

Model Notice Submission Cover Sheet

Date:	Plan Unique Identifier:
Plan Name:	Vendor Name (if applicable):

1) Which HMO products will this notice be used for? (Check all that apply):

 \Box Partial Cap \Box MAP

2) Identify the model notice type (Check one):

Initial Adverse Determination Denial Notice (IAD no A/C)	Initial Adverse Determination Reduce, Suspend or Stop Services (IAD with A/C)
Extension	Approval
Final Adverse Determination Denial Notice (FAD no A/C)	Final Adverse Determination Reduce, Suspend or Stop Services (FAD with A/C)
Complaint Resolution	Complaint Appeal Resolution Notice

3) Which decision types will this notice be used for? (Check all that apply):

Utilization Review	Concurrent Review	Retrospective / Claims Denials
Administrative Denials	Partial Approvals	Other:
Specific Service:		

Comments/Notes: I affirm that the attached model notice 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

Title

Email

Phone

Only the HMO may submit Model Notices for review. Submit a completed cover sheet with each notice to mltc.docs@health.ny.gov Rev 1/2024