NEW YORK STATE | Medical Indemnity Fund

Acknowledgment

I, _____, am the (**Please underline the appropriate designation**) Parent/Legal Guardian/Authorized Representative of/for _____, who is an Enrollee in the New York State Medical Indemnity Fund ("MIF").

By signing this form, I am acknowledging that I have received the following information about the MIF:

1. Information regarding how to access the website for the MIF (www.health.ny.gov/mif) on which the regulations that govern the MIF and other information about the MIF can be found and reviewed.
2. A hard copy of the MIF regulations, which contain the MIF definition of "qualifying health care costs", state what services, items, equipment, etc. require prior approval from the MIF as a condition for payment, and my right upon any denial of a claim or a request for prior approval by the MIF, to:
    a. An informal conference with a representative of the Fund administrator and/or
    b. A formal review by an administrative law judge.
3. Information about the case management process and the requirement that I participate in periodic telephone case conferences with the MIF case manager assigned to (**Name of Enrollee**) _____, as required by the Enrollee's health care related needs. I have also been advised of the availability of translation services as needed and how to request such services.
4. Instructions to contact Public Consulting Group at 1-855-NYMIF33 (1-855-696-4333) within 24 hours for any inpatient admission of the enrollee.
5. The toll-free phone number for the MIF which I may call during normal business hours with any questions or concerns that I may have about the Enrollee's coverage under the MIF. That number is 1-855-NYMIF33 (1-855-696-4333).

Date: _____

Signature of Parent/Legal Guardian/Authorized Representative	Address
Printed Name of Parent/Legal Guardian/Authorized Representative	Phone number
Witness Signature	Address
Printed Name of Witness	Phone number