Clear Form

Minnesota Department of **Human Services**

DHS-4074A-ENG 7-12

Minnesota Health Care Programs (MHCP)

Personal Care Assistance (PCA) Technical Change Request

Complete and fax this form to 651-431-7447 to request a technical change to an existing approved PCA service authorization (SA) for your agency. Complete and fax the Referral for PCA Services to the PHN to request a new authorization or report a change in condition.

Request Type (request for your agency only) Change/Start Date __ __/__ __/__ __ __ __ End Date __ __/__ __/__ __ __ __

- ☐ Provider Change (select one):
  - ☐ New provider (requires Recipient/Responsible party signature below)
  - ☐ Discontinuing provider – Total number of units to release _____
- ☐ Other (Explain in the additional information section):
  - ☐ Report change in Responsible Party
  - ☐ Reprocess SA __ __ __ __ __ __ __ __ __ __ __ __ due to update in eligibility or living arrangement
  - ☐ Partial Release of Units due to multiple providers
  - ☐ Reconsideration
  - ☐ Reinstate as enrollment record update __ __ __ __ __ __ __ __ __ __ __ __
- ☐ Duplicate copy of SA __ __ __ __ __ __ __ __ __ __ __ __
- ☐ Health Plan Disenrollment (PMAP lapse). Diagnosis: ____._____ ____._____ ____._____ (Attach a copy of the MCO authorization)

Recipient Information

LAST NAME	FIRST NAME	MI	SUBSCRIBER ID	DATE OF BIRTH
			__ __ __ __ __ __ __ __	__ __/__ __/__ __ __ __

☐ PCA Traditional ☐ PCA Choice

Provider Agency Information

AGENCY NAME		AGENCY NPI/UMPI
		__ __ __ __ __ __ __ __ __ __
NAME/TITLE OF REQUESTOR	**PHONE NUMBER**	**FAX NUMBER**

Additional Information

Recipient/Responsible Party – Required only when "New Provider" change requested

NAME (please print)	RELATIONSHIP TO RECIPIENT	DATE CHANGE IS REQUESTED	DATE CURRENT PROVIDER WAS NOTIFIED
		__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
SIGNATURE OF RECIPIENT/RESPONSIBLE PARTY			**DATE**
			__ __/__ __/__ __ __ __

Personal Care Assistance (PCA) Technical Change Request

Purpose of PCA Technical Change Request

To request technical changes and corrections to existing SAs for some Personal Care Assistance (PCA) services.

Eligibility

Verify MA eligibility using MN–ITS or call 651-431-4399 or 800-657-3613.

Third Party Payers

MA is the payer of last resort. Information regarding other payers is available through EVS.

Form Instructions

Request Type

Select the type of change or correction you are requesting. Refer to Authorization Requirements in the PCA section of the MHCP Provider Manual for additional information.

Enter the Change/Start and End Dates.

Recipient Information

- Enter complete legal name
- Enter the 8 digit Subscriber ID number (also known as MA number and recipient ID)
- Select PCA Traditional or PCA Choice
- Enter the date of birth

Provider Agency Information

- Enter the PCA Agency name
- Enter PCA Agency NPI/UMPI
- Enter name and title of the person submitting the request
- Enter the PCA Agency phone number
- Enter the PCA Agency fax number

Additional Information

Enter additional information regarding the request.

Recipient/Responsible Party Signatures

Required when "New Provider" request type.

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2670, toll-free 800-657-3739, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

651-431-2670 or 1-800-657-3739

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0005 (3-13)