PCA Provider Change/Notification Request

FOR PCA PROVIDER USE ONLY: This form is used only to select or change PCA providers. Fax completed form to UCare Clinical Services at (612) 884-2094 or Mail to: UCare Clinical Services Intake – PO BOX 52, Minneapolis, MN 55440-0052.
Incomplete or illegible forms will be returned. ***UCare has up to 14 days from the date we receive this form to process your request***.
Warning: Because this form contains confidential information, a cover sheet must be included.

Section 1. UCARE MEMBER INFORMATION

Member Name					
UCare ID#		PMI#		DOB	
ICD-10 Code		Diagnosis			

Section 2. *CURRENT* APPROVED PCA PROVIDER INFORMATION (If applicable)

PCA Provider Name					
Spoken to/Verified Info With		Date		Phone#	

Section 3. NEW PCA PROVIDER INFORMATION AND DATE REQUESTED - New provider MUST notify the current provider of this change. *************Please allow an advance transfer date of 14 days*************

PCA Provider UCare ID		Name of Requestor	
PCA Provider Name			
Phone#		Fax#	
Start/Transfer/Change Date:		Additional Info:	

MEMBER ACKNOWLEDGEMENT

By affixing my signature below, I have made a decision to switch to the new PCA provider on effective date shown in Section 3. 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 above provider in Section 3.

Member Signature: _____ Date: _____

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

Signature of RP or Witness: _____ Date: _____

****If member signs with an "X", signature of Responsible Party (RP) as per PCA Assessment or Witness is required.** ***Please note that a PCA caregiver cannot co-sign as a Responsible Party (RP) or Witness*****

NEW PCA PROVIDER ACKNOWLEDGEMENT

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 contract with UCare

Print Name: _____ Signature: _____

Title: _____ Date: _____

Reference and Instruction: UCare's PCA Provider Change Request Form

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. This form is used only to select, or change PCA Providers. When completed, fax this form to UCare Clinical Services at (612) 884-2094 or Mail to: UCare Clinical Services Intake – PO BOX 52, Minneapolis, MN 55440-0052.

Communication between the PCA providers will be required to complete the PCA Provider Change Request Form.

Section 1. UCare Member Information

- Member Name: Last Name, First Name format
- Member's UCare ID Number *(This information can be obtained by calling UCare Provider Service Center.)*
- Member's Medical Assistance PMI Number
- Member's Date of Birth
- Primary DX Code including ICD10 Codes
  (Please contact Primary Care Physician or ordering Physician for this information.)
- Other DX Codes including ICD10 Codes
  (Please contact Primary Care Physician or ordering Physician for this information.)

Section 2. CURRENT APPROVED PCA PROVIDER INFORMATION

- You may skip this section if the member has PCA services approved but has not chosen a PCA provider.
- Current PCA Provider Name
- Name of person you notified of this change of agency
- Phone number of the current PCA Provider

Section 3. NEW PCA Provider Information and Request - New PCA provider MUST notify current provider of this change, if applicable. (Allow an advance transfer date of 14 days for all change of provider to allow UCare to receive, research, and process.)

- PCA Provider's 6 Digit UCare ID Number
- PCA Provider Name
- Name/Title of person in the new provider agency requesting/submitting the change of agency.
- Provider Phone Number
- Fax Number
- Start/transfer/change date (provider change effective date)
  (Allow an advance transfer date of 14 days for UCare to receive, research, and process.)
- Additional information

MEMBER ACKNOWLEDGEMENT - *Please note that a PCA caregiver cannot co-sign as a Responsible Party (RP) or Witness.*

- UCare member signature and acknowledgement to change of agency
  (If member signs with an "X", a signature of a Responsible Party as per PCA Assessment or Witness is required.)
- Date member signature was authenticated
- Print name of Responsible Party or Witness
- Specify the relation to member of person representing as the Responsible Party or Witness.
- Signature of Responsible Party/Witness
- Date signature of Responsible Party/Witness was authenticated

NEW PCA PROVIDER ACKNOWLEDGEMENT

- Print name of person from NEW PCA provider acknowledging the information provided on the Provider Change Request Form.
- Signature, Title and Date of authentication

Foot Notations:

MN Statute 609.466 Medical Assistance Fraud - Any person who, with the intent to defraud, presents 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 - #10 – The rights 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.