MAP-ACCESS
(11/24)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

ACCESS TO CARE FORM

The reason for this form is to help Kentucky Medicaid Members report problems when they are not able to get an appointment to see an in-network provider. The Kentucky Department for Medicaid Services (DMS) wants to make sure members receive timely health care (1-2 days for an urgent appointment or within 30 days for a non-urgent or routine appointment).

Completing this form will help DMS see if there is a problem with the provider network. You may be contacted by DMS or your Managed Care Organization (MCO) to help you to get an appointment.
It is important to complete the information below as much as possible.

If it is an emergency, please call 911 for medical services or 988 for mental health services or go to the nearest emergency room.

Section 1: Member Information	
Member Name	
Member Medicaid ID	
Member Address	Street Address (include Apt/Suite): City, State, Zip Code:
Member Phone Number	
Member Email (if applicable)	
Member Managed Care Organization (MCO) or Fee for Service (FFS)	☐ Aetna BH-KY ☐ Humana ☐ United Healthcare ☐ Passport by Molina ☐ WellCare of KY ☐ Fee-for-Service (Traditional Medicaid)
Was the MCO contacted first? (If applicable)	Yes ☐ No ☐
Section 2: Referral & Appointment Information	
Provider Name (if available)	
Type of provider you need to see (Physician, Dentist, Cardiologist, Physical Therapy, etc.)	
Provider Address (if known)	Street Address (include Apt/Suite): City, State, Zip Code:
Date you first requested an appointment	Click or tap to enter a date.

Was this appointment urgent?	Yes ☐ No ☐
Appointment Date(s) Offered (if any)	1. Click or tap to enter a date.
	2. Click or tap to enter a date.
	3. Click or tap to enter a date.
Appointment date you accepted (if one was provided)	
If you were not offered an appointment, what reason(s) were you given? Select all that apply	◯ Provider does not participate with the MCO ◯ Provider does not participate with any Medicaid plan ◯ Provider is not taking new patients ◯ Provider did not have appointments available within the timeframe you needed to be seen ◯ Provider does not offer the service you need ◯ Other
Is there anything else we should know?	

To submit this form **automatically**, you must have Adobe Reader. Save the completed form to your device, open it within Adobe, and then click on the below 'Submit' button. You can download this app for free for your desktop or mobile at https://www.adobe.com/acrobat/pdf-reader.html .

Submit

To submit this form by **email**, save the completed form to your device, attach to an email and send to DMS.DQPH.QB@ky.gov with the Subject line 'Access to Care Form'.

To submit this form **by mail**, print the completed form and mail to:

Department for Medicaid Services
Quality and Population Health
275 East Main St, 6W-D
Frankfort, KY 40621