PCA/CFSS/CONSULTATION SERVICE AUTHORIZATION TRANSFER FORM

FOR PCA/CFSS PROVIDER USE ONLY: This form is used to request a transfer of a PCA/CFSS/Consultation Service Authorization from the member's previous health plan to UCare. When completed, fax this form to UCare Health Services Quality & Operations at (612) 884-2094 or Mail to: UCare Health Services Quality & Operations Intake – PO BOX 52, Minneapolis, Minnesota 55440-0052. ***Warning: Because this form contains protected health information (PHI), it must be submitted with a cover sheet with no PHI written on it.***

****Incomplete or illegible forms will be returned to sender.** ***UCare will make every effort to complete the request within 10 business days.***

MEMBER INFORMATION	
First Name:	Member UCare ID:
Last Name:	PMI Number:
Address:	Phone Number:
City/Zip Code:	
Gender: ☐ Female ☐ Male	DOB:
Diagnosis:	ICD-10 Code:

PREVIOUS HEALTH PLAN AUTHORIZATION INFORMATION	
Previous Health Plan:	***Member Effective with UCare on:***
Previous Authorization: Approved *Dates of Service*:	to

PCA/CFSS SERVICES INFORMATION		
PCA/CFSS was authorized at: hours per day		
☐ PCA/CFSS Agency model	PCA/CFSS Units Used:	PCA/CFSS Units Remaining:
☐ PCA/CFSS Budget model	Budget Used:	Budget Remaining:
Provider Name:		
Provider UMPI/NPI Number:	Provider Contact Person:	
Provider Phone Number:	Provider Fax Number:	
Additional Information:		

CFSS CONSULTATION SERVICES INFORMATION	
Number of Sessions Used:	Number of Sessions Remaining:
Provider Name:	
Provider UMPI/NPI Number:	Provider Contact Person:
Provider Phone Number:	Provider Fax Number:
Additional Information:	

Attach these documents along with this request.

- Copy of current approved PCA/CFSS service agreement from previous health plan.
- Copy of most recent PCA/CFSS Assessment and Service Delivery Plan.
- Completed PCA/CFSS Assessment Request Form ***(only if member is due for annual reassessment)***.
- **For Consultation Services:** Copy of Consultation service agreement from the previous health plan.

By affixing my signature below, I attest that the information provided above is true and accurate. I understand that intentional misrepresentation of this information is PCA/CFSS fraud and may result in termination of my provider contract with UCare

Print Name: _____ Signature: _____

Title: _____ Date: _____