NEW YORK STATE | Office of Mental Health | Office of Addiction Services and Supports

Community Oriented Recovery and Empowerment (CORE) Service Initiation Notification Form

The purpose of this notification is to ensure enrollees are not receiving duplicative services. This information must be shared via secure electronic communication.

- CORE providers submit this information to an enrollee's managed care plan (Health and Recovery Plan (HARP), HIV Special Needs Plan (HIV-SNP), or Medicaid Advantage Plus (MAP) Plan) within three business days of the first CORE Service visit. The form may be completed by any employee of the CORE designated provider.
- Submission of this form enables the HARP, HIV-SNP, or MAP Plan to prepare systems to receive claims. Claims submitted prior to this notification submission may lead to payment delay or denial.
- Within three business days of being notified of CORE Service initiation, the HARP, HIV-SNP, or MAP Plan must inform the CORE provider of any issues preventing further service provision and reimbursement. It is strongly encouraged that managed care plans confirm receipt of the CORE Service Initiation Notification with the submitting CORE Services provider. Please refer to the CORE Benefit & Billing Guidance for more details.

Enrollee information

Enrollee Name _____ DOB _____

Enrollee CIN_____

Managed Care Plan _____ Plan ID # _____

Enrollee Phone (optional) _____ Email (optional)_____

Enrollee Address (optional)_____

Health Home / Care Manager Contact (if applicable) _____

CORE Provider Agency Information

CORE Provider Agency _____

Agency Address _____

Agency NPI # _____ Tax ID # _____

Agency Contact Person Name _____

Phone _____ Email_____

Alternate Contact _____

Phone _____ Email_____

Secure Electronic Communication Contact Information

Secure Email_____ Fax_____

Other (if applicable) _____

CORE Service(s)

Please identify CORE Service(s) being initiated (select all that apply):

☐Community Psychiatric Support and Treatment (CPST)

☐Family Support and Training (FST)

☐Empowerment Services – Peer Supports

☐Psychosocial Rehabilitation (PSR)

I attest the enrollee elected to receive all CORE services requested above

_____ _____

Signature of CORE Provider Representative Date

_____ _____

Name (please print) Title