Nevada Medicaid and Check Up

# Personal Care Services Recipient Request for Provider Transfer

**Purpose:** Use this form to verify a recipient's request to transfer to another provider. All fields, signatures and initials must be completed and are required for processing of this transfer request. Provider is required to submit verification of release of information. Incomplete forms will not be acted upon.

Upload this request through the Provider Web Portal. **Questions? Call:** (800) 525-2395

**DATE OF REQUEST:** _____ /_____ /_____

**SECTION I: RECIPIENT INFORMATION**

*The Recipient, Legally Responsible Individual (LRI) or Personal Care Representative (PCR) must complete Section I. Indicate the reason for the transfer, initial the items below to indicate an understanding of the changes that may occur due to the transfer and sign the form.*

| Last Name: | First Name: |
|---|---|
| Medicaid ID: | Date of Birth: |

Reason for transfer of service to new provider: _____

_____

**Recipient/LRI/PCR must initial, complete the following and sign below:**

_____I/LRI/PCR understand that services will be terminated with my current personal care services agency: *(agency name)*_____and I have notified my current agency of my last date of service with them. I understand that I am authorized to receive service from only one agency at a time.

_____I/LRI/PCR understand that selecting a new agency may result in a new personal care assistant.

_____I/LRI/PCR understand that a request for transfer will not result in a change in my current personal care hours.

_____I/LRI/PCR have NOT been offered nor have I received financial incentives to authorize this transfer.

_____I/LRI/PCR for the Medicaid recipient identified above certify that I have completed this form and understand the actions that will take place upon my signature.

Recipient/LRI/PCR: *(print name)*_____

Relationship to Recipient:_____

**Recipient/LRI/PCR Signature:** **Date:**

**SECTION II: NEW PROVIDER INFORMATION**

*The provider must complete Section II. Be sure to complete the effective dates and sign the form.*

| New Provider Name: | |
|---|---|
| New Provider Agency NPI: | New Provider Agency Phone Number: |
| Last Date with Current Provider: | |
| Start Date with New Requesting Provider (*the day after the last date with current provider*): | |
| Additional comments or contact information not specified above *(that would assist in the completion of this request):* | |

**The Individual Representative from the New Provider must initial the following and sign below:**

_____I have met with the recipient and provided the recipient with a copy of our agency's policies and procedures.

_____No information has been provided to the recipient implying that a failure to transfer will result in consequences such as a decrease in PCS hours, loss of Medicaid eligibility or that the current/existing agency is now unable to provide services.

_____No financial incentives have been made or offered in relation to this transfer request.

_____No assurances regarding an increase in PCS hours have been made to the recipient.

Individual Representative from New Provider (*print name*):_____

**Provider Signature:** **Date:**

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