Clear Form

PCA Provider Notification/Change 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 providers. *Any misrepresentation of this information is PCA fraud and may result in a report to our Special Investigation Unit.*

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 Released/Unused _____

PCA Provider Name _____ NPI or UMPI _____

Provider Phone _____ Provider Fax _____

Name of Releaser _____ Title of Releaser _____

Notes/Comments:

CURRENT PCA PROVIDER

Current PCA Provider Name _____

Date current PCA Provider was notified _____ Spoke with _____

PCA Provider Phone _____

NEW PCA PROVIDER

New PCA Provider - Delivery Option: ☐ **PCA Traditional** ☐ **PCA Choice**

Start / Transfer/ Change Date _____

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

New PCA Provider Name _____

PCA Provider UCare ID _____ PCA 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 services to be delivered by the new PCA 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 services to the new PCA provider above.

If member signs with a " X ", signature of Responsible Party (RP) or witness is required. Please note that a PCA caregiver 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 Provider Notification/Change Request - Instructions

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

Purpose of PCA Provider Notification/Change Request

To select a new or to change to a different PCA provider agency and for a PCA provider agency to release unused units when services will no longer be provided.

Release Units

When services will no longer be provided PCA provider agency and unused PCA 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)
- PCA provider name
- NPI or UMPI
- PCA

Current PCA Provider

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

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

- Current PCA provider name
- Date current PCA provider was notified and name of person spoken with.
- Current PCA provider phone number

PCA Delivery

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

New PCA Provider

- PCA provider name
- PCA provider UCare legacy ID number
- PCA provider NPI or UMPI number
- PCA provider phone number
- PCA provider fax number
- Name of Requestor from new PCA provider agency
- Title of requestor

Start/Transfer/Change Date

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