Health Homes (HH)
Managed Care Organizations (MCOs)
Notification Form

Please print clearly or complete electronically — accuracy is important.

Complete this form to report enrollment of a member in your health home, the transfer of a member from the Iowa Department of Human Services (DHS) or another MCO, a change in tier for a member, or disenrollment of a member from your health home.

Please check the box by the impacted MCO and submit form as directed below:

☐ **Fax to Amerigroup Iowa Inc. at 1-844-556-6125.**

☐ **Fax to AmeriHealth Caritas Iowa at 1-844-280-9130.**

☐ **Email to UnitedHealthcare Plan of the River Valley Inc. at uhc_iowa_healthhomes@uhc.com or fax to 1-855-237-0574.**

Check one:	☐ Other (specify)	Reason for change (see back of this page if disenrollment):
☐ Enrollment ☐ Change in tier ☐ Disenrollment		Effective date of change:

Section 1: Member Information

Name:	Date of birth:	Phone:
MCO-Assigned Member ID #:	Medicaid Member ID #:	
Home Address:		

Section 2: Provider Information

Health Home Name:
National Provider Identifier (NPI) #:
MCO-Assigned Provider #:
Primary Care Provider:

Section 3: Enrollment

Integrated Health Home (check all that apply)

☐ Psychotic Disorders
☐ Schizophrenia
☐ Schizoaffective Disorder
☐ Major Depression
☐ Bipolar Disorder
☐ Obsessive-compulsive disorder
☐ Delusional Disorder
☐ Serious Emotional Disturbance in Children
☑ Mental Health Condition Resulting in Functional Impairment

Note: Explain functional limitations on the back of this page.

Tier Level (check one)
☐ 5. Adult Non-Habilitation
☐ 6. Child Non-Children's Mental Health (MH) Waiver
☐ 7. Habilitation
☐ 8. Children's MH Waiver

If Tier 7 or 8, assessment date:

Chronic Condition Health Home (check all that apply)

☐ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI over 25 or child BMI >85th Percentile
☐ Hypertension
☐ At risk for another condition (list risk):

Patient Tier Assessment Tool (PTAT)

Assessment Date:

Tier Level (check one)
☐ 1 – 3 Conditions
☐ 4 – 6 Conditions
☐ 7 – 9 Conditions
☐ 10+ Conditions

Health Home Case Manager signature:	
Phone:	Date:

Submission of enrollment form does not guarantee enrollment or payment for the health home. Members must meet Iowa Medicaid eligibility guidelines for successful enrollment.

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Reason for Disenrollment (check one)	
☐ Member requested.	☐ Member is effectively self-coordinating services.
☐ Member not participating or provider unable to reach.	☐ Member is deceased.
☐ Member changed MCOs or DHS.	☐ Member has lost Medicaid eligibility long term.
☐ Member transferred to another health home.	☐ Provider requested.
☐ Member moved from the area.	☐ Provider terminated member enrollment.
☐ Member no longer meets criteria for health home.	

Explain Functional Limitations: