# 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

ARMHS Provider UCare ID ______________________ 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

Other ARMHS Provider Name _____________________ Phone Number _____________________

Has the member discharged from services with other ARMHS provider?

☐ Yes – Discharge Date ____________ ☐ No

**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*

Please provide details about the collaboration between all involved ARMHS providers

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

**Please submit: Diagnostic Assessment, Functional Assessment and Individual Treatment Plan documents dated within the past year.*

# 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 _____________________

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: ___________________