NEW YORK STATE | Office of Addiction Services and Supports

ANDREW M. CUOMO
Governor

ARLENE GONZÁLEZ-SÁNCHEZ, M.S., L.M.S.W.
Commissioner

Reimbursement Complaint Form

Please download and fill out the below form and return to the PICM Mailbox at:

PICM@oasas.ny.gov

Provider Name:	
Person filing complaint	
Phone #	
NPI#	
Medicaid Provider #	
Program Type	Choose an item.
Rate Code:	Choose an item.
Plan Type:	Choose an item.
Plan Name (BH Contract):	Choose an item.
Network Status:	Choose an item.
Primary Area of Inquiry	Choose an item.
Details of question/complaint:	
Prior to filing a complaint providers should attempt to work through their concerns directly with the Plan. Please provide detailed information on the following:	
Plan Representatives Name	
Plan Representatives Contact #	
Dates of Contact	
Results of Contact/Appeal	