients in your CMCM. Use Form MAP 2166A to disenroll clients, and Form MAP 2166B to transfer a client from another CMCM agency to yours.

Prepare Form MAP 2166 in triplicate. Forward two copies of Form MAP 2166 to the Medical Assistance Programs, Computer Systems Services, 330 West 34th Street, Room ~~803~~, New York, NY 10001. A self-addressed return envelope should be included. Retain the third copy for your file.

Please **type or print** clearly.

Fill in the required information for your CMCM agency and each client, including:

> FROM DATE: Enter the client's date of initial service with your agency.
>
> EMEVS TAPE/VERIFICATION: Check the box if you are providing EMEVS verification for the client.
>
> AUTHORIZED PROVIDER SIGNATURE: Only the NYS authorized representative of your agency must sign this form. By signing, he or she certifies the validity of the data submitted.

MAP

If the information submitted was entered in our computer file, MAP staff will check "Successful Data Entry."

If the information supplied could not be entered in our computer system, MAP staff will check "Unable to Process" and specify the reason. Resubmit your request on a new Form MAP 2166 if appropriate.

If the client is already enrolled in another CMCM program, MAP staff will provide the name and address of the other CMCM agency. Your agency must resolve this contradiction with the client and the other CMCM agency. If appropriate, submit Form MAP 2166B, CMCM Provider Transfer Request.

MAP staff will mail the completed form back to your agency.

COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) DISENROLLMENT REQUEST

CMCM AGENCY NAME:______________________ PROVIDER NUMBER: |__|__|__|__|__|__|__|__|

ADDRESS:______________________ ZIP CODE:__________

CONTACT PERSON:______________________ TELEPHONE NUMBER:(_____)__________

CASE MANAGEMENT AGENCY DATA

	CLIENT NAME (Last, First)	CLIENT ID (CIN)	CASE NUMBER	SSN	BIRTH DATE	SEX	THRU (disenroll) MM/DD/YY
1							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________							
2							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________							
3							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________							
4							
MAP: ☐ Successful Data Entry ☐ Unable to Process - Reason: 1, 2, 3, 4, 5__________							

CMCM PROVIDER CERTIFICATION: In signing this form, this agency attests to the following for each individual listed enrolling for CMCM services: Each client is part of the targeted population and documentation verifying this is in the case record; each client understands the voluntary nature of CMCM and freely accepts services from this agency; and the client's signed statement to that effect is in the case record. This agency has asked the client if he or she is currently enrolled in another CMCM, and this agency is satisfied that this agency is the sole provider of requested CMCM services.

AUTHORIZED PROVIDER SIGNATURE: ______________________ **DATE:**__________

UNABLE TO PROCESS CODES

1	CURRENT RESTRICTION ALREADY EXISTS
2	INDIVIDUAL HAS NO MA COVERAGE FOR DISENROLLMENT REQUEST
3	NO DISENROLLMENT REQUIRED
4	SPECIFIED CLIENT NOT FOUND IN DATA BASE
5	OTHER (Explain)

MEDICAL ASSISTANCE PROGRAMS (MAP)

MAP SIGNATURE:______________________ DATE:__________ TELEPHONE:(_____)__________

INSTRUCTIONS FOR FORM MAP 2166A, COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) DISENROLLMENT REQUEST

CMCM Agency

Use Form **MAP 2166A** to request **disenrollment** of clients in your CMCM. Use Form MAP 2166 to enroll clients, and Form MAP 2166B to transfer a client from another CMCM agency to yours.

Prepare Form MAP 2166A in triplicate. Forward two copies of Form MAP 2166A to the Medical Assistance Programs, Computer Systems Services, 330 West 34th Street, Room ~~803~~ 517, New York, NY 10001. A self-addressed return envelope should be included. Retain the third copy for your file.

Please **type or print** clearly.

Fill in the required information for your CMCM agency and each client, including:

> THRU DATE: Enter the date that the client disenrolled or is planning to disenroll from your agency.
>
> EMEVS TAPE/VERIFICATION: Check the box if you are providing EMEVS verification for the client.
>
> AUTHORIZED PROVIDER SIGNATURE: Only the NYS authorized representative of your agency must sign this form. By signing, he or she certifies the validity of the data submitted.

MAP

If the information submitted was entered in our computer file, MAP staff will check "Successful Data Entry."

If the information supplied could not be entered in our computer system, MAP staff will check "Unable to Process" and specify the reason. Resubmit your request on a new Form MAP 2166 if appropriate.

MAP staff will mail the completed form back to your agency.