

**CONSUMER REQUEST TO CHANGE INFORMATION ON FILE**



MAP-751k (E) 11/13/2012

Case Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**CHANGE REQUESTS REQUIRING DOCUMENTATION**

- Name:** → from \_\_\_\_\_ to \_\_\_\_\_

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- Date of Birth:** for \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

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- Gender Information:** for \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

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- Change Social Security Number:** for \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

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- Immigration Status:** for \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

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- Notification of Death:** for \_\_\_\_\_ date of death \_\_\_\_\_

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- Coverage Type (RVI) Upgrade:** for \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

Community Based Long-Term Care coverage, which includes coverage for home care and waiver services, requires resource documentation for the current month **only**. Coverage for nursing home services requires resource documentation for the past **60** months **and** an immediate need for the services.

**NOTE:** You must provide identification to prove that you are either an adult household member on the case or have authorization to request changes on their behalf, along with documents to support the change you are requesting.

Signature of Consumer: \_\_\_\_\_ Date: \_\_\_\_\_

**CHANGE REQUESTS NOT REQUIRING DOCUMENTATION**

- Change of Residency Address:** from \_\_\_\_\_ to \_\_\_\_\_
  - Within New York City
  - Within New York State
  - Outside of New York State

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- Change of Mailing Address:** from \_\_\_\_\_ to \_\_\_\_\_

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- Add/Change of Secondary Mailing Address:** from \_\_\_\_\_ to \_\_\_\_\_

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- Add Social Security Number (SSN):** for \_\_\_\_\_ her/his SSN is \_\_\_\_\_

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- Add/Change of Phone Number:** from \_\_\_\_\_ to \_\_\_\_\_

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- Remove the Following Person From Medicaid Case:**

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- Combine Medicaid Case** current number \_\_\_\_\_ with \_\_\_\_\_

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- Close Medicaid Case** \_\_\_\_\_

Signature of Consumer: \_\_\_\_\_ Date: \_\_\_\_\_

**ASK MEDICAL ASSISTANCE PROGRAM STAFF TO ADVISE YOU IF DOCUMENTATION IS REQUIRED:**

**Other:** (Specify) \_\_\_\_\_

Signature of Consumer: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY MEDICAL ASSISTANCE PROGRAM STAFF [Check box(es) that apply]**

The documents checked below were provided by the consumer and the requested change(s) were made to her/his case file.

- Birth/Death Certificate     SSA Award Letter     Driver's License     Bank/Financial Statements     None Required
- Passport     SS Card     Court Document     Other (specify) \_\_\_\_\_

Signature of MAP Staff: \_\_\_\_\_ Date: \_\_\_\_\_