DSS-MS-102-01/25

CARE MANAGEMENT PROVIDER SELECTION/CHANGE FORM

Case Name:___________________________________ **Case Number:**_____________________ **County:**______

Providers may also be selected **online at https://pcphhselection.appssd.sd.gov/**

NOTE: All Care Management eligible family members do **not** have to choose the same provider.

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I understand that:

- I MUST choose a Care Management Provider for each eligible Medicaid family member by completing the section below AND returning the completed form to the Department of Social Services.
- If I do not choose a Provider, the State Medicaid Program will choose a provider for me and all other eligible family members.
- Providers with an asterisk * next to their name have a full caseload. If the provider has a full caseload, written approval from the provider is required to choose that provider. Without written approval, a different provider will need to be selected.
- I may change my provider at any time. All requested changes will become effective the 1st of the next month.
- In order to receive reimbursement for travel to appointments, please choose the closest provider that can provide the services needed.

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	MEDICAID RECIPIENT'S NAME (Family members eligible for Medicaid)	**MEDICAID CARD NUMBER**	**DATE OF BIRTH**	**PROVIDER NAME** (from Provider list)	**PROVIDER ID #** (from list)
0					
1					
2					
3					
4					
5					
6					

If you are pregnant, please provide your due date: ________________________

If requesting a change in your Care Management Provider, please state your main reason for requesting a change:

____ Long waiting periods to see the Provider
____ Not being referred (authorized) to specialists when medically necessary
____ Provider (or on-call staff) not available 24 hours a day, 7 days a week
____ Dissatisfaction with Provider
____ Provider not accepting new patients
____ Moved to new area
____ Other____

NOTE: ALL PROVIDER SELECTION AND CHANGE FORMS WILL TAKE EFFECT THE FIRST DAY OF THE MONTH FOLLOWING THE DATE THIS FORM IS RECEIVED.

I understand the Medicaid Care Management Program rules and requirements and also understand that by not following those rules and requirements, I may be responsible for payment of medical bills.

Signature______________________________________ **Date**______________________

Telephone Number______________________________