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Service Request Form for Statewide Medicaid Managed Care Long-Term Care Program Enrollees

Today's date: ______________________________
Requesting provider's name: ______________________________
Provider's contact name and title: ______________________________
Provider's phone number: ______________________________
Provider's fax number: ______________________________

Member's name: ______________________________
Member ID: ______________________________
Date of birth: ______________________________
Case manager's name (if known): ______________________________
Case manager's phone (if known): ______________________________

Service type (i.e., home health, respite, bath visit, assisted living, nursing home, etc.)	Procedure code/ rev code	Frequency and duration	Requested start date/times

Comments or additional information:

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Please fax this form to [1-888-762-3220].