PCA AUTHORIZATION TRANSFER FORM

FOR PCA PROVIDER USE ONLY: <u>This form is used to request a transfer of a PCA Authorization from the member's previous health plan to UCare.</u> When completed, fax this form to UCare Clinical Services at (612) 884-2094 or Mail to: UCare Clinical Services 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 has up to 14 days from the day we receive this form to process your request.*****

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:

PRIMARY CARE PHYSICIAN INFORMATION	
Physician Name:	Phone:
Primary Clinic:	Fax:

PREVIOUS HEALTH PLAN AUTHORIZATION INFORMATION		
Previous Health Plan:		
Previous Authorization: Approved *Dates of Service*: to		
PCA was authorized at: hours per day	PCA Units Used:	PCA Units Remaining:
Member Effective with UCare on:		

PCA PROVIDER INFORMATION	
PCA Agency Name:	PCA Agency Tax ID:
Agency - UCare Provider ID:	Agency Contact Person:
PCA Caregiver Name #1	PCA Caregiver UMPI #:
PCA Caregiver Name #2:	PCA Caregiver UMPI #:
Agency Phone Number:	Agency Fax Number:
Additional Information:	

Attach these documents along with this request.

- Copy of current approved PCA service agreement from previous health plan.
- Copy of most recent PCA Assessment and Service Plan (DHS-3244 or DHS-3428D-ENG).
- Completed PCA Assessment Request Form ***(only if member is due for annual reassessment)***.

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 fraud and may result in termination of my PCA Provider contract with UCare

Print Name: ______________________________ Signature: ______________________________

Title: ______________________________ Date: ______________________________

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