FPBP Provider Request for Enrollment Activity

To: New York Health Options FPBP Processing Unit
P.O. Box 11640 Albany, NY 12211

Fax# 1-866-839-8508

Complete this coversheet for <u>each</u> individual applicant / recipient (A/R) you are requesting us to take action on and indicate the type of documents that are being faxed/mailed to us.

<u>Provide individual's information:</u>

A/R Name: _____

DOB: ____/_____/_____ CIN (if known):_____ Sex (circle one): M-F

From: (Provider Agency Name) _____

Agency Address: _____

Sender Name: _____

Sender Phone #: _____

Sender E-mail Address: _____

Sender Fax #: _____

Date Faxed: ____/_____/____ Total number of pages in this Fax including cover sheet _____

<u>Attachments (check box if included):</u>

☐ PE for FPBP Screening Form

☐ PE for FPBP Screening Determination Letter

☐ FPBP Documentation Checklist

☐ FPBP Application – DOH-4282

☐ Documents provided by A/R necessary for eligibility verification

☐ Additional Case Comments (Ex: Retro requested, A/R needs Card, Good Cause – check EmedNY, etc.)

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