DSS-MS-103-02/02

MEDICAID MANAGED CARE PROVIDER FORM

State Office Use Only

Case Number:______________________ **County:**________________________

Benefit Specialist:________________________ **User ID:**______________________

Annual Redetermination:_____________ **County Transfer:**_______________

BENEFIT SPECIALIST USE ONLY

CHANGE FORM

SECTION 1 – GOOD CAUSE REASONS

When requesting a change in your Primary Care Provider selection **you must clearly state your reasons for requesting a change in detail.**

I request a change of my Primary Care Provider for the following "good cause" reason(s) (check as many as apply): You must include dates, times, length of waits, specific details, etc. If you FAIL to include the specific information, your change request WILL BE DENIED. ALL CHANGE REQUESTS FOR "GOOD CAUSE" REASONS ARE SUBJECT TO APPROVAL BY SD MEDICAID.

_______Long waiting periods to see the Doctor
_______Not being referred (authorized) to specialists when medically necessary
_______Doctor (or on-call staff) not available 24 hours a day, 7 days a week
_______Other____

Use the back of this form to give dates, times and specific details relating to the above indicated change reasons.

NOTE: IF YOUR CHANGE REQUEST IS APPROVED, YOUR NEW PCP DOES NOT TAKE EFFECT IMMEDIATELY. CHANGE APPROVALS ARE EFFECTIVE ON THE FIRST DAY OF THE MONTH AFTER APPROVAL.

SECTION 2 – NEW PRIMARY CARE PROVIDER(S)

	RECIPIENT'S NAME	RECIPIENT ID NUMBER	PRIMARY CARE PROVIDER NAME	PROVIDER PCP CODE
0				
1				
2				
3				
4				
5				
6				

I understand the Managed Care Program rules and requirements and also understand that by not following those rules and requirements I may be responsible for payment of medical bills. Refer to your *Recipient Handbook* for more information.

Recipient's Signature_______________________________________ Date______________________

Recipient's Telephone Number__________________________________