

Complete all applicable sections of the form and fax to AmeriHealth Caritas North Carolina Long Term Services and Supports at 1-833-893-2262. For questions, call 1-833-900-2262.

Step 1 Please select one: New Request Change of Status: Medical Date of Request:

Section A. Beneficiary Demographics

Beneficiary's name: First:		MI:	Last:	Date of birth:
Medicaid ID number:		PASRR number (For ACHs Only):		PASRR Date:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
Address:				
City:	County:	ZIP:	Phone number:	
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18) Name:				
Relationship to Beneficiary:			Phone number:	
Active Adult Protective Services Case? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Beneficiary currently resides:				
<input type="checkbox"/> At home	<input type="checkbox"/> Hospitalized/medical facility	<input type="checkbox"/> Group Home	<input type="checkbox"/> Other:	
<input type="checkbox"/> Adult Care Home	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Special Care Unit (SCU)	D/C date (Hospital/SNF):	
Enter RSVP Service ID #:				

Step 2

Section B. Beneficiary's Conditions That Result in Need for Assistance With ADLS

Identify the current **medical diagnoses related to the beneficiary's need for assistance** with qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List **both** the diagnosis and the ICD-10 code for each.

Medical Diagnosis	ICD-10 Code (Complete Codes Only)	Impacts ADLs	Date of Onset (mm/yyyy)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Step 3

In your clinical judgment, the ADL limitations are: Short Term (3 Months) Intermediate (6 Months)
 Expected to resolve or improve (with or without treatment) Chronic and stable Age Appropriate

Is Beneficiary Medically Stable? Yes No Is 24-hour caregiver availability required to ensure beneficiary's safety? Yes No

Attestation: Practitioner identifies change in need for current PCS services, if applicable:

The beneficiary requires an increased level of supervision.	Initial if Yes:
The beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial if Yes:
Regardless of setting, the beneficiary requires a physical environment that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial if Yes:
The beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial if Yes:

Step 4



Beneficiary Name: _____

MID number: _____

Step 5 Section C. Practitioner Information

Attesting Practitioner's name:	Practitioner NPI number:
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Select one: Beneficiary's Primary Care Practitioner Outpatient Specialty Practitioner Inpatient Practitioner Practice

Name:	Practice Stamp:
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Practice NPI number:	Practice Stamp:
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Practice contact name:	Practice Stamp:
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Address:	Practice Stamp:
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Phone number:	Fax number:	Practice Stamp:
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Date of last visit to practitioner (Must be < 90 days from request date):

Sign here Practitioner signature and credentials: _____ Date: _____

Signature stamp is not allowed

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

**Section D. Change of status: Medical
Complete for medical change of status request only.**

Describe the specific medical change in condition and its impact on the beneficiary's need for hands-on assistance (required for all reasons):

**Change
of Status
Medical**

Practitioner Form Ends Here

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Beneficiary Name: _____ MID number: _____

For non-medical change of status or change of provider requests, complete this page only.

Step 1 Please select one: New Request Change of Status: Non-Medical Date of Request: _____

Step 2

Beneficiary's name: First:		MI:	Last:	Date of birth:
Medicaid ID number:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
Address:				
City:	County:	ZIP:	Phone number:	
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18) Name:				
Relationship to Beneficiary:			Phone number:	
Beneficiary currently resides:				
<input type="checkbox"/> At home	<input type="checkbox"/> Hospitalized/medical facility	<input type="checkbox"/> Group Home	<input type="checkbox"/> Other:	
<input type="checkbox"/> Adult Care Home	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Special Care Unit (SCU)	D/C date (Hospital/SNF):	

Section E. Change of Status: Non-Medical

Change of Status Non-Medical

Requested by (select one): <input type="checkbox"/> PCS Provider <input type="checkbox"/> Beneficiary	
Responsible Party: <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Power of Attorney (POA) <input type="checkbox"/> Family (Relationship):	
Requestor name:	
PCS Provider NPI number:	PCS Provider Locator Code number (three-digit code):
Facility License number (if applicable):	License date (if applicable): (mm/dd/yyyy)
Provider contact name:	Contact's position:
Provider phone number:	Provider fax number:
Email:	
Reason for Change in Condition Requiring Reassessment:	
<input type="checkbox"/> Change in beneficiary's location affecting ability to perform ADLs	<input type="checkbox"/> Change in days of need
<input type="checkbox"/> Change in caregiver status	<input type="checkbox"/> Other:
Describe the specific change in condition and its impact on the beneficiary's need for hands-on assistance (required for all reasons):	



Beneficiary Name: _____

MID number: _____

Section F. Change of PCS Providers

Requested by (select one): Care Facility Beneficiary Other (Relationship to Beneficiary)

Requestor contact's name:	Phone number:
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Reason for Provider Change (select one):
 Beneficiary or legal representative's choice Current provider unable to continue providing services Other:

Change of Provider

Status of PCS Services (select one):
 Discharged/Transferred on _____ (mm/dd/yyyy)
 Scheduled for discharge/transfer on _____ (mm/dd/yyyy)
 Continue receiving services until beneficiary is established with a new provider agency; no discharge/transfer is planned

Beneficiary's Preferred Provider (select one):

Home Care Agency Family Care Home Adult Care Home Adult Care Bed in Nursing Facility SLF-5600a SLF-5600c Special Care Unit

Agency name:	Phone number:
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PCS Provider NPI number:	PCS Provider Locator Code number (three-digit code):
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Facility License number (if applicable):	License Date (if applicable): (mm/dd/yyyy)
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Physical address: