Clear Form

PCA/CFSS Provider Change/Notification Request

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form. This form is used to select or change PCA/CFSS and consultation service providers. *Any misrepresentation of this information is PCA/CFSS fraud and may result in a report to our Special Investigation Unit.*

**** For a change in consultation service provider or CFSS PERS service provider, contact the member's UCare Care Coordinator**

*** **UCare will make every effort to complete the request within 10 business days.***

Fax form and any relevant documentation to **612-884-2094**

For questions, **call**: **612-676-6705.** or **1-877-447-4384**

MEMBER INFO

Member Name _____ Member ID _____

PMI _____ Date of Birth _____ Gender: ☐ Female ☐ Male

ICD 10 _____

RELEASE UNITS

Last Date of Service _____

Total Units (Agency) Released/Unused _____

Total Budget (FMS) Released/Unused _____

CURRENT PCA/CFSS PROVIDER

Current Provider Name _____

Date Current Provider was notified _____

Provider Phone _____ Fax Number _____

Name of Releasor _____ Title of Releasor _____

NEW PCA/CFSS PROVIDER

New PCA/CFSS Provider - Delivery Option: ☐ **PCA/CFSS Agency** ☐ **CFSS Budget**

Start / Transfer/ Change Date _____

New provider MUST notify the current provider of this change. Allow an advance transfer/change date of at least 14 calendar days.

New Provider Name _____

Provider NPI or UMPI _____

Provider Phone _____ Provider Fax _____

Name of Requestor _____ Title of Requestor _____

Notes/Comments:

MEMBER ACKNOWLEDGEMENT

By affixing my signature below, I have made a decision for my PCA/CFSS services to be delivered by the new PCA/CFSS provider listed above. I was informed of the transfer process and all of the information above is accurate to the best of my knowledge. I agree that UCare may use and release information regarding my PCA/CFSS services to the new PCA/CFSS provider above.

If member signs with a "X ", signature of Responsible Party (RP) or witness is required. Please note that a PCA/CFSS caregiver or support worker cannot co-sign as a RP or Witness.

Member Signature: _____ Signature Date: _____

Name of RP or Witness: (Print Name) _____ Relation to Member: _____

Responsible Party Signature: _____ Signature Date: _____

PCA/CFSS Provider Notification/Change Request - Instructions

Any misrepresentation of this information is PCA/CFSS fraud and may result in a report to our Special Investigation Unit.

Purpose of PCA/CFSS Provider Notification/Change Request

- To select a new or to change to a different PCA/CFSS provider agency or FMS.
- For a PCA/CFSS provider agency or FMS to release unused units or budget dollars when services will no longer be provided

Release Units

When services will no longer be provided by the PCA/CFSS provider agency and unused PCA/CFSS units are available, PCA provider agency should indicate release of units using this section. *(e.g. termination of service with member, change of agency)*

- Last date of service
- Total units released/unused (based on the total number of units approved on service authorization)

Budget Model

When services will no longer be provided by the FMS provider agency and unused CFSS budget are available, The FMS provider should indicate release of budget using this section. *(e.g. termination of service with member, change of agency)*

- Last date of service
- Total budgets released/unused (based on the total number of units approved on service authorization)

Current PCA/CFSS Provider

This section is not necessary if member never started PCA/CFSS services with another provider.

New provider must complete this section if member's PCA services are approved to another provider agency. New PCA/CFSS provider must notify the current PCA/CFSS or FMS provider of the change and allow an advance transfer/change date of at least 14 calendar days.

- Current provider name
- Date current provider was notified.
- Name and Title of releasor of person spoke with
- Current provider phone number and fax number

PCA/CFSS Delivery

Indicate the delivery option that will be provided to the member.

New PCA/CFSS Provider

- Provider name
- Provider NPI or UMPI number
- Provider phone and fax number
- Name and Title of Requestor from new provider agency.

Start/Transfer/Change Date

Include the date services will begin with new PCA/CFSS provider agency. New PCA/CFSS provider must notify current PCA/CFSS provider of the change and allow an advanced transfer/change date of at least 14 calendar days.

Note/Comments

Include any notes and comments relevant to the change of provider request.

Member Acknowledgement

Member and/or Responsible Party (RP) must sign the change of agency request. If member signs with a "X ", RP or Witness signature(s) is required. PCA caregiver or support worker cannot co-sign this change of agency form as a RP or Witness.

Signatures

All parties required for signatures/date.

- Member
- Responsible Party (RP)/Witness (if applicable)

Foot Notation:
Mn Statute 609.466 Medical Assistance Fraud – Any person who, with the intent to defraud, present a claim for reimbursement, a cost report or a rate application, relating to the payment of medical assistance funds pursuant to chap 256B, to the state agency, which is false in whole or in part, is guilty of an attempt to commit theft of public funds and may be sentenced accordingly.

Home Care Bill of rights: The right to choose freely among available providers; and to change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs.