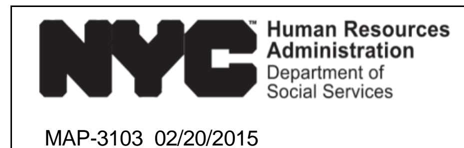
FORMERLY INCARCERATED INDIVIDUALS REACTIVATION TRANSMITTAL



MAP-3103 02/20/2015

FROM:

FACILITY NAME		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE NUMBER	FAX NUMBER	

TO:

Medical Assistance Program (MAP)
Incarcerated Unit - 5th Floor
785 Atlantic Avenue
Brooklyn, NY 11238
Fax Number: 718-636-7757

Please provide the MAP-751e, **Authorization to Release Medical Information** :

AND

- A copy of the consumer's photo identification **and**
- A current paystub

OR

- A signed statement from employer, Navigator/Certified Application Counselor (CAC) or Community Based Organization or provider that formerly individual is now in the community.

TO BE COMPLETED BY FACILITY				TO BE COMPLETED BY MAP	
				RECEIVED	
LAST NAME	FIRST NAME	CIN	RELEASE DATE* (Required for retro-reinstatement for medical bills)	Yes	No

*Proof of a release date is required if the consumer requests retro active reinstatement for medical bills incurred after their release date, while still in suspended status.

FACILITY (Print)	FACILITY (Sign)	DATE
INCARCERATED UNIT (Print)	INCARCERATED UNIT (Sign)	DATE