

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
MEMBER REQUEST FOR SPECIFIC MEDICAID PROTECTED HEALTH INFORMATION**

Federal regulations permit you to request a specific designated record set. We will try to meet your request. If you wish to request this information, please complete the following:

Medicaid Member Name (required): _____

Date of Birth (required): _____ / _____ / _____

AT LEAST ONE OF THE FOLLOWING IDENTIFICATION NUMBERS IS REQUIRED, PREFERABLY BOTH.

Client Identification Number (CIN): _____ Social Security Number (SSN): _____ - _____ - _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: (_____) _____ - _____

Dates of records requested – From: _____ / _____ / _____ To: _____ / _____ / _____

Reason:

Member Signature

Date

Please return to:

Records Custodian
NYSDOH, Medicaid Information Services Center of New York
800 North Pearl Street, Room 322
Albany, New York 12204