Medicaid Confidential Data Request Form

Instructions

Medicaid Confidential Data (MCD) requestors must use this form to provide relevant decision-making information to the New York State (NYS) Department of Health's (DOH) Office of Health Insurance Programs (OHIP).

OHIP will evaluate the information submitted on this form to determine if the request provides a discernable benefit to the New York State Medicaid program. OHIP will also determine whether the request meets the HIPAA Privacy Rule's Minimum Necessary Requirement. In making its determination, OHIP's first priority will be to limit unnecessary or inappropriate access to and disclosure of protected health information (PHI) or personally identifiable information (PII).

OHIP will notify the requestor of the approval or denial decision. If OHIP approves the data request, the Security and Privacy Bureau will send a Data Sharing Agreement (DSA) for the requestor to complete. The requestor will be able to re-use much of the information from the current form to complete the DSA.

Form

1) Requestor Information

Requestor Name:	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Entity:	Click or tap here to enter text.
Organization Address - Street:	Click or tap here to enter text.
Organization Address – City, State and Zip:	Click or tap here to enter text.
Telephone with Area Code:	Click or tap here to enter text.
Email Address:	Click or tap here to enter text.
Date of Request:	Click or tap here to enter text.

2) Please describe, as specifically as possible, why access to MCD is needed and how the data will be utilized. Click or tap here to enter text.
3) Data Requested
   a. Check all types of data being requested.
      ☐ Aggregate ☐ PHI ☐ PII
   b. What specific MCD is being requested? Provide a description of the data being requested in the box below including a list of fields or data elements.
      Click or tap here to enter text.
   c. Specify the inclusive dates for the MCD requested.
      Click or tap here to enter text.
4) If the use of the data is for a specific state program, please specify which state program.
   Click or tap here to enter text.
5) Contracts
   a. Do you have a contract with DOH, another state entity or a federal/NYS grant to perform this work? If yes, in the box below provide the state entity, the contact information for that entity, the contract/grant number and attach a copy of the contract/grant when submitting this form.
      ☐ No ☐ Yes Click or tap here to enter text.
6) How many individuals will be accessing/using/processing/working with the data?
   Click or tap here to enter text.
7) Research
   a. Does your entity have an Institutional Review Board (IRB)?
      ☐ No ☐ Yes
   b. If yes, has your IRB reviewed your proposal?
      ☐ No ☐ Yes
   c. If your entity has an IRB but has not reviewed or is not planning to review your proposal, provide an explanation as to why.
   d. If your entity has an IRB and has reviewed your proposal, provide the IRB documentation when submitting this application.
8) Is the data for use in a publication? If Yes, include what type of publication, where, when and the subject matter of the publication.
   ☐ No ☐ Yes Click or tap here to enter text.

DOH Use Only

Sponsor Name:	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Department/Division:	Click or tap here to enter text.
Sponsorship Decision:	☐ Sponsor ☐ Rejected ☐ Rejected, will review if resubmitted
Reason for Rejection:	Click or tap here to enter text.
Date for Project End:	Click or tap here to enter text.
Type of Access:	Click or tap here to enter text.
Date of Decision:	Click or tap to enter a date.