PRESBYTERIAN
Health Plan, Inc.

P.O. Box 27489, Albuquerque, NM 87125-7489
www.phs.org

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New Personal Care Transfer/Closure Form for Personal Care Services Providers

Presbyterian Health Plan Inc. (Presbyterian) is committed to keeping you updated about changes that may affect your practice. This communication contains information regarding the new Medical Assistance Division (MAD) 062 Personal Care Transfer/Closure Form.

Effective immediately, all personal care services providers must begin using the new MAD 062 Personal Care Transfer/Closure Form when requesting any of the following:

- A change in model.
- When a member has not received personal care services for 90 days or has passed away.
- When a member wishes to transfer personal care services agencies.

When a PCS agency transfer request is received, Presbyterian Care Coordination will facilitate outreach to both the current and the receiving agencies to ensure appropriateness and capacity. It is imperative that we receive the necessary signatures as soon as possible to ensure a seamless transition. Please fax completed MAD 062 forms to Presbyterian intake at (505) 843-3150.

Thank you for your continued partnership with Presbyterian. If you have any questions regarding this notification, please contact your Provider Network Management long-term care relationship executive using the contact box below.

Enclosure: Medical Assistance Division (MAD) 062 Personal Care Transfer/Closure Form

Provider Network Management
Hours: Monday through Friday, 8 a.m. to 5 p.m. Phone: (505) 923-5141 www.phs.org/ContactGuide Mailing address: P.O. Box 27489, Albuquerque, NM 87125 Location: 9521 San Mateo Blvd NE, Albuquerque, NM 87113

MEDICAL ASSISTANCE DIVISION
PERSONAL CARE TRANSFER/CLOSURE FORM

Date: ____/____/____

Consumer Name: ____ Consumer Date of Birth: ___________

TRANSFER

You are currently receiving Personal Care Services through: ____.
You have indicated that you want to change your Personal Care Agency to: ______________________________.
The reason you would like to transfer agencies is because:

____

____

The agreed date of the transfer is _________________________. By signing this form, all parties agree the above to be true and agree to this transfer. If someone other than the consumer is initiating the transfer, the Personal Care Agency must have verification on file that the person is the consumer's legal representative. All signatures must be present to validate the transfer.

_______________________________ ____/____/____ _______________________________________
Consumer/Legal Guardian Signature Date Consumer's Street Address

______________________________ _______________________________________
Consumer/Legal Guardian's Phone # City, State, Zip

_______________________________ ______________ ________________________ ____/____/____
Receiving Agency Name Provider Phone # Agency Signature Date

CLOSURE

____
Reason

_______________________________ ______________ ________________________ ____/____/____
Agency Name Provider Number Agency Signature Date

If you have any questions about Personal Care, you may contact your assigned Managed Care Organization (MCO).

TO BE FILLED OUT BY THE MCO ONLY

____/____/____ ____/____/____ ____/____/____ ____________________ ______________
Review Date Effective Date Expiration Date Authorization Number MCO

MCO Care Coordinator name:____.

Date copy of completed transfer form sent to the ***originating*** agency ____/____/_____.

Date copy of completed transfer form sent to the r***eceiving*** agency ____/____/_____.

Date ending authorization sent to the ***originating*** agency ____/____/_____.