Reset Form

ARMHS Provider Notification / Change Request

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision.

For questions, call Mental Health and Substance Use Disorder Services at: **612-676-6533** or **1-833-276-1185**

Fax form and any relevant documentation to: **612-884-2033** or **1-855-260-9710**

Submit Request: UCare's Secure Email Site
Email: MHSUDservices@ucare.org

MEMBER INFORMATION

UCare ID _____ PMI _____

Member Name _____ DOB _____

Address, City, State, Zip _____

Phone _____ ICD-10 _____

REQUESTING ARMHS PROVIDER INFORMATION

NPI/UMPI _____

ARMHS Provider Name _____

ARMHS Service Location _____

Provider Phone _____ Provider Fax _____

Name of Requester _____ Email _____

Does member have more than one ARMHS provider currently? ☐ * Yes ☐ No

** If yes, please provide the following information and include documentation of service coordination between providers. Include how requested units will be divided between providers.*

Current ARMHS Provider Name _____ Phone Number _____

Has the member discharged from services with other ARMHS provider?

☐ Yes – Discharge Date _____ ☐ No

Date Current ARMHS Provider was notified _____

* *Please note: New ARMHS provider MUST notify the current ARMHS provider of this change. Allow an advance transfer/change date of at least 14 days.*

* Providers are responsible to ask UCare members or their responsible party if they are currently receiving the same health care services from another provider. If the member is receiving the same services from another provider, the providers must coordinate the services and document in the member's record how the services were coordinated. *UCare will not inform providers of services the member is receiving from other providers.*

In accordance, with the DHS language above, UCare ensures compliance by following the same standards.

Has the member received ARMHS services greater than 36 months? ☐ Yes ☐ No

**Please submit: up-to-date Diagnostic Assessment, Functional Assessment and Individual Treatment Plan documents.*

ARMHS Provider Notification / Change Request (Continued)

REQUESTED DATE/PROCEDURE CODES/UNITS

Start date _____ End Date _____

Procedure Code _____ Units _____

Procedure Code _____ Units _____

Procedure Code _____ Units _____

Procedure Code _____ Units _____

Procedure Code _____ Units _____

MEMBER ACKNOWLEDGEMENT

By affixing my signature below, I have decided for my ARMHS services to be delivered by the new ARMHS provider listed above. I was informed of the transfer process and all the information above is accurate to the best of my knowledge. I agree that UCare may use and release information regarding my ARMHS services to the new ARMHS provider above. ***If member signs with a "X", signature of Responsible Party (RP) or witness is required.***

Member Signature: _____ Signature Date: _____

Responsible Member Signature: _____ Signature Date: _____