CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE

NYC Human Resources Administration
Department of Social Services

MAP-751k (E) 02/18/2020
Replaces MAP-751, MAP-751a, and MAP-3069b

Case Name: _____

Case Number _____ CIN: _____

A. CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

- ☐ Change Name
  - To: _____
- ☐ Correct Date of Birth
  - For: _____
  - To: _____
- ☐ Correct Gender Information
  - For: _____
  - To: _____
- ☐ Add/Change Phone Number
  - For: _____
  - To: _____
- ☐ Change Residency Address
  - To: _____
- ☐ Change Mailing Address
  - To: _____
- ☐ Add/Change Secondary Mailing Address
  - To: _____
- ☐ Add/Correct Social Security Number (SSN)
  - For: _____
  - To: _____
- ☐ Coverage Type
  - To: _____

B. PROVIDER INFORMATION (TO BE COMPLETED BY PROVIDERS ONLY)

Note: This section is not to be used for Home Care Services Program Providers submissions.

Provider Name: _____

Provider Address: _____

Provider Code: _____ Original Determination Date: _____

Admission Date: _____ Admission Number: _____ Discharge Date: _____

Phone Number: _____ Fax Number: _____

NAME (PRINT)	SIGNATURE	DATE

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 888-692-6116. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.